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Tuesday 31 January 2006

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Mardi 31 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
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 31 January 2006

Mardi 31 janvier 2006

The committee met at 0902 at the Four Points by Sheraton, London.

COMMITTEE BUSINESS

The Chair (Mr. Mario G. Racco): Welcome to London. We are here on our second day hearing deputations on the LHIN act. We are happy to be in London, Ontario. Our first deputation is from the Oneida Nation of the Thames.

The Clerk of the Committee (Ms. Anne Stokes): They're not here yet.

The Chair: They're not here yet. Ms. Wynne?

Ms. Kathleen O. Wynne (Don Valley West): I'm wondering if we could deal with this item of business just very quickly, the motion regarding February 15 and the clause-by-clause for Bill 210. Would you like me to read it?

The Chair: Fine, for the record.

Ms. Wynne: I move that the standing committee on social policy meet on Wednesday, February 15, 2006, for clause-by-clause consideration of Bill 210; that the deadline for amendments be noon on Friday, February 10, 2006; and that the committee request the House leaders' authority to sit on February 15, 2006, outside its normally scheduled meeting time.

The Chair: Any debate? Any questions? Anyone in favour of the motion? Anyone opposed? The motion carries.

Should we move to the second presentation, if they're in attendance? It is Addictions Ontario. Anyone here? None? How about the Canadian Union of Public Employees? Is anyone present here with us this morning who has to make a deputation? No one? Well, if that is the case, then unless there is any other new business, we'll just wait until the first deputants show—unless any of you have anything else that you want to debate or discuss. So until I recall, you can have a break. That's a good way of starting the day.

The committee recessed from 0904 to 0909.

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.

ADDICTIONS ONTARIO

The Chair: Good morning again. We will restart the meeting. I understand that Addictions Ontario has arrived, and I ask that you please make your deputation. Since our first deputant is not here yet, we thank you for starting earlier.

Mr. Jeff Wilbee: Our pleasure, sir. Good morning.

Ms. Catherine Hardman: Good morning. I'd like to thank you for this opportunity to make this brief presentation to you today. I am Catherine Hardman. I'm the president of Addictions Ontario, which is an organization representing over 120 addiction service agencies and resources across Ontario. My colleague is Jeff Wilbee, the executive director of Addictions Ontario.

We wish to make several points regarding Bill 36. First of all, Addictions Ontario supports Bill 36 because we believe authorities operating at a level of aggregation smaller than the province as a whole and with a mandate to promote service integration and coordination are necessary. We say this for two reasons. Many clients of addiction services have multi-dimensional needs, not all of which can be met by addiction services. Accordingly, a more integrated service system would expedite access by our clients to other health services they need. Many users of other health services have problems that are caused by, or made worse by, their substance abuse or problem gambling issues. A more integrated system would expedite access by these other service users to the services of the addiction system.

Much service integration has already taken place as a result of efforts by addiction service providers to work in co-operation with each other and with other parts of the health system. The creation of LHINs legitimizes, supports and extends these efforts.

We have concerns about the vast geographical areas covered by some LHINs. We recognize that the determination of LHIN boundaries was made as a result of an analysis of population sizes and hospital service patterns. However, we do not believe that a LHIN can be considered local when, for instance, it covers an area stretching from the border with Michigan to the shores of James Bay. Indeed, the LHIN that we are in today, the southwest, encompasses Tobermory to St. Thomas. In

effect, LHINs are regional rather than local in terms of focus and area covered.

We note, however, that Bill 36 contains flexibility to allow LHINs to evolve, if and when necessary, into bodies that are truly local in nature. The bill specifies that, "The Lieutenant Governor in Council may, by regulation, amalgamate or dissolve one or more local health integration networks, or divide a local health integration network into two or more local health integration networks."

Bill 36 also seems to contain sufficient flexibility to allow the creation of both local and regional capacity to create a more integrated system. This flexibility seems inherent in the bill's provision, section 6.3, that "A local health integration network shall not exercise the following powers without the approval of the Lieutenant Governor in Council ... creating a subsidiary." We interpret this to mean that a LHIN can, in fact, create a subsidiary provided that the LHIN has prior approval of the Lieutenant Governor in Council. If our interpretation is correct, we welcome this flexibility in Bill 36.

Under Bill 36, a LHIN is empowered, under certain conditions, to make an integration decision about a health service provider that would cause the provider to effectively cease to be a LHIN-funded service provider. For many service providers who rely entirely or almost entirely on LHIN funding to operate, this would be tantamount to causing them to cease to exist as a service provider, even though the LHIN could not cause them to cease to exist as a legal entity.

Bill 36 provides an appeal process for the provider after such a decision has been made by the LHIN. However, it does not require the LHIN, in advance of the decision, to consult with, meet with or otherwise engage the provider in any discussion of factors that would lead to the decision under consideration by the LHIN. A requirement to consult with and enter into discussion with a provider prior to such a decision by a LHIN should be included in the legislation.

We can envision situations in which a LHIN is concerned about the operation of a provider and the LHIN may consider making a draconian decision as a way to deal with this concern. However, we believe a degree of negotiation between a LHIN and a provider to determine if there is an appropriate and mutually acceptable way to deal with the concern is the preferred starting point for resolving any such concern.

Embedding in Bill 36 a notification and discussion provision would not prevent a LHIN from ultimately making a decision if it is not satisfied with the result of the discussion; nor would it prevent the provider from making an appeal to the LHIN after such a decision is made.

Subsection 16(1) of Bill 36 refers to engagement of community. The role of networks, LHIN region or broader, in the health care system is important in setting standards and providing voices for providers, their clients and members of their families. A liberal interpretation of this subsection clearly should include the input of networks, but we are concerned that a more conservative view could exclude input from this very valuable resource.

We therefore recommend that the term "community" be defined in section 2, with the definition including "networks" and "provincial associations."

We are concerned that the wording of subsection 16(2) of Bill 36 limits participation in the advisory committee process to regulated health professionals. It has been estimated that there are over 40,000 counsellors and therapists offering quality services to clients in the addiction and mental health field who will not have a voice at the LHIN. In fact, most of the human resources dealing with those suffering from addiction and mental health problems are not regulated.

We therefore recommend that the wording of the section be amended to delete the term "regulated."

Section 28 gives the minister a number of powers, all of which he or she is required to exercise in the public interest. Previous legislation, recently enacted, provides some guidance to the interpretation of the term "public interest."

We would recommend that the wording of Bill 8, the Commitment to the Future of Medicare Act, 2004, be incorporated into this legislation and that the wording further includes "prevention," "brief intervention" and "determinants of health."

We note that under Bill 36 the objects or purposes of CCACs remain largely the same but with the addition of a sixth object: "To carry out any charitable object that is prescribed and that is related to any of the objects described in paragraphs 1 to 5."

Many health care providers are concerned that the role of CCACs will change into placement management and case management activities in service areas in which CCACs are not currently involved; that they will become the first point of contact for a broader array of services, without consideration to the systems already in place, such as in the case of the addiction treatment system. It is the view of Addictions Ontario that a good therapeutic relationship leading to positive recovery outcomes is established at the very earliest contact with the client, including screening, scheduling and assessment processes, and that the CCAC resources and organization are not a clinically appropriate mechanism.

In conclusion, our above comments are made within the context of our support for LHINs. However, we believe that the pragmatic issues of the LHIN boundaries, as well as issues related to procedural fairness, openness and respectful dialogue, should be acknowledged as part of the language and intent of Bill 36. Thank you.

The Chair: Thank you. There are about four minutes left and we'll allow some questions.

Mr. Ted Arnott (Waterloo–Wellington): Thank you very much for your interesting presentation. As I understand it, the LHINs, assuming this bill passes, will be empowered to make local health resource allocation decisions. As you pointed out, in some cases perhaps a LHIN might be deciding to transfer resources from a

hospital, let's say, to put more money into home care, if that's needed in the local community. But you've talked about the appeal issue and you've said that if indeed an appeal is launched on one of these decisions, there should be a requirement for the LHIN to at least engage the parties in some meaningful discussion so as to acquire additional information. I would certainly agree with that.

Yesterday we heard from one of the groups, and I forget which one it was, that said it doesn't make sense, if you're going to appeal a LHIN decision, to appeal right back to the same people who made the decision. Would you agree with that, that there needs to be some alternative organization set up—an appeals board, I guess you'd call it—to deal with these kinds of appeals?

Ms. Hardman: I would certainly agree with that. I think they're quite right in saying that you're appealing back to the organization that has already made the decision. So an appeals board would make sense.

Mr. Wilbee: Further to that, Mr. Arnott, we are also suggesting that there needs to be some provision for discussion prior to that. There need to be some checks or controls there if in fact the LHIN was unhappy with the service provider. We'd want to see some kind of mechanism that is resolved before a decision is made, but not in any way negating the ability to appeal to an arbitrator.

Ms. Shelley Martel (Nickel Belt): Thank you for being here. Further to that, you'd probably want some kind of provision whereby the public could have some say in where the LHIN is going. There's no provision right now for any kind of input from the public—consumers, patients etc.—when the LHIN makes a decision to integrate a service, end a service, consolidate services etc. Any discussion happens essentially with the service provider after the fact, as you pointed out.

I want to ask you about the CCACs, though, because it is very clear that the CCACs are angling to have a greater role in the provision of service. That came through yesterday in a presentation that was made to us by the Association of Community Care Access Centres, but also I saw a document that they produced last summer that talked about a greater case management role. Tell the committee what your concerns would be—you've outlined them briefly—because I've heard concerns like this before from other addiction agencies closer to my home, which is in northeastern Ontario, that they're not really interested in seeing the CCAC have a greater role in case management. Do you want to flesh that out for us?

Ms. Hardman: Sure. At this point, the CCACs really have no interface whatsoever with the addiction treatment system. It's not a system that they know. We have a very well orchestrated system in regard to referral and intake and assessment and that sort of thing. So to have an organization take on that piece when they really don't have any knowledge of it at this point would probably just complicate the system more, and I think also it would have a negative impact on the clientele. As we said, on the first point of contact we start forming our relationship with people. Also, often these people are in severe crisis and really are needing assistance immediately. So to kind of complicate that mechanism or put another barrier, another wall up there for them, I think would be detrimental to them. I don't know if Jeff has something to add.

0920

Mr. Wilbee: No, I think you covered it. The essence is that you have to deal with people as they present. That doesn't mean to say that somewhere down the line—that is not to take away the good work that CCACs do. I think we would add, though, that we feel this is a specialized area. First of all, good assessment is not just the tools that are used, but that rapport that is built very quickly with skilled counsellors in this particular specialized area of addictions.

Ms. Wynne: Just on that point, I think it's important—as recently as yesterday I spoke to the minister, and his vision of what the LHINs are going to do and what is laid out in this legislation is that they're going to have a coordinating and planning function, and I think that's critical. We've had district health councils that—somebody described them yesterday as bears without teeth or something. There was the planning function but there was no way to implement the plans. So what we envision the LHINs doing is coordinating and planning and figuring out where the gaps are and then moving to fill those gaps. So it's not a consolidation of services that's envisioned, but it's a coordination of services. Integration doesn't mean consolidation. I think we have to bear that in mind.

Thank you very much for your presentation. There are some very interesting points. On the issue of the pre-decision negotiation mechanism, I just wanted to ask you about the language that is in the object. It's part II, section 5 of the bill, clause (c): "to engage the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal channels for community input and consultation." It seems to me that it's in that planning function that the entities and the public will be engaged. I guess as a member of the government and as a citizen, I'm putting my eggs in that basket in terms of the rational process that the LHIN will engage in. Can you just speak to that section and how you might change it or add to it or whether it suffices?

Mr. Wilbee: I'm not sure whether it suffices or not. I think that's part of the debate that goes on here.

Again, this is dealing with language and I think we're concerned about, what does it mean to be community, what is that kind of consultation, where will the input be? One of our concerns, of course, is even around the advisory. Do you want the language to restrict the broad experience that we have? In trying to answer that, we even have concerns around the terms of only those professions that are named under the regulatory act. If that's to be legislated, then in fact we would restrict a wealth of information that would assist that planning. So I think that we're concerned around the language: What does community mean, what is that consultation, who are the experts who should be spoken to?

Ms. Wynne: I understand. Actually someone made the point yesterday about that advisory committee. So thank you very much.

The Chair: Thank you very much for your presentation.

ONEIDA NATION OF THE THAMES

The Chair: The next presentation will be from the Oneida Nation of the Thames, Chief Randall Phillips. Good morning, Chief.

Chief Randall Phillips: Good morning, Mr. Chair. How are you?

The Chair: Very well, thanks.

You can start any time, sir.

Chief Phillips: Good morning, members. It's an honour to be here in front of you today. I have a prepared text and I've made copies of it so it will be available for you.

The Chair: They are distributing it to us.

Chief Phillips: I hope that all members are in good health and spirit. I would like to thank you for the opportunity to speak to you here today. As the elected Chief of the Oneida Settlement, it is nice to welcome you to traditional Iroquoian hunting territory. My name is Randall Phillips and I am a member of the Bear clan of the Oneida Nation of the Thames Settlement.

I wish to take this opportunity to inform the members that this submission is presented in my capacity as an elected Chief of the Oneida Nation of the Thames First Nation community. This system of elected representation and governance through the Indian Act was imposed on our community in 1934. I make this distinction to recognize the legitimate role and responsibility of the clan mothers and titleholders of the Oneida Nation to deal with nation issues and to provide reassurance that I'm not here to represent those nation interests. Rather, I make this presentation as a duly authorized representative of the Oneida Nation of the Thames First Nation settlement, as recognized under current federal legislation.

I wish to make the following comments regarding Bill 36, An Act to provide for the integration of the local system for the delivery of health services, and the creation of local health integration networks.

As that recognized representative, it is also, in part, my responsibility to ensure that the rights of the Oneida people, whether they be treaty or aboriginally based, are protected against any federal or provincial encroachment through legislative or other means. It is, and has always been, our assertion that the governments must recognize health as an existing aboriginal and treaty right. Based on that assertion, it is my further responsibility to ensure that any service or program, health or otherwise, that is related to or is a consequence of this right is also protected. There is no difference if that service is delivered through federal or provincial sources. It is in that sense of protection and responsibility that the following comments are made. I'd also like to say that, given the short amount of time, we won't be able to address all the concerns we have.

Bill 36 is designed specially to transfer the decision-making responsibility from the Minister of Health and Long-Term Care into the hands of a government-appointed local board of directors. This board of directors will have the authority to determine what health service will be available, when it will available and who will deliver that service. This authority will be confirmed and exercised via the financial controls available to the LHIN boards provided through the legislation. This transfer will formally recognize the role of the LHIN boards in establishing local health priorities and the allocation of resources to address those priorities. Although the minister may still intervene if necessary, the responsibility to implement change on the access to and availability of health services at the local level lies solely with each of the 14 regionally based LHIN boards. It is this transfer of responsibility, with seemingly no regard for First Nations, that I wish to address.

In the spring of 2005, I was made aware of a presentation that was made by Barbara Hall, a member of the health transition team, to the Health/Social Advisory Board of the Association of Iroquois and Allied Indians. The AIAI consists of eight First Nations communities and is recognized as a regional organization by the federal government. Oneida is one of those eight communities. H/SAB is made up of various health program and social program directors at the community level. It is H/SAB's responsibility to review and bring forward issues to the AIAI chiefs for information and direction.

The H/SAB members raised some initial concerns with the LHIN presentation. Subsequently, these concerns were raised by the AIAI health director to the health coordination unit at the Chiefs of Ontario Office. Representatives of the Chiefs of Ontario Office then met with the minister to discuss these concerns. Initially, the minister outright objected to all the recommendations brought forward by the Chiefs of Ontario Office. Upon further reflection, the minister did agree to establish a First Nations task force to identify the concerns and real/potential impact on First Nations and First Nations health programs with respect to these LHINs. The First Nations task force included representatives from First Nations political organizations, including political and technical representation. I was appointed as a political representative for the AIAI chiefs' council. Janet Brant-Nelles, from the Mohawks of the Bay of Quinte, was appointed as the technical representative. The task force began its review of the available information on LHINs in September 2005. We were given a two-month time frame to report back to the minister. That report was delivered to the minister at the end of November.

I just want to take time to acknowledge the work of those task force members in dealing with that report. There was an awful lot of information that we had to cover in a very short period of time, and I think the report reflected that.

I would like to talk a little bit about the process. With regard to process, I would suggest that the actions taken

by the Ministry of Health and Long-Term Care in the early stages were not designed to specifically address First Nations health concerns nor the integration of First Nations health services and programs. First Nations were regarded as mere stakeholders in this process. This stakeholder status directly conflicts with the duty of the crown in dealing with First Nations with respect to consultation. Recent Supreme Court decisions confirm this fact. Given the unique fiscal arrangements that exist between First Nations communities and the crown regarding the delivery of health services, direct consultation would have seemed prudent.

0930

This made-in-Ontario health reform was taking place in the midst of ongoing discussions relating to a first ministers' meeting on aboriginal issues, which included substantial investments and discussions in the area of health. The position put forward by First Nations at the first ministers' meeting was captured in a document entitled First Nations Blueprint to Health. This blueprint called for a specific First Nations stream; a process to discuss these very issues and concerns, like the creation of new health institutions like LHINs and how they would impact on First Nations health services. The first ministers' meeting was about inclusion of First Nations, not exclusion.

In reviewing this government's own documents with respect to aboriginal policy, I have found further evidence that First Nations are not treated in the government-to-government manner that the policy outlines. This lack of direct consultation with the First Nations of Ontario on this issue is a breach of that policy and totally disregards our involvement in planning for our future health needs. The absence of direct consultations with First Nations must be addressed.

First Nations health services are provided through a complex process of funding arrangements, designed to deliver a variety of health services in a culturally appropriate manner and environment. Responsibility for the primary health care needs of First Nations people rests with the federal government. Recognizing the right to determine the best method to address the health needs of First Nations is formally expressed through contribution agreements with the federal government. These contribution agreements are administered by Health Canada and the First Nations and Inuit health branch.

In other instances, health care services for First Nations are funded by the provincial government. The aboriginal healing and wellness strategy is an example of funding through contributions of several provincial governments. This strategy is designed to provide funds for various aboriginal health-related programs. This funding can either enhance an existing service or be directed towards addressing another need. Although the minister has provided some assurance that the funding for the AHWS will not be subject to the LHINs, we anticipate that it is temporary, as there is only a five-year contribution agreement to deal with LHINs.

In yet other circumstances, the province receives federal funding which includes First Nations populations and must ensure access to these services. It is difficult to determine how these resources are allocated to improve access and availability of existing health services to benefit all First Nations people.

Given these complexities, it is prudent, if not necessary, to discuss the impact of creating new decision-making bodies that would be directly responsible for the allocation of health resources without specifically including a process that would include First Nations. The failure to address the unique funding arrangements of First Nations health programs and services must be addressed.

The legislation makes reference to First Nations only in the preamble, with this statement: "The people of Ontario and their government....

"(e) recognize the role of First Nations and aboriginal peoples in the planning and delivery of health services in their communities...."

This statement clearly identifies that First Nations should be included. However, the evidence with respect to exclusion is contained in the body of the legislation. Nowhere in the legislation are First Nations mentioned. First Nations health programs and services are not mentioned. There is no requirement for LHIN boards to consider First Nations. There is no requirement for the minister to deal with First Nations issues. There is no mention of any mechanism that would directly involve First Nations or include their participation. Yet the legislative preamble recognizes the role in planning and delivery. It should be removed, and the preamble should only contain a non-derogation clause with respect to the recognition of aboriginal and treaty rights.

In order for the proper consultation to occur with First Nations regarding the impact of this change in the delivery of health services, I would suggest that a separate First Nations process be established. In the interim, I would support the following legislative placeholders. The exact wording could be drafted by our technicians.

(1) "First Nations health programs and services are exempt from this legislation."

To ensure that existing and future First Nations health programs and services remain available to meet the health needs of the people and are not threatened by LHINs in the future, the legislation should clearly provide an exemption for First Nations health programs and services.

(2) "The minister can enter into specific agreements with First Nations health providers."

To ensure that First Nations people are not excluded from any increase or enhancement of LHIN-sponsored health services by the Ontario government, the minister should retain the ability to enter into specific funding agreements with First Nations representatives. This provision is also included in other provincial legislation regarding health integration.

(3) "LHINs must identify a separate process to include First Nations health providers."

To ensure that First Nations are included in local planning of health services and other public health concerns, the legislation must direct the LHINs boards to develop mechanisms to include First Nations.

(4) "LHINs can enter into specific agreements with First Nations health providers."

To support the development or enhancement of the integration of First Nations health services with the LHINs, the legislation should recognize a mechanism to provide resources to a First Nations health service provider.

The legislation was presented to the House without addressing any of these concerns. I know we had talked and sent a letter to the minister on these. It's my experience in dealing with these legislative processes that it becomes significantly more difficult to make these kinds of changes that are being introduced.

Now, I'm here to convince the members to ensure that the legislation presented for your review will address our concerns before it is returned to the House for third reading and final approval. Committee members must also uphold the honour of the crown.

In closing, I've got two more recommendations for committee members' consideration:

(1) I would further recommend that committee members endorse the continuation of the LHINs First Nations task force. The report of the impact of LHINs on First Nations health services outlines many concerns that should be the subject of a separate process. The First Nations task force is inclusive of all aboriginal health service providers and represents the needs of First Nations people regardless of residency. Although the final decision will rest with the minister, the stand committee would recognize the complexities of First Nations health service systems and the need for further research.

(2) For the committee members' further consideration, I am currently involved with another ministry that also produced legislation that will have a direct impact on First Nations: Bill 210, An Act to amend the Children and Family Services Act. These amendments will impact on the many First Nations specific provisions contained within the Child and Family Services Act. Minister Mary Anne Chambers agreed that we do have a vested interest in the act and that the amendments would indeed have an impact on First Nations. The minister agreed that a separate process be established to examine the concerns associated with the act and the amendments. The minister committed to ongoing dialogue to this issue with the chiefs committee on child welfare.

I would suggest that this process, which recognizes and creates a specific First Nations stream, could also be utilized in this review. The First Nations task force is well positioned to meet with ministry officials to participate in a specific process. Without this, First Nations are once again denied our constitutionally protected rights with regard to consultation.

I thank you for time, Chair. I'm available for any comments.

The Chair: Thank you, Chief of the Oneida Nation of the Thames. There is no time. In fact, you went over the allotted time, but we thank you for your presentation. Thanks for coming and talking to us.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 4727

The Chair: The next presentation is from the Canadian Union of Public Employees, Local 4727, and Huron Perth Healthcare Alliance.

Ms. Deb Hirdes: Good morning. My name is Deb Hirdes. I'm president of CUPE Local 4727 of the Huron-Perth Healthcare Alliance. I represent 500 service and clerical workers at Stratford General Hospital, St. Marys Memorial Hospital, Clinton Public Hospital and Seaforth Community Hospital.

Once again, the Ontario government wants to transform health care and certain social services, this time by creating local health integration networks. Fourteen LHINs have been established in the past year to plan, integrate and fund hospitals, nursing homes, homes for the aged, home care, addiction, child treatment, community support and mental health services

The LHINs are local in name only. Bill 36 would grant little real power to local communities and providers to make decisions. The bill grants unprecedented authority to the Minister of Health and cabinet to effectively control most public health care service providers and to completely restructure public health care delivery, including the power to turn delivery over to for-profit corporations.

What follows is an outline of these problems and their likely consequences. We would also like to suggest some very different reforms that could actually improve health care and social services in Ontario.

0940

LHINs cover a vast and very diverse area. The LHINs' boundaries have been formed based on hospital referral patterns, overriding municipal, provincial and social boundaries. The proposed LHINs are not local, they are not based on communities and they do not represent communities of interest. As a result, they lack political coherence. The southwest LHIN, where I live, runs approximately from St. Thomas up to Tobermory and just west of London to this side of Kitchener-Waterloo. It will be very difficult for the people living within a LHIN to have a significant voice over the direction of that LHIN, even if the LHIN board wishes to listen.

LHIN boards will be responsible to the provincial government rather than to local communities. Recently, however, the government has found a way to blunt the criticism of underfunding and privatization. The key is to replace the community boards with government-controlled boards. This is the model for the LHINs. This was an experiment taken at the community care access centres and it suggests that this is a very poor model for the LHINs to follow.

CCACs were taken over by the provincial government in 2001. Their funding was flatlined for years and home care services were cut back dramatically. Tens of

thousands of frail elderly and disabled lost their home support services. In total, the effect was a reduction of 30% of hours available for patient service from 2001 to 2003. The problems with competitive bidding became so severe that the government has suspended the bidding process for some time.

Despite these problems, the Ontario government now is talking of extending the purchaser/provider split to other areas of health care. There are no provisions in the bill which ensure, require or even encourage the LHINs, the minister or cabinet to preserve the public, not-for-profit character of our health care system. Indeed, these bodies would now have legal authority to privatize large parts of our health care system. Government-controlled regional agencies are a poor model for health care and social service reform, yet this is what we are facing.

The large, socially diverse areas covered by the LHINs also suggest that there will be significant conflict over resource allocation. What service will the LHIN provide in each area of the LHIN? Smaller communities may be the first to see their services integrated into other communities.

These serious problems suggest another direction must be investigated. We need to provide for the democratic election of LHIN directors by all residents in the LHIN geographic area. There should be a requirement in the bill for extensive public consultation on the existing geographic boundaries of the LHINs. We need a requirement that each LHIN must establish a health sector employee advisory committee, made up of union representatives and representatives of non-unionized employees. We need to eliminate cabinet's authority to enact regulations closing LHIN meetings to the public. We need to ensure the right to seek reconsideration and full judicial review by any affected person, including trade unions, of any LHIN, ministerial or cabinet decision or regulation.

Bill 36 gives LHINs and the government a wide range of tools to restructure public health care organizations. LHINs are given the power to issue compulsory integration decisions requiring health care providers to cease providing a service or transfer of a service. The bill gives the minister even more powers to order integrations directly. Specifically, the minister may order a not-for-profit health service provider to cease operating, amalgamate or transfer all of its operations. For-profit providers are exempted from this threat. The bill allows cabinet to order any public hospital to cease performing any non-clinical service and to transfer it to another organization. The bill gives cabinet the authority to contract out these services despite the wishes of the hospital. There is no definition in the act of non-clinical service, so this definition may be a matter of considerable controversy.

The government refers to this restructuring as integration, stating that the goal is the creation of seamless care and a true health care system; but this is misleading. The LHINs restructuring will not unite hospitals, homes, doctors, laboratories, home care providers and clinics as it has in other provinces. Plans to spin off to for-profit corporations private clinics and regionally based support service providers will mean more fragmentation and less integration of our health care system.

A key goal of this reform is to constrain costs by integrating services, but this also raises questions about cutting services to local communities. The government plan is to regionalize hospital support services.

With government support, 14 hospitals in the greater Toronto area plan to regionalize supply chain and office services by turning work over to another new organization, Hospital Business Services. This organization would take approximately 1,000 employees out of the hospitals, turn over a significant portion of the work to for-profit corporations, and then sever roughly 20% to 25% of these employees. This is a major change that may have far-ranging consequences for workers and local communities, and more such plans are in the works.

Like so much of restructuring, these moves will have a major negative impact on hospital support workers, but they will certainly not create seamless care for the patients. Instead, they will create more employers and bring more for-profit corporations into health care. In many respects, it will create more fragmentation.

In April 2005, the health minister publicly called for the centralization of hospital surgeries: "We don't need to do hip and knee surgeries in 57 different hospitals." Instead, he suggested that about 20, which is a 60% cut, might be appropriate. The minister went on to indicate that hospital specialization is the order of the day: "Each hospital in Ontario will be given an opportunity to celebrate a very special mission ... but not necessarily operating with as broad a range of services as they're tending to right now." This squarely raises the prospect of even more travel for health care services.

The government has also begun to move surgeries right out of hospitals and place them in clinics. But the creation of new surgical clinics only fragments health care, creating more employers and more destinations for seniors to run around to as they tend to their health care needs. It also raises the possibility of the establishment of for-profit surgical clinics.

A better solution would be to create surgical clinics in the facilities and organizations in which they are already invested. Hospitals have the infrastructure needed to support these surgical clinics. Local services are under threat; we cannot let local hospitals and the communities they service be shut out.

In the communities that I represent, the number of patient beds available for admission to hospital has been drastically reduced in the last number of years. This has resulted in the holding of patients in the emergency room. This in turn severely limits the space available for true emergency patients. Housekeeping has been reduced. Only clinical areas of the hospital are routinely cleaned. Food is no longer prepared on-site. Staffing is at a minimum, and we are constantly struggling to meet the benchmarks set by this government. Under these LHINs, where will my local hospital be next?

LHINs are to be given powers to fund and manage health care and social services. This raises the question of whether service levels will vary by LHIN. Currently, we have no sense from the government of how far it will allow regional variation to proceed, yet the consequences could be quite significant. Consolidation of services doesn't necessarily mean cost savings.

The LHIN reform does not directly deal with the undisputed real health care cost drivers: soaring costs for drugs and equipment supplied by transnational corporations. Instead, health care workers and patients will bear the brunt.

Integration will remove jobs and services from local communities, hampering access. Support services are likely the first target, but direct clinical care is also under attack. Reductions in community control and provincial government accountability will make it easier for the government to implement these threats. We need fundamental change:

—Provide in the bill that the cabinet, the minister and LHINs may only exercise their powers in the public interest.

—Provide in the bill that the LHINs, the minister and the cabinet cannot order or direct integration, nor approve or disapprove integration. The power that LHINs have to withhold funding is power enough to encourage consolidation. The LHIN, minister and cabinet should not have the right to transform the health care system unilaterally; otherwise there is no reality to the claim that we are enhancing local decision-making and no point in retaining provider governance structures.

—Provide in the bill that the LHIN, ministerial or cabinet power to withhold funding to force integration only be exercised where necessary in the public interest and where integrated services remain publicly delivered on a not-for-profit basis.

—Provide in the bill that transportation subsidies will be paid by LHINs if the required service is no longer provided in a given community. No purpose is served if integration creates new costs for residents.

—Provide in the bill that nothing in the legislation authorizes cabinet, the minister or LHINs to override the terms and conditions of employment contained in freely negotiated or freely arbitrated collective agreements.

This legislation allows for the establishment of private clinics and the expansion of private hospitals, even though a recent poll showed 89% of the people in this province are against privatization of public health care.

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Impact on bargaining units: The change in health care delivery contemplated in these reforms opens up possibilities of enormous changes in our bargaining units, collective agreements and collective bargaining for health care workers. We've been through many rounds of restructuring, and we're about to do it again. We want the protection in the Public Sector Labour Relations Transition Act in Bill 36 so that the act, which is also in effect, will be kept in effect when you're transferring our people. We want to remove from the bill the authority to exempt application of this act, and we want to provide that nothing in Bill 36 but the application of this act can have the effect of overriding our negotiated security provisions.

That ends my formal presentation today. But what I would like to say now on a personal note is that even though I stand here representing health care workers, on a much larger scale, I'm a resident of this province. I have three daughters, parents, grandparents and a large extended family in this province. I live in what is termed a rural area and I am concerned that the appropriate health care for my family will not be available to them. I am concerned that they will have to travel many kilometres for care or that I will be driving under circumstances not ideal, because under the direction of the LHINs board, my local hospital does not offer services to my community, or worse, they will offer these services outside of my hospital and I will have to pay for them.

While I understand the problems in health care, I urge the government to slow down. Let the public really have a say in something that will have a huge effect on all of us. To hold these public meetings after this bill has already passed second reading, when Bill 36 will most likely pass into law by the beginning of March, is shameful. The fact that this bill does not specifically say that our health care will not be privatized is a huge issue for all the residents of this province. To only hold four days of public hearings for an issue of this magnitude should be unacceptable to all of us in this province. Thank you.

The Chair: There is no time for questions, but thank you for your presentation. The hearings, by the way, are seven days. It's four in Toronto and in London, Ottawa and—

Ms. Hirdes: So that's been changed not too long ago.

The Chair: Yes, because we responded to the request. We had lots of requests and we had agreed in principle to do that, and we have done so. But thank you for the presentation. It's a pleasure to be here in London and vicinity.

Welcome the local MPP from London, Khalil Ramal, joining us. Can we have the next presentation—

Ms. Wynne: And Maria Van Bommel.

The Chair: Oh, I'm sorry, Maria. She was here from the beginning. So two of our London representatives.

AAMJIWNAANG FIRST NATION

The Chair: The next presentation is Aamjiwnaang First Nation. Thank you for making the presentation. Welcome. You can start anytime, sir. There are 15 minutes total. You may want to introduce your colleagues and friends.

Mr. James Maness: My name is James Maness. I'm a councillor from the Aamjiwnaang First Nation. My portfolio is health. To my left is Darren Henry. He is a councillor. With us and on my right is Stacey Phillips, who will be making the presentation.

I'd just like to thank you on behalf of the Aamjiwnaang First Nations. A big meegwetch to give us time to declare our position and our concerns to the committee.

I'll turn this over to Stacey.

Mr. Stacey Phillips: Good morning and meegwetch. Thank you for giving us this time. Any comments that are contained in this submission should not be interpreted as consultation with Aamjiwnaang or on behalf of any other First Nation.

Aamjiwnaang has a unique nation-to-nation relationship with Canada. We are opposed to Canada's yielding of this relationship by assuming that we support the downloading of their fiduciary responsibilities for First Nation health to the provincial and local health integration network.

Aamjiwnaang opposes having to address our First Nation health issues with these local boards. Canada is placing First Nation decision-making authority as it relates to health with entities that have no experience in funding First Nation health. These boards also have no understanding of or focus on our priorities pertaining to First Nation health, thus relenting their fiduciary duty and responsibilities to First Nations people.

It is suggested that decisions regarding Aamjiwnaang's First Nation health will not be made by the First Nations in Canada or by the province. Individuals selected for the local health integration network boards from surrounding communities and municipalities will make these decisions. This will completely erase First Nation health jurisdiction.

There is always concern about strained relationships with surrounding communities and systematic racism impacting First Nation priority in terms of allocating health services and health resources. First Nations consultation did not occur to ensure that proper checks and balances are in place to protect Aamjiwnaang's right to self-government, our unique nation-to-nation relationship and Canada's fiduciary responsibility to the First Nation peoples of Canada.

Our provincial tribal organizations, such as the Union of Ontario Indians, will now be addressing health-related issues as they arise with as many as 14 different LIHN boards instead of Health Canada or the Ministry of Health. This is a real efficiency issue, as our PTO leadership is involved in addressing First Nations issues outside the health sector as well.

LHIN legislation bureaucracies will lead to First Nations reporting on health funding not to Canada but to these boards. This is clearly in violation of our authority and jurisdiction over First Nations health. Furthermore, Aamjiwnaang has concerns with privacy issues regarding LHIN data collection on First Nation communities.

Finally, I would like to reiterate the shift of fundamental issues regarding relations with Aamjiwnaang and Canada. The issue of fiduciary relations with First Nations health will cease to exist, as the bureaucracies created will assume this responsibility, completely erasing First Nation jurisdiction for health. This is a huge price for First Nations to pay, as our funds can now supplement the provincial and the LHIN system.

On behalf of Aamjiwnaang, I would like again to say meegwetch for this opportunity to declare our opposition to Bill 36, the Local Health System Integration Act, 2006.

Mr. Maness: Again, we'd like to thank you very much. Meegwetch. A copy of the presentation has been given to the clerk.

The Chair: Yes, we all have a copy, and we'll be happy to ask some questions or make some statements. I'll start with Madam Martel. You have about a minute and a half each.

Ms. Martel: I heard an earlier presentation expressing very similar concerns, and concerns yesterday in Toronto as well about the lack of consultation with First Nations with respect to the bill. We heard it particularly in the context of the blueprint that was produced between the first ministers, which set out a process of consultation that was completely set aside with respect to this particular bill, and also the context whereby the government announced this summer that there would be a new relationship with First Nations and yet, despite this announcement by the government, despite the blueprint, there was absolutely no consultation with First Nations about the bill. We have heard that message very clearly, and I regret that that was the position taken by the government with respect to this bill, most particularly in light of the announcement the government made about a new relationship just this summer, while the bill was obviously being drafted.

What would you like to see now with respect to this bill? I assume you would like it to be set aside and have no impact on First Nations, and that the government work with you to develop a real process around problems facing aboriginal people with respect to health care.

Mr. Phillips: I completely agree, and I think it was stated by the Oneida First Nation as well that there be a separate process. It's very complex because, as you know, the province has agreements with Health Canada such that there are organizations that deliver health care services, and money is put in by both the provincial and federal governments. The aboriginal healing and wellness strategy is one example. I think one of the questions is, how much is this going to impact and where is this going to impact First Nations in terms of health services? We're uncertain of that in terms of how to prepare and how this legislation is going to affect our First Nation communities, both on and off reserve.

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The Chair: Ms. Wynne.

Ms. Wynne: Thank you very much for being here. I just wanted to go back to a comment you made, and that Randall Phillips of Oneida made earlier; that is, that a task force report was commissioned by the minister before the legislation was introduced. So that task force report has come to the minister. I believe there was also one from the Metis. Can you tell us at this point what the major recommendation in that task force report is? I understand also that those recommendations are being reviewed and the minister is in conversation with you as a result of that task force report. Is that true?

Mr. Phillips: I'm not a member of that task force, so I would hate to comment on some of their strong recommendations. That question should have been directed to

the Chief from Oneida, who was actually a member on that task force.

Ms. Wynne: Yes, I wanted to ask that question. I was trying to sneak it in here because I couldn't ask Mr. Phillips.

Mr. Phillips: I wasn't a part of that task force; I just reviewed their document. I do think some of their concerns have already been expressed throughout the seven days, or however many you're into. I reviewed that document. I didn't want to reiterate many of their concerns, because their concerns affect all areas, not only health. But I think a lot of it is lack of consultation in terms of how this is going to impact First Nations.

Ms. Wynne: My understanding is that that document is being reviewed by the minister and that he is in conversation with the people from the First Nations who wrote that document. Our hope is that there will be a resolution of some of the issues you've raised.

The Chair: Mr. Arnott.

Mr. Arnott: Thank you very much for your clear and concise presentation; it's very helpful. We've heard a lot of concern from First Nations organizations about the lack of consultation prior to the introduction of Bill 36, and you've identified that as a huge issue. What would have been an appropriate consultation exercise, in your opinion, prior to the introduction of a bill of this nature?

Mr. Phillips: One of the things I've heard, not only in the First Nation communities but in general, even in the Sarnia-Lambton area, is the lack of information regarding the LHINs and how they're going to impact our communities. I think the biggest concern we have is how it's going to impact us at the local level.

I think one of the challenges we have right now is in long-term-care services. We haven't been able to access long-term-care facilities on reserve, and we've always struggled to do that. We need those services right now, because we have a lot of senior people who have their culture and their language as their mother-tongue, and there are no appropriate services on reserve at this point to accommodate those needs. That's one area I can think of right now. First Nations have had a difficult time securing long-term-care services on reserve. We need them now, not 10 years from now, because the people who have their language and their culture are at that age and in those facilities with no programming geared to their needs.

The Chair: Thank you very much for your presentation. Have a nice day. Thank you for coming. Meegwetch.

WATERLOO REGIONAL LABOUR COUNCIL

The Chair: The next presentation is from the Waterloo Regional Labour Council. Rick Moffitt. We already have some material from you, which we are distributing. You may start any time.

Mr. Rick Moffitt: The Waterloo Regional Labour Council represents 26,000 union members in our umbrella organization, affiliated through their individual locals. The Waterloo Regional Labour Council represents blue-collar and white-collar workers in both the public and private sectors. We are active in all aspects of the economic, social and political life of our community, and we work with our community partners to maintain and strengthen health care and the public education system and to protect our social programs.

We are pleased to have an opportunity to address this committee, and look forward to sharing our concerns about the legislation proposed in Bill 36 and to making recommendations for change that will make it more palatable both to the public, which is accessing health care, and to those who work in health care on the front lines.

Our first concern, frankly, has to do with the manner in which this proposed legislation has been introduced and the procedural decisions that have been made regarding the debate in the Legislature, as well as the opportunity that members of the public have had or will have to comment on the proposed legislation. In our view, it is unacceptable that a proposed government bill that will have such a far-reaching effect should not be granted far more debate time in the Legislature. When one considers that the current government never sought nor received a mandate to create a new system of health care delivery in the last election, all legislation ought to be put on hold.

Adequate public consultation should be obtained prior to second reading, not after. Such consultations need to take place in all parts of the province, and not be confined to four cities in a compressed time period, holding hearings, as I understand now, over a seven-day period. At an absolute minimum, hearings should be held in each of the 14 proposed LHIN catchment areas. Hearings should be held during hours in which members of the public are available to attend, not just during business hours. So our first recommendation is that the standing committee on social policy should hold public hearings and consultations in all proposed catchment areas during hours in which members of the public ought reasonably to be able to attend. Such meetings should be held over a two-day period and in a format that both explains the proposed changes to current practices and allows for feedback from the parties attending.

A reading of the proposed legislation in Bill 36 suggests that there will be both reduced community control over health care services and reduced government accountability. Neither is in the best interests of the citizens of the province. The LHIN structure puts up significant barriers to local control over health care. In fact, it centralizes power in the Ministry of Health and in cabinet, taking control away from local, community-based providers. It creates a new layer of bureaucracy that is accountable not to local communities, which they aim to serve, but to the Ministry of Health. A board appointed by the Minister of Health will govern LHINs, and it will be accountable to the Minister of Health. It will not be accountable to the community.

This is a very different model than we currently have, where the government does not, for instance, appoint

hospital board members. In the past 10 years, hospital boards across this province have repeatedly held the government accountable for funding cuts and funding shortfalls, and they have been very successful in restoring funding to local communities.

I live in Cambridge. Cambridge has a hospital that was cut out of the last round of funding announcements by this government and by the Ministry of Health. Pressure from our local community—from the hospital, from community leaders—forced the government to restore a funding promise that had been cut. It's clear that Bill 36 proposes to end the possibility of this type of community action.

It is clear that transferring fixed amounts of funding to a LHIN and having them announce funding decisions will provide a level of insulation for the government. The government will control the LHIN, but the LHIN will actually implement decisions on privatization and the amalgamation of services.

I must say, as a school teacher and as somebody who lived through a whole bunch of cutbacks in education, watched powers being taken away from school boards and watched the former government use school boards to take the flack for funding cuts and decisions they made, it's really disturbing for me to see this government heading in the same direction.

The large, socially diverse area covered by a LHIN suggests there will inevitably be conflict over resource allocation. How will a community fight back when services in that community are amalgamated with those in another community? Whom will they launch complaints with over service cutbacks and the introduction of privatization?

This leads to our second recommendation: There must be democratic elections at the local level for LHIN board members and directors, based on their geographical areas. There must be public hearings on the proposed boundaries for all LHINs, to ensure that they do in fact constitute a local/regional geographic service area. There must be a mechanism for local communities to appeal decisions, including the use of arbitration and the courts.

Again, I want to point out some parallels to what the former government did. We had some 60-odd boards of education in the province, and they reduced those to 31. This is much like what is being done here. We are talking about 14 service areas across the province—service areas that are as big as countries in Europe. To my mind, it is really absurd to think about this. It is unacceptable that someone living in Cambridge could have their parents put into a long-term health care facility in Orangeville because Orangeville, in a competitive bidding process, somehow came up with the best rate for long-term care, or that somebody who needs a hip replacement and lives in Orangeville has to come down to Kitchener to get a hip replacement, because the Kitchener hospital wins a competitive bidding war to do hip surgery; or that someone who has a heart problem, perhaps in Guelph, has to travel to another community. It's really unacceptable.

The proposed legislation will provide reduced access to care and increased service integration. Many citizens view terms such as "increased service integration" as the language of privatization, and view this as the portal for private participation in our health care system.

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It is clear to those who understand the language of government that increased integration is an Orwellian synonym for service cuts. Simply put, service cuts mean cutting back on the number of hospitals offering particular services.

The minister himself has been quoted in the Toronto Star on numerous occasions. At one point, he suggested a cut of 60% of the hospitals that perform hip and knee surgery, meaning people will have to travel those longer distances. It means that we will see a trend of moving services out of hospitals and into clinics. We now have eye clinics in this province. We have heart clinics, hernia clinics and others operating outside of the facilities built to cater to the overall needs of the community, i.e., our hospitals. This means a duplication of administrative and support services that are already available in the very hospitals that the minister is proposing to have procedures removed from.

Patients will need to travel to multiple sites and see multiple medical professionals. This proposed legislation will fragment health care as patients run from provider to provider to service their multiple needs.

It is clear that the hospital consolidations that the previous Conservative government implemented over the protests of the community did not save money and, frankly, there is no reason to believe that these integrations and consolidations will save money either unless they are accompanied by significant cuts to overall service.

Our third recommendation, then, is that provisions be placed in the legislation that allow for the integration of services only when there is a demonstrable benefit to public interest, and that the public interest cannot be met solely by a financial savings.

"Public interest" should also be defined to include a provision that includes a public, not-for-profit health care delivery model. Private for-profit diagnostic and surgical clinics should not and cannot be a part any LHIN.

In conclusion, the Waterloo Regional Labour Council has serious misgivings about the proposed legislation. I believe that we have been clear in these recommendations. Our final comments must address the potential use of P3 or alternative financial procurements to fund capital costs incurred by LHINs. Let me be clear: Our council is totally and adamantly opposed to these financing arrangements, which are clearly not in the public interest.

We have viewed with much horror the unfolding facts about the P3 financing of the new Osler hospital in Brampton. The Liberal government set out criteria for the use of P3 financing. They said that it had to save money. They said that it must enable the public sector to expand without incurring risk and that it must attract private

capital to be used for the public good. This is clearly not the case in the Osler hospital construction. Details about the contract are now making their way out to the public. The contract signed by the government agrees to set an interest payment for the mortgage on the facility at 2% more than the 10-year government of Ontario bond rate. So it cannot save money. It is impossible to save money when you've set an interest rate at 2% higher than the rate at which you, this government, can borrow money in the first place.

Second, the Osler hospital contract contains an agreement to pay service fees to the consortium for arranging that same financing at an excessive rate of $10 million, or 4% of the overall cost of the contract.

Finally, given that the government has already allowed the consortium to contract to provide administration, cleaning, food services and maintenance services, it is clear that there is no public interest being protected here. The increased costs associated with the mortgage means that the government could have built a facility 1.75 times the size of the hospital for the same money. Shame on the government for agreeing to use the taxpayers' hard-earned money this way. Shame on private companies for inducing them to do so.

Our final recommendation is that the commercialization of public services must not be facilitated by the use of P3 financing in any LHIN capital project.

The Chair: Thank you, Mr. Moffitt. There is less than two minutes; one minute each. We'll start with Ms. Wynne, please.

Ms. Wynne: Thank you for being here this morning. I want to pick up on your comment about the reduced community control. I'm a former public school trustee in Toronto—

Mr. Moffitt: I'm well aware.

Ms. Wynne: I know that there are now only 72 boards in the province, and I am here because I fought the amalgamations of the previous government tooth and nail for eight years.

Mr. Moffitt: And were supported by the ETFO union, of which I am a member.

Ms. Wynne: Exactly.

One of the things I want to say is that in putting these LHINs in place, we're putting in place a structure so that citizens actually will have more information. When you talk about activism and the ability to react to a plan of a government, right now, if somebody wants to know what the overall plan is for health care in their area, there's really nowhere to go. There's no public meeting, there's no opportunity to have that conversation.

With the LHIN in place, citizens will have more information, and my experience is that activism and ability to oppose or to approve is fed by information. I really think, as a former activist, as a current activist, that giving people more information, helping them understand what the plan is, where the gaps are, is going to make a more informed citizenry and is going to allow the government to be more accountable to community, and that's what this bill is about. I'm supporting it as a member of the government because I believe it's going to be better for people and it's going to give people more information.

Mr. Moffitt: With all due respect, that didn't sound much like a question.

Ms. Wynne: Sorry, it was just a soapbox moment. I apologize.

The Chair: It's a question or a statement. One minute each, Mr. Arnott.

Mr. Arnott: If I have a minute, I'd like to give Mr. Moffitt a chance to respond to Ms. Wynne.

The Chair: Thank you, Ted.

Mr. Moffitt: I would very much like to respond. Given that you're suggesting that the government has such lofty ideals in introducing this legislation, perhaps you can explain to me why nobody in this province seems to know what a LHIN is unless they're an activist within a union that is fighting against it or they're somebody who represents a special interest. Quite frankly, this government has treated this whole proposal like they're growing mushrooms; i.e., in the dark, plenty of manure.

The Chair: Madam Martel.

Ms. Martel: Thank you for being here today. The legislation holds no provisions with respect to how the LHINs will meet with people, how there will be consultation. There's nothing in the legislation. It says that will be developed in the dark by regulation. It says that the LHINs are supposed to develop a health care plan based on the provincial health care plan. That hasn't been developed. We don't know who's part of that. There has been no consultation with the broader public community. That's being done in the dark. It's silent with respect to what the LHINs will do in terms of making decisions about integration. We do know that they don't have to go to the public when they decide to integrate a service or consolidate a service; the only discussion they have is with the service provider after the decision is made. Frankly, in terms of public input either into a plan or into decisions, there is none, zero, nada.

The LHINs are agents of the government. It's very clear in the legislation. My concern is, as you've already described, they will become the buffer between the government making decisions that are distasteful and the LHINs having to carry that out and them taking the flak on the local level.

I don't know if you want to add anything else with respect to what else you see in this bill.

Mr. Moffitt: I think it's pretty clear from the experience in England, where most of the structure for this program has been lifted from, that it has caused nothing but problems. Health care is not getting better. The largest hospital in London, England, went bankrupt just before Christmas. It was a hospital that was built with P3 funding and had all of the same bundling of contracts that is being done up in Osler; i.e., all of the services within the hospital. Now they find that they are in fact able to make their mortgage payments, clean the hospital and provide food; they just can't spend any money on health

care, because they don't have any money left when they finish doing that.

My fear is that that's what's going to happen with the LHINs when you bring the private sector in and when your first commitment is to deal with the financing of the Ministry of Health, not with the care of patients who need services.

The Chair: Thank you very much for your presentation and your answers. Have a nice day.

COUNTRY TERRACE

The Chair: We're moving to Country Terrace and Mary Raithby. Good morning. Thanks for coming.

Ms. Mary Raithby: Good morning. My name is Mary Raithby. I'm the executive director of Country Terrace, a 120-bed, licensed, not-for-profit nursing home in Komoka and the best long-term-care home in Middlesex Centre.

We are committed to helping meet London and Middlesex's long-term-care needs. We are proud of the job we do. We also recognize that we can increase our value to our community by continuing to provide access to provincially standardized and regulated core long-term-care services for our oldest and frailest citizens; developing new programs and services that respond to the area's needs; and providing a more seamless health care journey that provides people with the care they need, when they need it, in a setting that is most conducive to their need. This is why I'm here today.

Community engagement, local decision-making, service integration and the other key elements of Bill 36 provide a solid legislative framework to make this happen. Generally speaking, I am pleased to be included as a health service provider, and I am encouraged by the bill's vision. My 20 years of long-term-care experience, however, tempers this optimism with caution. Unless specific implications of Bill 36 are addressed, they will negatively impact the ability of Country Terrace to contribute effectively to the LHIN vision. I am pleased to have the opportunity to raise these issues and offer my solutions to the committee.

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I want to begin with three overarching observations.

My first observation is that I do not expect this committee to end up defining all of Bill 36's unknowns. I believe it is appropriate that this occur through a combination of improvements to Bill 36, the accompanying regulations, government policy and changes in other legislation. I hope instead that this committee will improve Bill 36's ability to foster a stable environment where Country Terrace can be an equal and confident partner in developing an integrated health care system.

My second observation is that Bill 36 does not appear to have fully contemplated its impact on long-term care. I am not surprised, given that we are often the exception to the rule of health care system planning. This exception stems from three facts: All homes deliver a provincially standardized and regulated program of care and services within a standardized funding and accountability framework; this standardized program is delivered in over 600 homes across Ontario by a mix of not-for-profit, charitable, municipal and private providers; and, unlike other health care services, both the province and the residents fund long-term care. Residents in Komoka write the same cheque for this service as residents in London and Toronto. In return, they expect access to the same level of service.

My remarks today primarily focus on continuing our ability to deliver this core provincial program. Of all the things we can, or might, do in the future, this has the most value to our community.

My third observation is that it's difficult for me to comment on Bill 36 without reference to the pending new long-term-care homes act. This act will define how we operate as long-term-care homes within Bill 36's overall operating framework. I believe this has contextual relevance for you, as legislators, in your task today.

These two new pieces of legislation must be mutually supportive. This supportive relationship offers the best opportunity to resolve the major implications of Bill 36 on my home's core services. It all boils down to the fact that as a long-term-care provider my service is my beds. Let me explain.

The ministry issues a licence to Country Terrace, other not-for-profit, private and some charitable homes for the number of beds that we operate. The remaining charitable and municipal homes have ministry-approved beds. This mix of licensed and approved beds is the result of the fact that there are three separate acts currently governing operators.

I receive per diem, not global, operating funding directly tied to my licence. Homes with approved beds are funded on the same basis. In both cases, operating funding, and thus service, will adjust directly with any changes to the number of licensed or approved beds.

As a licensed operator, there is a second link between my licence and my service. My licence factored heavily in my bank's decision to lend Country Terrace mortgage money. Any reduction to my licensed beds, of course, impacts the collateral value of my licence and thus increases my risk in being able to continue as a provider.

In the new long-term-care homes act, it is clear that the minister will retain total control over beds. The government's consultation document on this new legislation contains a whole section on the treatment of licensed and approved beds. In retaining authority over beds, the minister will in fact also retain authority over long-term-care services.

This is, of course, inconsistent with the direction of Bill 36 to devolve service authority to LHINs. If this inconsistency is not resolved, Bill 36 will place service access equity and provider stability at risk.

I would now like to offer some solutions to mitigate this.

As currently written, the relevant parts of part IV, section 20, provide me with no assurance that my LHIN will fund all of the beds that the province licenses me for.

This uncertainty is cold comfort to the 120 Ontarians who call Country Terrace home, to say nothing of the 20 on my wait-list or those in my community who will need our services in the future.

You can remove this uncertainty with language changes that would require LHINs to fund homes consistent with their provincially licensed or provincially approved bed capacity. Specifically, part IV, subsection 20(1) should be amended by adding "where a health service provider is a long-term-care home, the service accountability agreement shall provide funding for the home's total capacity of licensed or approved beds."

The benefits of these changes would be enhanced with an assurance that I will continue to have equal access to core program funding when funding devolves to LHINs. This can be achieved by retaining a common approach to funding core services, including elements of our current envelope funding system. This is a matter that we hope will be appropriately addressed in government policy.

Possibly the best opportunity for Country Terrace to contribute to the LHIN vision is in developing specialized programs that respond to our community's unique needs. I am referring to services such as geriatric mental health, peritoneal dialysis and after-stroke rehab. Stable centralized funding provides a platform for us to pursue these local opportunities without risking the erosion of our core services. This committee can provide LHINs with strengthened authority and flexibility to support such local solutions with a fair and transparent framework by amending part IV, subsection 19(1) to read: "a local health integration network shall provide specialized program funding as deemed appropriate to the health service provider, based on the local population's unique needs," and amending part IV, subsection 19(2) to read:

"The funding that a local health integration network provides under subsection (1) shall be on terms and conditions that the network considers appropriate with consultation with the respective health service provider(s) and in accordance with the funding...."

I would now like to comment on part V, sections 25 to 28, which deal with service integration. This is an area where additional clarity is also required, based on the fact that beds equal service in long-term care.

Simply stated, if the basic service in all homes is the same and the authority over that service already resides with the minister through control of the beds, then the application of integration orders and minister's decisions to operators should also be the same. I would therefore request that this committee exempt all licensed and approved bed operators from section 28.

I am a not-for-profit, licensed long-term-care operator. I provide the same service on behalf of government according to the same funding and rules as all other long-term-care homes. I therefore have difficulty with the concept that my residents should be treated differently or put at a different level of risk based on the type of operator who owns the home. This current effect of section 28 contravenes the concept of service equity. It is also unnecessary, given the control the minister will retain over all operators under the long-term-care homes act.

With the effective authority over our core services remaining central, it naturally follows that this should be supported by a uniform accountability structure that applies to all operators. Bill 36, however, creates the potential for the emergence of two parallel accountability processes: one local, from the service accountability agreements between the LHIN and operators, and the other provincial, from inspection criteria we expect to be outlined in the new long-term-care homes act. If this is allowed to occur, there will inevitably be inconsistencies between the two that will confuse operators, residents and families. It will also add unnecessary bureaucracy and costs.

Bill 36 can be made to eliminate this potential while effectively and efficiently supporting provincial performance accountability in long-term-care legislation. A single and consistent service accountability agreement would enable LHINs to discharge their responsibility for ensuring compliance with provincial performance accountabilities. This instrument would be similar in concept to the standardized service agreement that now exists between the ministry and all homes.

I ask that the committee add language to part II, subsection 20(1) and part IV, subsections 47(7), (8) and (21) to ensure that this standardized agreement is developed in regulation and that there is a fair dispute resolution process. Further, this language should stipulate that the development process should include consultations with sector associations. In Alberta, where total performance accountability was devolved to the local level, significant variations in basic services have resulted. We must ensure that we avoid this in Ontario.

I also don't think LHINs need 600 long-term-care homes lining up with other providers on their doorstep each year to negotiate and sign individualized agreements. The inefficiencies and cost of that bureaucracy boggles my mind. I would add, however, that I would expect to be directly accountable to my LHIN for any specialized local services I provide. I am sure that these one-offs can be easily amended to a service accountability agreement which is otherwise standardized.

I would also suggest that LHINs retain the current Ministry of Health and Long-Term Care action line as the process for addressing public concerns. Part II, section 5, clause (d) seems to indicate that LHINs would develop their own processes. I believe that adding 14 additional and potentially different complaint processes is costly and unnecessary.

1030

I would now like to briefly comment on three other elements of Bill 36. As a small provider with limited administrative resources, transparency is important for ensuring that I have an equal opportunity to participate in service integration and that this process is accountable. This can be supported with provincial guidelines to define Bill 36's "community of persons and entities involved with the local health system in planning...." As a provider, I would like to be consulted in this process.

Transparency can be further supported by language in part II, subsection 9(3) to ensure that the conditions under which a LHIN board can hold in camera hearings is defined in regulation. It is critical that key decisions, particularly those related to service integration, not be made behind closed doors. Without this transparency, these decisions will be suspect by providers and citizens alike, regardless of their impact.

As a provider and a nurse, I was particularly encouraged to see the implementation of a health professionals advisory committee in part II, subsection 16(2). The potential benefit of this initiative could be greatly enhanced with language to specify the committee's term and mandate and to define in regulation that it contain a minimum of one regulated health professional from each sector. It is critical that health professionals with specific knowledge of individual sectors be available to advise LHINs. Inasmuch as we are the same, our clinical settings are often distinctly different.

Finally, as you may know, long-term care has an umbilical relationship with the community care access centres. All residents require CCAC approval to be admitted. A smooth working relationship helps ensure that system resources are effectively utilized to provide care to people where and when they need it.

We view Bill 36 as an opportunity to resolve some long-standing issues with placement and an emerging opportunity to utilize placement more effectively to achieve the LHIN vision, particularly in facilitating placement processes between hospitals and long-term-care homes. Legislators can help set the stage for this by encouraging effective placement accountability measures in the service accountability agreements between LHINs and CCACs and by encouraging that the regulations governing both hospital and long-term-care admissions be mutually supportive.

In closing, I again thank you for allowing me to make these remarks. If you take away one thought from them, let it be that as a provider and an Ontarian, I share much of the vision of this bill. I also believe that it needs some adjustments to make it work for both those who deliver and those who receive long-term-care services.

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

CHARLOTTE'S TASK FORCE FOR RURAL HEALTH

The Chair: We'll move to the next presentation, Charlotte's Task Force for Rural Health. There are three presenters, I believe. Welcome. You can start any time you're ready. We have a total of 15 minutes, and if there's any time left, there will be some questions for you.

Mr. Norm Sutherland: Good morning. I'm Norm Sutherland, a member of Charlotte's Task Force for Rural Health in Petrolia. I will make a five-minute presentation, followed by a five-minute presentation by Mary-Pat Gleeson. Helen Havlek is one of the resource persons on the task force.

Charlotte's Task Force for Rural Health is an advocate on behalf of the citizens of rural Lambton county. We believe that all citizens are entitled to timely accessibility to a full-service general hospital within the geographic boundaries of their community. We were formed just over a year ago in response to our communities' concerns around the erosion of essential services and experienced staff at our rural hospital because of amalgamation with a larger hospital corporation. We have held public meetings to inform Lambton county communities of our findings and have received the overwhelming support of residents.

We are here today because we want to be certain that our residents have a voice in the future of our health care system. We believe that issues can only be resolved through open and frank communications among all sectors, and that the health care needs of rural communities must be acknowledged.

All the great presentation pundits tell us not to start off with negatives, but this is such an egregious negative that we must bring it to your attention. If you look at the ad that was in the papers across the province, you are holding meetings in Toronto, Ottawa, Thunder Bay and London. There is not one small or rural community mentioned. Why can't government agencies, just once, travel to rural Ontario? Please understand that to us this urban-centric focus is symptomatic of an inability or unwillingness to understand the needs of the rural community.

Having said this, we believe there are positive ideas in Bill 36. We believe that the vision itself of local communities being responsible for their own health care, the concept of local budgetary control and governance, the recognition by the ministry of the importance of primary care that has been overlooked until now, the guidelines and standards in place to ensure fiscal responsibility and transparency, and the concept that the government wants to create a sustainable health care system are all good news.

Keep in mind, however, that previous attempts to create cost-effective systems have resulted in many small, extremely efficient and cost-effective hospitals, like Petrolia, Newbury and Picton, being absorbed by larger city bureaucracies where the deficits are now crippling the system.

We are here today to help you understand that larger is not always better. We are here to suggest that even the Health Services Restructuring Commission under Premier Mike Harris acknowledged the need for rural, full-service hospitals. We hope to ensure that you do not abandon that concept.

Now, let's talk about rural health. What works in the city does not necessarily work in rural communities. It is well known that rural populations have a higher incidence of illness, accidents and death rates. The following are just some of the challenges that impact the delivery of health care in rural communities.

Transportation: There is no public transportation system in rural areas. Distance is a factor, and weather often plays havoc with the ability to travel to larger

centres. Seniors in particular wisely restrict and limit themselves to driving locally and will not venture into large urban centres.

Let's look at the population base in rural areas. Lambton county, as an example, has the highest senior citizens' rate in the province, so accessible health care services are crucial. As the size of rural hospitals shrinks, the number of doctors attached to them decreases. The number of doctors decreases. Community care access centres have been touted as a replacement service for services being eliminated from small and rural hospitals. In the case of Lambton county, the CCAC office has been moved to Chatham, at least an hour from most of rural Lambton.

We have the highest teenage suicide rate in the province. After the social worker for outpatients was removed from our hospital, we called the Sarnia CCAC office concerning the needs of a suicidal teenager. The answer from the caseworker was that she might be able to give support over the phone. Previously, the teenager could have walked to the social worker's office. So there is a huge gap between what is promised and what is being delivered.

The thoughtless elimination of experienced resource nurses affects the delivery of quality care, particularly in emergency departments of small and rural hospitals. As an example, in rural areas, there is a higher incidence of accidents that require specialized knowledge. Victims of strokes and heart attacks must be diagnosed quickly; the increased time in getting a patient to a well-staffed emergency department is a matter of life and death.

In her paper in the spring edition of the Canadian Journal of Rural Medicine, Dr. Trina Larsen Soles, president of the Society of Rural Physicians of Canada, points out that by urbanizing health care both in location and philosophy, rural people are discouraged from using the system. Dr. Larsen Soles went on to suggest that if rural residents cannot access the system, they will simply all die off—another way of reducing costs.

Ms. Mary-Pat Gleeson: Let's look at issues raised in Bill 36 itself. The boundaries of the LHINs were determined by patient referral patterns. Our patient referral patterns, as the ministry has been told by Dr. Kathy Pratt, on behalf of the Lambton county medical association, are from west to east, not north to south. We are at a loss to understand how our patient referral pattern could possibly indicate Windsor as our tertiary centre. The boundaries of the Erie-St. Clair LHIN raise several other questions. How does a geographic area of this enormous size, which covers territory from Grand Bend to Windsor, define "local?" How will the LHINs guarantee that there is no restriction of access to other LHINs when we are seeing restrictions already?

Moving on to other issues: How is the definition of "integrate" as set out in Bill 36 any different from the mandate set out by the Harris government's Health Services Restructuring Commission? Mr. Harris won an election by stating he would not cut hospital services and then invented a supposed arm's-length commission to make the cuts for him. Are the LHINs the reincarnation of Mr. Harris' commission?

Have your strategic plans included public input, especially from rural communities? By "public" we mean ordinary citizens, not just health care professionals and bureaucrats.

1040

Bill 36 lists cost effectiveness as just one of its objectives. However, the CEO of the Erie-St. Clair LHIN stated publicly that cost effectiveness was one of the most important parts of the equation. Which is it? Are LHINs to be more concerned about cost or patient care?

Small and rural hospitals have proven to be cost effective for various reasons. They are close to their community and there's a sense of ownership that ensures accountability and staff commitment to that community. Bigger is not always better. For instance, a smaller hospital's share of the administration costs is higher in an amalgamated corporation.

Integration has not saved money. Have you looked at other ways of saving money? Perhaps small, efficiently run hospitals are one way. We know from a recent edition of the New England Journal of Medicine that a study at McMaster University indicated that for-profit health care costs more money than publicly administered and provided health care. Creeping privatization will not save money.

Bill 36 states that there will be a system in place for auditing performance standards, targets and measures, performance goals and objectives. What action will be taken if standards for performance and outcomes are not met? The lack of public education about the bill sends up a red flag.

What is the basis for setting standards? Is it quality or is it cost? When the only criterion for setting standards, targets, measures, goals and objectives is achieving the lowest cost instead of providing accessible highest quality, the result is the inevitable rationing of services. We've seen that rural communities are the first in line to suffer. The extraordinary needs of rural communities must be considered.

We would like to continue by offering constructive suggestions that we feel are important to consider as amendments before Bill 36 can be passed into law. We have identified a basket of services which must be listed in Bill 36 as being necessary for rural hospitals. These include: emergency services that provide 24/7 access to physicians and experienced nursing staff certified in cardiac life support and trauma care; in-patient beds for medical and surgical services; all diagnostic imaging except CAT scans and MRIs. Critical care services: operating room services for emergency and elective surgeries, clinics, full laboratory services, full-time pharmacist, full-time social worker for both in-patients and outpatients, dietitian and support services. We know from our own experience with CEE Hospital in Petrolia that these services can be provided in a rural setting both efficiently and effectively.

Suggestion number 2: In order to be accountable to the public and the ministry, and to avoid self-perpetuation,

the governing body of the LHINs should be elected. The board should meet more than four times a year. May we suggest 12 times a year, minimum.

All information coming from the LHINs should be made readily available to local communities. May we suggest that it be placed in our MPPs' offices and the clerks' offices of local municipalities, in addition to doctors' offices and hospitals.

There must be a patient's bill of rights included in Bill 36.

There must be a legal avenue in place for the public to appeal decisions made by LHIN boards. To be allowed only to appeal to your executioner is ludicrous.

It is obvious to us that one of the nagging concerns that people have with the LHINs is the size of the geographic areas they encompass. We are suggesting that before you institute the LHINs program across the province, a pilot project of a smaller LHIN, based on county boundaries, be put in place. We are suggesting that Lambton county be that pilot project. Let us show you that smaller can be effective and efficient while providing quality care.

In closing, we would like to reiterate our concerns for rural health care. Rural health care has exceptional needs that must be met in the bill. While we applaud the bill's philosophy of including the public in the decision-making process, in reality, sadly, the bill lacks any meaningful or significant participation by the public.

I hope you can understand that our recent experience dealing with health care administrators and bureaucrats has given us little comfort. We are counting on you to protect rural Ontario.

The Chair: Thank you for your presentation. There's about three minutes; one minute each. Mr. Arnott, you're first.

Mr. Arnott: Thank you very much for your presentation. In listening to it, I'm sitting here thinking, what would Lorne Henderson have to say about Bill 36?

Ms. Gleeson: I think he probably would have cheered us on.

Mr. Arnott: I think he would have indeed. For those of you in the room who don't know, Lorne Henderson was a long-serving member of provincial Parliament representing Lambton. After he retired from the Legislature, I used to run into him at the OHA conferences, where he served as a volunteer board member of one of the local hospitals in Lambton county.

I would agree with you completely: There has to be some sort of appeal board for LHIN decisions. If you're appealing to the same people who turned you down in the first go without any prescribed format for how they would engage in public consultation, there is going to be a real problem, for rural Ontario in particular. Would you envision a provincial appeal board for the whole province, or would you suggest that there should be a local appeal board for each individual local LHIN? How would you structure it?

Ms. Gleeson: I suppose it would have to be a step-up program; in other words, it would go to the supreme court of LHINs. It has to be a system that will work for the public, and that's not so heavy with jargon and bureaucracy that it's not accessible. The whole point is that people feel they can appeal and are not going to be turned away by the bureaucracy.

The Chair: Ms. Martel.

Ms. Martel: Thank you very much for being here today. You've described to us some of the challenges you've faced in the past and said at the start that you're hoping that the vision of local communities being responsible for their own health care, as described in the bill, will probably make things better. But I wonder if you can comment on the fact that the LHINs are essentially creatures of the province. I have my serious doubts about how much local community control or input there is going to be.

I'd ask you to consider this in the bill. It's very clear that cabinet—the government—creates, amalgamates or dissolves the LHINs. The LHIN boards of directors are appointed by the province; they serve at the behest of the province. The only members of the LHIN non-profit corporations are their directors themselves, which is different from hospital boards, for example. The LHIN is explicitly defined as an agent of the crown in the legislation. The LHINs are funded by the ministry "on the terms and conditions that the minister considers appropriate." The LHINs may fund health service providers, but that funding has to be "in accordance with government requirements, including the terms of the funding that the LHIN receives from the ministry, the terms of the accountability agreement by which it is bound to the ministry and other requirements that cabinet"—government—"may prescribe," and the list goes on.

If those are the conditions under which LHINs are set up and operate, how much room do you see there for control at the community level by the community?

Ms. Helen Havlek: We don't see very much control at the community level. We think there's enough information and statistics and everything else around that these decisions can be made not based on emotion but based on real needs. That seems to be the problem: The actual needs of people are not listened to or don't have any effect with the government. This is not just this government; most governments act in the same way. Having elected representatives makes it necessary for those people to respond to the needs of their community. They can't get away with not doing that because they'll be turfed out the next time. That's one of the reasons why we like the election part of it. Also, as we mention in our brief, to be able to actually talk to people and have the common person's input is a difficult thing. Service providers can do that pretty well, because they have spokespeople or somebody who talks for the union or for the service provider or whatever. But the common person has difficulty, I think, in being able to express their concerns.

The Chair: Thank you. Mrs. Van Bommel, please.

1050

Mrs. Maria Van Bommel (Lambton–Kent–Middlesex): I certainly welcome my constituents to this. I'm glad you've taken the opportunity to avail yourselves of

this democratic process. For all the people who are here, Petrolia has a wonderful history of defending rural health care. When the restructuring commission came through under a previous government, they were stopped dead in their tracks at Petrolia by the citizens of Petrolia. I think most of rural Ontario has Petrolia to thank for that.

There are a couple of different things I wanted to address. One is the concerns Mary-Pat expressed about costs, and that this is a way to reduce costs. But I've spoken with the Minister of Health, George Smitherman, and I know that for him the priority here is coordination and delivery of better services. That's a very important thing for me as well in terms of rural health care. I agree: Bigger is not always better. We certainly have a long way to go in making sure that rural health care is delivered in an appropriate way, but I believe that LHINs are a big step in that direction.

One of the other things you talk about is the boundaries of the LHIN. I know that in Petrolia and in the Sarnia area, there has been a lot of controversy about the issue of where you would be able to go for care. I can assure you—and I have spoken with the minister's staff about this as well—that there is no boundary in terms of where patients can go for health care. You can go where you feel the services are best delivered to you. This is about coordination of good service. The LHIN boundaries are not a restriction on the constituents in my riding in terms of where they can best get their services. If you feel that your services are best delivered to the east of you instead of to the south of you, you can use that as your way of getting the health care services you need.

I'm not going to ask a question, because I know these people have the best intentions for their community and I applaud the fact that they've taken the time to come here. Thank you very much.

The Chair: Thank you for your presentation, and enjoy the balance of the day.

Ms. Havlek: I just want to say that we've already met with barriers. We've been turned down by the London tertiary centre because they said we're not in their LHIN. If they don't get the money to serve us, how can they serve us?

The Chair: I'm sure that your local MPP will follow up on that. Thanks for letting us know—or anybody else, for that matter. We can continue this discussion.

CANADIAN HEARING SOCIETY, LONDON

The Chair: We'll move to the next presentation. We're just a little behind. The next one is the Canadian Hearing Society, London. You can start whenever you're ready. There is 15 minutes' total time.

Ms. Marilyn Reid: Thank you very much for having us today. My co-presenters are Diane Robitaille, who is a consumer of our agency and also a counsellor with our agency. Beside her is Marilyn Bullas, who is also a consumer and is a member of our community development board here in London. They'll be assisting me, sharing some of their experiences and some of their issues.

In terms of the Canadian Hearing Society and who we are, we were founded in 1940 and provide a whole range of services to enhance the independence of individuals who are deaf, deafened and hard of hearing. We have 28 offices across Ontario, and a presence in each of the 14 LHINs.

In terms of statistics, hearing loss is one of the fastest-growing disabilities in North America and is going to continue to grow with increased noise pollution and aging of the population. As a younger member of the baby boom population, we're coming along, so we're going to see increased numbers. According to StatsCan, 10% of the population suffers a hearing loss, and as I said, that's going to grow. So it's going to impact a significant number of people in Ontario.

In dealing with people with a hearing loss, we basically have four different groups that have very different access, support and communication needs. To explain what those four groups are and what they need, I'm going to ask my colleague Diane to talk about the first two groups.

Ms. Diane Robitaille (Interpretation): I'm a culturally deaf person, and there are people like me who require ASL to communicate and use interpreters. For clarification, I should say that's ASL or LSQ, which is langue des signes Québécois. Our communication needs are through ASL English interpreters. We often also use real-time captioning, like you see here, and communication devices such as TTY, teletype or telephone devices, as well as a variety of visual amplification or visual sound devices like baby monitors or doorbells that actually flash a light, and things of that nature. There are also oral deaf people who choose to speak and communicate in that way. They often rely on speech reading and real-time captioning, and many people are also now using cochlear implants.

Ms. Marilyn Bullas: My name is Marilyn Bullas, and I am a deafened adult. I was a hearing person until four years ago, when I suffered profound hearing loss. Deafened is different from hard of hearing. Hard of hearing is much more common, especially as people age. They have nerve deafness and become hard of hearing.

This hearing loss for me was a devastating time. Although I could speak, I was unable to understand speech. I couldn't hear the phone, I couldn't hear the door, the alarm clock, the smoke alarm. Understandably, I felt very frightened and vulnerable. My children were most upset. My son called the Canadian Hearing Society in a panic, asking for help. Within a week, assistive devices were brought to my home, explained and set up for me. My councillor offered to speak to my family and friends. But most of all, she taught me to hear differently.

Speech reading, closed-captioning and real-time captioning, which this is, were introduced to me. It was such a relief to know that with practice, people could learn to speak clearly to me. My life is different now, but it's good. I have made many friends among the hard of hearing who rely on hearing aids and captioning as well. I have had a cochlear implant also, which has provided

some improvement for me. But I want you to know that sitting back there without the captioning, I hear nothing; I hear a little rumble, but I hear nothing. I look normal, I think I act normally, but I'm anything but normal.

We have an ongoing support and advocacy group through the hearing society, which has really enriched my life. Part of our advocacy is trying to get more of this real-time captioning in theatres and other places. There's very little that I can do without captioning. With that one phone call four years ago, the Canadian Hearing Society has met my communication needs in a timely, expert manner. Their service is unique and irreplaceable.

I would like to make one more comment in terms of having the sign-language interpreter and having the captioning here. It's available for two hours and was kind of fussy to set up. I wonder how acceptable it would be to have the room wheelchair accessible for only two hours.

I know that I'm a voice crying in the wilderness, because there aren't very many of me, but I just wanted my voice heard. Thank you.

Ms. Reid: Just to add to that, I think Marilyn is certainly not alone in terms of her access needs.

I think the other group that we talk about, and that Marilyn mentioned, is the hard of hearing Ontarians. That's probably the majority of individuals you may have had contact with. They do have spoken language. They also use all the same access needs that Marilyn would use.

I think that every Ontarian has the right to access to health care, and yet, as we can see even at this meeting, there are barriers in terms of accessing the meeting.

We support the basic concepts and philosophies of the LHINs. We see that there are three major issues with respect to the legislation that, again, we want to highlight. The first is accessibility, obviously; the second is the central versus the community roles; and the third is the possibilities for system integration.

I am going to ask Diane to talk a little bit more about accessibility.

1100

Ms. Robitaille (Interpretation): Accessibility: When you're talking about geographic accessibility, there is a lot of concern around appropriate services being in one's local community area. Where disabilities are concerned, for people with disabilities access means something different. According to the AODA, the piece of legislation that was passed only last year, the issues and the mandates that have been established in that legislation must be followed in the development and implementation of Bill 36 so that all barriers are broken down.

It is critical that all accessibility needs are met within the local health care service providers. In the Eldridge decision in 1997, the Supreme Court of Canada decided that the human rights have already been declared and decided and that access to health care is mandatory in all environments for people with hearing loss. So in the implementation of the new LHIN system, from the groundwork up it is critical that all health care providers and all the health care services are made accessible to people with all disabilities, particularly people who are deaf, deafened and hard of hearing, as we've already mentioned, as an expanding community of people due to the aging population. Their needs are going to be critical and must be a priority in the provision of health care services.

I'm here today with an ASL interpreter only for an hour. That service should have been made available for the entire day and all of the proceedings taking place here.

My experience has been that when I go in with my husband to the emergency room it's often a 12-hour stay, and that entire time is taken up without any kind of ASL interpreting provided. So I'm meeting doctors and nurses without having access to communication and information. This has been a gross frustration over my lifetime. Occasionally, if you find a particularly willing doctor, they may take the time to write the explanation of whatever the issue is that you're being seen at the hospital for. But that rarely happens. In ASL, the information is much clearer, it's more accessible. It's my first language. In English, it can be very frustrating, because not all the terminology is necessarily understood and it can be just as frustrating as not having the information at all.

Thank you very much.

Ms. Reid: In terms of community roles, the concept of responding to local needs is admirable, but again, we need to look at it being equitable across the province. We want to stress that it be accessible for all individuals.

I have just been told that I have less than a minute now, so I guess our last word that we really want to stress is the need for specialized services for the deaf, deafened and hard of hearing across the province. Our agency has the unique skills and knowledge base to address those needs, as Marilyn has pointed out. Again, we stress the need that access be in place across the province. LHINs have the opportunity to set the stage for that access.

The Chair: Thank you for your presentations. There is no time for questioning.

GUELPH WELLINGTON HEALTH COALITION

The Chair: We'll move on to the next one and call on the Guelph Wellington Health Coalition. Is Magee McGuire in the room? Is anyone from the Guelph Wellington Health Coalition present? Good morning. Please have a seat, madam. Anywhere; there are two chairs, so wherever you prefer. Whenever you are ready, you can start your presentation.

Ms. Magee McGuire: Good morning. I timed this last night; it's about two minutes over. I'll try to shorten it as I go along.

The Chair: Okay.

Ms. McGuire: My name is Magee McGuire, and I chair the Guelph Wellington Health Coalition. I'm also a nurse with 35 years' experience; I've just retired. I worked mostly in clinical units, with short stints in emer-

gency and critical care, and I also worked in community clinics in Toronto.

The vision of our coalition is for all Canadians to have access to health care according to the principles of the Canada Health Act. Our mission is to educate and inform the general public about the status of the first tier of our health care system, the one for everyone regardless of economic or social status. Our mandate is inspired by the desire of 80% of Canadians to reform the weak links in public delivery and strengthen accountability.

The local health integrated network, or LHIN, mimics the current government policy to apply management principles of private enterprise to the public health sector. Its priority is fiscal, not people. It does not address its impact on social fabric.

We note that the LHIN has a definition and clear goals, but no implementation plan. We want to address the latter in respect of the huge losses our community has endured. We want to connect it to issues of privatization. To evaluate its worth, consideration will be given to its character as a co-dependent provider of opportunity for private, for-profit health delivery.

We cannot endorse private clinics that require membership fees for prevention services. These are not essential. There is no legislation to exempt these members from returning to the public system. It is not acceptable that our elected representatives want to abdicate their job to be the hands-on providers of the one-tier, publicly funded and delivered health care system.

I wish to digress for a moment. We have two other tiers. One is an insured tier that covers extra services covered by private plans. Then there is a third tier, where cash is required for all of these services. We pay regular tax contributions to health and the recent health tax of Ontario, 2004. Don't you think the private dollar is already paying enough?

Wait lines are the issue. We do not endorse the sensationalizing of wait times over someone's death. The real source of the problem is in the funding or in the delivery.

The principle behind the Harris cuts was to save and to reduce deficit. Now we know from CIHI that the cost per capita for health care has increased less than a full percentage point since the 1990s. So what is causing this deficit? It's not transparent. The real drivers for these costs are not in patient care but in drugs and technologies. What are the plans for reducing these drivers?

The current government justifies private partnerships in hospital care, which the LHIN will administrate. However, this is wasted time and effort, because it will not produce the doctors and nurses we need to shorten the wait lines, nor will it save dollars or lives. According to the American Journal of Medicine and the Canadian Medical Association Journal, both peer-reviewed magazines, research was printed that demonstrated both higher death rates in for-profit hospitals and higher costs. I have attached these research articles.

So we're asking again, how will the LHIN increase the number of doctors and nurses in the public system? How will it ensure that there is no brain drain away from our region or public hospitals? What disincentive will it give to queue-jumpers? How will it prevent the private clinics from snatching up all the lucrative, low-risk patients who will not need the post-op care in an intensive care unit or need longer-term recovery? To date, day surgeries have provided efficiencies for the public system. Cataracts, tubal ligations and hernia repairs are but a few of the day surgeries. If this is so lucrative to the private sector, why is the public system not organizing hospitals that have ORs sitting idle to do this surgery more frequently? Lastly, how will the LHIN be able to sustain itself?

1110

The LHIN executive has responsibilities not unlike those of a CEO, a human resources director and CAO. In fact, one wonders if the job of the hospital executives of the same name will become obsolete in their organizations. After all, it will be duplication.

These were the people most responsible for the restructuring of the years 1998 to 2002. They received their orders from the Ontario Hospital Association, which, in turn, was agreeable to the cutbacks.

Also, it is clear that the LHIN policy is about restructuring. However, it lacks a clear implementation plan with constructive details that clarify the need for the goals, and it lacks an evaluation component to measure the impacts.

To evaluate, we would like to stress the outcomes. We can predict the outcomes of this legislation best by looking at what happened to Guelph in the last round of restructuring, whose methods of implementation are now known to us—kind of a mini-meta analysis; that is, forecasting after the fact. Plus, we can name goals achieved and measure their efficacy by the outcomes.

In Guelph, the satisfaction of patient surveys after restructuring stood at 70%—doing its very best. The greatest good that came from restructuring was the formation of purchasing consortiums, a leap out of the skin of the silo. Yet the silo, in a city where there is only one acute care facility, is still a fact of life. We are still not holistically engaged as health providers.

I will now list what we have lost in Guelph due to the restructuring. In home care, we lost nurses and homemakers—never replaced nor increased for the ever-growing home care sector. Remember, home care was to take the convalescing hospital patient into the home to decrease the costs of running a hospital. Remember, there was no funding shifted to home care to take on this burden. It is not an administrative solution we needed; it was physical bodies to do the work. Hours of service were lost. Overburdened families returned the patients to the hospital.

For palliative patients, the scenario became even more dire. The qualifications for extended care hours for the dying patient requires a predictable estimate of six weeks to time of death. Are these uncompassionate goals the stuff of government stewardship? Whether you planned it or not, what you have achieved is the goal you achieved.

Must I rant about the competition? Do these outcomes demonstrate that the home care sector is more effective

with its piecemeal schedules, its record duplication and its inability to continue to meet the requirements of a stable but very ill patient?

Remember, elderly people were to be encouraged to stay in their homes longer. The cost of a weekly homemaker was certainly much cheaper than the minimum of $1,200-a-month room and board in a retirement or nursing home. But this service too has been restricted. Now increasing numbers of people wait for nursing homes close to their families upwards of two years.

For hospital patients ready for discharge to extended-care facilities, there is minimal to no choice of placement for this patient. It may be several towns away.

Then there was the loss of acute care beds. Medical beds were reduced—our population is 120,000, by the way—from 60 to 42, pediatric beds from 40 to 10 and surgical beds from 30 to 24. We lost an acute care hospital with its own emergency and critical care services, and the emergency services were transferred to the Guelph General Hospital months before the funding was in place. The danger of this situation for months should never have been overlooked.

We lost staff when two hospitals amalgamated on the pretence that the alternate hospital would be specialized as a rehab and chronic care hospital. Within two years, the rehab hospital, which never received its full funding for rehab, was demoted to the status of a long-term-care facility and lost its special funding. There is one RN and two RPNs to care for 36 dependent patients on the 12-hour night-shift.

We lost staff trust and morale when nurses were laid off and the bumping started. Trained RPNs were forced to bump into housekeeping, dietary and ward clerk positions just to keep a job. Interpersonal conflict is now a big workplace issue.

We lost the head nurse position to a business unit manager position, requiring hours of meetings and little time for staff interaction or patient communication, major complaints excepted. The solution was to take a nurse off the floor and make her a charge nurse to reclaim the fort and be at the beck and call of both manager and bedside as well. Complaints, you say? Well, they just never seem to stop any more.

We lost in-house laundry, we lost the outside groundskeeper and we lost the in-house painter, yet these seem to be daily, ongoing services. They're all contracted out. We don't know what the cost comparison was. No one knows.

We lost a nurse educator who for years would orientate staff, supervise the new skills and update staff uniformly.

Nurses use a recognized measuring tool for their work by law. The numbers indicate increasing patient hours and not enough nursing hours to cover the cares. They are ignored because of budget constraints over which they have no control or input. The increased stress is leading to increased sick time, combined with increased overtime hours, not to mention increased injuries. This is a significant fact because, as you know, payroll makes up 75% of hospital budgets.

We lost doctors and nurses to the US due to lack of jobs. The 8,000 nursing jobs promised to Ontario have not materialized. The outcome is long wait lines for all services. By prioritizing the five areas of medicine to meet provincial benchmarks, the wait lines in other areas are going to be longer. Are we happy yet?

We lost time to give foot care and back care. A tub bath is rare. We lost the evening snack for all patients except diabetics or hypoglycemic patients.

We lost dedicated housekeepers so that the nurses have to pick up the slack, and some never do. Now we are incorporating the metal giant, the computer, known to be a sinkhole for time, known to excessively tire us and negatively—we now know—affect our intelligence. Wouldn't you know it? The doctors do not have to learn this until 2007. Only the nurses and the rest of the hospital have to learn it.

We have lost our public lab because the funding was not there. Guelphites now have a choice of several private labs to go to. Prices for infrequent tests are not standardized. The unsuspecting patient is a victim.

We have lost our range of responsibility for city and township to larger areas. Critical care now has to admit patients from St. Catharines because of lack of beds there, even though the patient is routed there because they require tertiary care, which this hospital is not funded or staffed for. The extra cost comes out of our local hospital budget, and the occupied bed is closed.

We just lost 12 transition rehab beds, and we're going to lose our outpatient chemotherapy department.

Labour is going to have a blow as we now lose more jobs.

So where in these goals is the vision of health care for Joe Public in the realms of safe and competent delivery? These outcomes speak for themselves.

We believe that with each deficit that appears, another service will be lost. Staff reps will be lost. Rights of staff and patients will be eroded. There will be more amalgamations and contracting out, bigger workloads, union amalgamations, loss of bargaining units and benefits. Pensions will be affected. There is no sunset clause.

When the hospital can't operate, it will have to close its doors or sell. This will be taken up by a private investor, who then will open this up to foreign investment because it's protected by the law of NAFTA.

So tell me, with lower wages and job losses, where's the government going to collect its tax? Certainly not from the corporations to which it gives these tax cuts.

We've lost perspective. Quality is defined only by specific, best-practice treatment of a patient.

Then there are doctors. We're sure that they will love working in these chaotic conditions and encourage their children to study for medicine. I'm sure they will turn their patients and wipe their noses. It is strange that they're exempt from this LHIN process, for they are part of the very survival of health care in any form.

Three generations ago, their fathers traded chickens for services. They need to be partners in this.

The Chair: Thank you.

Ms. McGuire: I just have one more.

We're concerned about the democratic aspect of the LHIN, the lack of checks and balances for Joe Public to address inconsistencies of this government or future governments. There's no legislative passage to ensure the protection of the principles of the Canada Health Act, and the Minister of Health has set himself up as the wizard.

So the process by which the LHIN has come to be is incomplete, and it's also out of traditional order—no white paper and no first round of meetings recorded that we can refer to. At these hearings, we have incomplete information. What is this plan going to cost us? What's it going to save us? Where are our tax dollars going?

1120

These goals are the ones that we see that the government will achieve. Is that what it wanted? Outcomes are the true goals achieved. Outcomes in a health system are measured in people satisfaction, in death rates, in social responsibility.

We have given you some of the predictable red flags of the LHIN in its present form. Reform now means "destroy"; change now means one more tier of finance. It is not incongruous to suggest that this government cannot see the invisible and therefore it cannot do the impossible.

Thank you very much.

The Chair: Thank you very much for your presentation. We have the entire package, all of us here, so it's all on public record. Thank you again.

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1, LOCAL 145

The Chair: Is anyone from the Service Employees International Union, Bluewater Health, present? Claudette Drapeau and Ann Steadman. You can start any time you're ready. There's a total of 15 minutes.

Ms. Claudette Drapeau: It'll be short and sweet. Hello. My name is Claudette Drapeau and I'm an RPN at Bluewater Health and co-chair of SEIU, Local 1, in Sarnia.

I am here to appeal to your sense of propriety. I am not opposed to change, but I am against inequity and the demise of our health care, which should be made available to all Canadians, regardless of their status.

The LHINs structure is undemocratic. Health care does not need more bureaucracy. With the LHINs being appointed by the government and accountable only to the government, who will serve the people? How can you justify spending $52 million to hire 550 new bureaucrats, and add to this $200 million to set up a new LHINs organization, while not one cent—not one cent—is being utilized to add a single family doctor, medical specialist or direct hands-on care provider to our health care system?

Fourteen million dollars had to be cut from Bluewater Health, which resulted in 164 professionals being laid off. You cut at our local levels to balance so-called budgets and turn around and create another expense that does not serve the people. Health care taxes should be utilized for what they were intended for—health care. The Liberal government is not being accountable to the people, and our tax dollars are being wasted on bureaucracy while people are dying waiting for care.

How can you ensure that there is a clear understanding that patients can continue to receive care across LHIN boundaries? We are always going to be closer to London than Windsor, so will our referral process continue?

Some things may work in Toronto, having one hospital do all hips, knees, etc., but that won't work in smaller communities, and Sarnia is a smaller community. If you move a service such as hip and knee surgeries to one location, we will lose our orthos, and then our emergency department will not function as needed and down we go. How is this going to benefit our community? Does the government equate the reduction of services to better health care?

Will our rural hospitals be nothing more than walk-in clinics? How are senior citizens expected to shoulder the cost of travelling expenses on fixed incomes? Secondly, can you ensure their safety on our major highways during inclement weather?

I have been told that they can rely on family. Well, not all senior citizens have that privilege, and for those fortunate enough to have families, again, there will be a cost: lost wages, hotel bills, meals, etc., and additional stress due to travelling highways and having to leave a loved one behind in a strange city.

People are not just cases; they are individuals with physical and emotional needs. By putting senior citizens in disorienting environments without family and moral support, you decrease their chances of a quick and full recovery. It seems to me that only the rich can afford this new health care system. The poor and the senior citizens will be left out in the cold.

Our hospital, Bluewater Health, is a community focus point and it is staffed with professionals who are educated to respond to extreme emergencies. We live in the Chemical Valley, where first response must be upheld. We cannot afford a second-rate, substandard health care system which can jeopardize the lives of our citizens in our community. By contracting out services to the lowest bidder, you put us at risk. You will lose stability and gain greater disparities.

Clearly, this legislation is jeopardizing every health care worker's livelihood. The government wants to remove the protection of the current collective agreements, debase staff to work at lower wages and remove their hard-earned pensions, with no benefits. Odd, don't you think, for a health care worker to be working in a hospital for a private company yet have no health benefits? The Liberal government is attempting to balance budgets on the backs of workers, with total disregard for the chaos and hardships it will create. Displaced non-clinical service workers will have no right to transfer their union contracts to the for-profit private

providers of non-clinical services. It is essential that a human resource plan be developed. Health care sector workers' rights must be protected.

You need to meet and have dialogue with front-line health care workers to find resolution, people with integrity and common sense who understand what is at stake and understand the needs of the patients. Do not put our health care system in the hands of bureaucrats and businessmen who have a different agenda and who are ignorant of the dynamics of true health care. Do not pass this flawed legislation. Thank you.

Ms. Ann Steadman: My name is Ann Steadman. I am an occupational therapist and the unit chair of OPSEU Local 145, Bluewater Health, Sarnia. I come before this body to express a few of my many concerns about the local health integration networks, LHINs, as proposed under Bill 36. This bill, supposedly about the transformation of health care, will result in ongoing health care chaos and instability.

First, this bill has been implemented, in many ways, without due process. Before these hearings and prior to a third reading in the Legislature, LHIN CEOs have been hired and board members appointed. In fact, the LHIN CEOs have been on the job since August 2005. Thirteen of the 14 CEOs are reportedly making some $225,000 a year; one is getting $325,000 annually. Other than meeting and greeting, renting office space and hiring some staff, can the government point to anything else they've done for a cost of some $1,624,000? This amount of money would fund Sarnia's much beloved but endangered palliative care unit for a year.

Second, the government calls these proposed new bodies "local health integration networks." I would suggest that this name, LHINs, is a misleading and deliberately inaccurate description, designed to fool the public into thinking that there is some local control going on. LHINs have nothing local about them. Rather, the government is putting into place RHINs, regional health integration networks, another layer of bureaucracy insulating the government from the public.

What does "integration" mean? My dictionary tells me it means "to form, coordinate, or blend into a functioning or unified whole." However, the ministry defines "integrate" to include "transfer, merge, or amalgamate, to start or cease to provide services, to cease to operate." Given that the LHIN-appointed CEOs and board members are accountable to the minister, not to their communities, how can any community be assured that a LHIN CEO and/or board will be able to forcefully represent their community's position when what is right for the community is in conflict with a ministry direction? Where are our checks and balances?

Further, these regions are very large. Sarnia-Lambton is in the Erie-St. Clair LHIN, which stretches from Grand Bend in the north to Pelee Island in the south and consists of three counties: Lambton, Kent and Essex. The LHIN boundaries do not represent medical referral networks that are historically and currently in place. In Sarnia-Lambton, we relate to London, not Windsor, which is at least a two-hour drive from Sarnia in good weather.

Third, across the province, the appointed LHIN board members have a stunning lack of health care experience. As for our CEO, the same could be said. The Erie-St. Clair LHIN CEO has no health care experience. He is a former telecommunications industry executive. This point was brought home when he stated in a public forum in November that he didn't know what community care access centres, CCACs, were until last summer. Will the board members and especially our CEO, lacking health care backgrounds, understand the key elements for delivering good patient care?

1130

Finally, the human resources issue has not been adequately addressed. Quality patient care depends entirely on the quality and continuity of the staff providing that care. This legislation opens the door for the competitive bidding of service provision and an ongoing process of service transfers and amalgamations, a sure recipe for health care chaos and permanent instability. We have already been down this road in Sarnia-Lambton with our CCACs. We've been through three rounds of requests for proposals. There have been significant changes in service providers, with the resultant disruption to patient care and dislocation of workers. In one case, a new-to-the-area, low-bidding service provider got contracts for both nursing and homemaking and ended up having to default on the nursing contract within one year.

Already, Bluewater Health and the Chatham-Kent Health Alliance are sharing occupational health staff. Essentially, what were three full-time-equivalent positions at Bluewater Health have been cut in half, and this is just the beginning of an erosion of local services and local jobs. As this process continues, workers will be forced to drive great distances to keep their jobs or be forced to choose between their communities and their jobs. This will lead to a recruitment and retention nightmare at a time when there are substantial shortages in many key health care professions.

How can we attract young people into health care professions when the future is so uncertain? To put patients first, the government must ensure both the retention and recruitment of health care professionals. LHIN bureaucrats will not be providing patient care. Care means health professionals at the bedside, in the labs, running MRI and CAT scanners and providing rehabilitative services.

I urge the McGuinty government to put the brakes on this LHIN implementation. Stop the LHINs before they literally crash our health system. Postpone this legislation until a comprehensive strategic plan is developed in consultation with all stakeholders.

The Chair: Thank you for your presentation.

We have about three minutes left, and I would ask Madam Martel to start, please.

Ms. Martel: Thank you, both of you, for coming from Sarnia today to make this presentation. I wanted to ask you a question about competitive bidding, or cutthroat

bidding, which is the way I normally describe it. The minister, in his opening statement yesterday, said we were going to hear a lot of misleading information—that was his word, not mine—at these hearings from critics of the legislation, that one piece of misleading information we were going to hear was that, through this process, LHINs were going to purchase or acquire services through competitive bidding, and that nowhere in the legislation was that referenced. Nowhere in the legislation does it say they're not going to do that, either. So what is the government's intention? We already know they have not changed cutthroat bidding in home care. Despite the review by Elinor Caplan, it still goes on.

From your perspective, because you have seen how this has operated in your community, why would you be worried about cutthroat bidding being extended from home care to all the other services that LHINs are expected to purchase in the future?

Ms. Steadman: To recap what we've seen happen in Sarnia-Lambton, we've had three rounds of requests for proposals. In the first round, a very long-established large company, ParaMed, ended up being gone. In the second round, VON lost their homemaking contract, Lambton Elderly Outreach lost theirs and, as well, a small community occupational therapy service organization was cut. That's when We Care was introduced, and that's the company that defaulted on nursing. In the third round, another large, significant service provider, Comcare, left.

This means that as soon as a service provider leaves, all their employees are out of work. Typically, because the bidding tends to go to the person putting in the lower bid, workers are then picked up at lower rates of pay. That's our basic concern. If we see this translated throughout the rest of the health care system, I think you'll see, again, more chaos and less patient care. Getting back to the CCAC situation, it's exceptionally disruptive for someone who is elderly, for instance, and maybe has had a homemaker for a few years—the homemaker has almost become part of the family—when that homemaker is yanked out of the situation because of a bidding process.

The Chair: Mr. Ramal.

Mr. Khalil Ramal (London–Fanshawe): Thank you both for coming from Sarnia. Just for the record, you mentioned that our government cut your budget. As a matter of fact, we have a record showing we gave you an extra $13 million. Also, the budget for Sarnia hospital: over $600 million. So we never cut your budget.

Also, I don't understand how you can describe the LHIN as going to affect health delivery. I don't know if you were here listening to my colleague Maria Van Bommel from Lambton–Kent–Middlesex when she was talking about when she had to communicate with the minister in terms of, if you want to seek some kind of service in your boundary, whatever you prefer, you can go to it, and the LHIN is not going to affect that service. It is, as a matter of fact, working at the administrative level in order to consolidate the health delivery.

Ms. Drapeau: That's good to know, but I want to say that we, as employees at Bluewater Health, were cut $14 million. They claimed we were $14 million over budget and they cut. So services were lost. To say that you've given the hospital money, it wasn't enough.

Mr. Ramal: This increased the budget $13 million.

Ms. Drapeau: Increased the budget. We needed a $14-million increase, sir.

Mr. Ramal: We never cut the budget.

Ms. Drapeau: We lost. They cut our budget $14 million. They claimed that we were $14 million over budget. So we had to lay off 164 professionals from the hospital, and we had to decrease services and amalgamate services.

The Chair: Mr. Arnott.

Mr. Arnott: Thank you both very much for your presentation.

Ms. Steadman, I was pleased that you raised as your first concern the fact that Bill 36 hasn't been passed into law, and yet the government has moved forward, showing what I would characterize as profound indifference to the Legislature and the role of the Legislature, which is to look at these bills that are introduced in the Legislature, debate them at length and allow for public input before final decisions are made. Yet the government has appointed LHIN boards, has appointed CEOs—you've described some of the salaries. There's something really wrong here when the government shows this kind of indifference to the legislative process. Would you not agree?

Ms. Steadman: I would call it disrespect.

Mr. Arnott: Would you call it contempt of the Legislature?

Ms. Steadman: Yes, I'll be led into that.

The Chair: The 15 minutes are now over. Thank you for coming and sharing your opinions.

COMMUNITY CARE ACCESS CENTRE OF WATERLOO REGION

COMMUNITY CARE ACCESS CENTRE OF LONDON-MIDDLESEX

The Chair: There is another presentation before we break, from the Community Care Access Centre of London-Middlesex and the Community Care Access Centre of Waterloo Region. Are they in attendance at this time? Please have a seat. There will be a total of 15 minutes for your presentation and potential comments and/or questions.

For those who have an agenda, the 11:30 presentation has been cancelled. That's why there is only one left before the break.

You can start any time.

Mr. John Enns: Good morning, Mr. Chairman and members of the committee. I'm John Enns, chair of the Community Care Access Centre of Waterloo Region. It is a great honour for me to come and speak to the standing committee on social policy today. I'd particularly like to

acknowledge Ted Arnott, the member of the Legislature on the standing committee who represents our riding in the Waterloo-Wellington area and with whom the CCAC of Waterloo region has had the privilege of interacting over the years.

As one of the founding board members of the CCAC of Waterloo region back in 1996, I felt, as does the board of directors, that it was important to come here today and provide the committee with our input on the proposed legislation, Bill 36. I must tell you that we consulted with the CCAC of London-Middlesex, and because our views on Bill 36 are in agreement, we decided to do one presentation so that the committee would not have to hear the same message twice.

I have asked Kevin Mercer, the executive director from the CCAC of Waterloo region, to make some comments today. Sandra Coleman, executive director of the CCAC of London-Middlesex, is also here with us today and is available to respond to your questions.

1140

Before I ask Kevin Mercer to address you, I did want to emphasize that we support this legislation in terms of the development of the local health integration networks and also in terms of the amalgamation of CCACs within LHIN boundaries as noted in section 15 of the proposed legislation.

In our opinion, the proposed legislation will allow community care access centres to further advance our organizational vision and mandate. Our vision, which was developed in consultation with our stakeholders, clearly highlights the importance of the pursuit of integration. I want to take a moment and read you our vision, because we plan and prioritize our activities around this statement: "The community care access centre"—of Waterloo region—"is a leader in delivering integrated health care through innovation and partnership to an aware and informed clientele."

In other words, our organization has always focused on integration and planning of services in partnership with providers in all program areas in health care, with the school system and with a number of social services. As an example, recently we developed, in partnership with the Waterloo Regional Police, an elder abuse prevention team.

CCACs are all about integration, creativity and flexibility across the numerous silos in the health care system. We are not about organizational structure. We are about the services that we can make happen and the difference we can make in the lives of the people we serve. Our most significant partners, our clients, need an organization like ours to help them understand and access the various options of community-based support when they require assistance. Our case managers do that. They are at the front line. They have been referred to as both "knowledge managers" and "boundroids" because they know how to move across the various boundaries and the silos in the health system to ensure that our clients get the service they need when they need it.

So this legislation, Bill 36, is going to advance integration of services for the client. From our perspective, addressing the fragmentation, inconsistency and siloed nature of health care in Ontario makes sense, so we urge you to move forward with this legislation. Ontarians will thank you for it.

As well, the intention to move CCACs back to community-based organizations with local membership and locally elected boards is a positive step. The plan to remove the order-in-council appointment process for board members and executive directors within the next two years is supported by our board. We believe that with community membership and community selection of board members, there is a stronger community ownership of local planning and resolution of issues. From the beginning of the order-in-council appointment process for CCACs, the finalization of appointments has been a slow process and not always respectful in terms of recognizing the contributions of volunteers. These are key governance changes that are welcomed by our board.

I would now like to ask Kevin Mercer to make a few comments, following which we, along with Ms. Coleman, will answer, to the best of our ability, any questions that you may have.

Mr. Kevin Mercer: It's a pleasure to be here, Mr. Chairman. I want to share with you comments developed by the CCAC of Waterloo Region and endorsed by the CCAC of London-Middlesex in relation to advancing health system integration in Ontario. The comments are in relation to three specific areas: first, case management and system navigation; second, investing in community-based services; and third, proposed amalgamation of CCACs in Ontario.

Case management and system navigation: In June 2005 at the Ontario Association of Community Care Access Centres annual convention, the Minister of Health and Long-Term Care, the Honourable George Smitherman, clearly challenged our sector to move beyond our traditional roles and functions in the plan to transform health care in Ontario. Mr. Smitherman said, "Home care is the linchpin in our plan for health care. We will be counting on CCACs not only to continue doing the great work you have been doing, but to persistently push yourselves to do even better to deliver to Ontarians the care that they need."

The challenge from the minister was taken very seriously across the province by the CCACs. When we reflected on where we could add value to the health system and transformation initiative, clearly the area of system navigation was identified. As care is being shifted from institutions and acute care to the home, it is essential to guide clients in terms of the options and the supports that are available to them. Case managers are able to link and coordinate service delivery in an increasingly complex and ever changing health system.

Case management is the mechanism for making sure integration, health promotion and disease management can occur. As we engage in the transformation proposed in the establishment of LHINs, case management is a core service. With the support from the Ministry of Health and Long-Term Care, CCACs and their partners are positioned to have a positive and immediate impact.

In the OACCAC provincial report on health system navigation, there are six recommendations on system navigation currently being pursued by CCACs: Improve system access by expanding the CCAC information and referral function; introduce and include CCAC case managers in family health teams; merge the role of hospital discharge planner and the CCAC hospital case manager; initiate planning processes among partners to develop disease management strategies; advocate for the development of province-wide health care strategies for subpopulations; and, finally, initiate a process to develop evidence-based best practices for all initiatives.

We recently amalgamated discharge planning and case management at Grand River Hospital in Kitchener. In collaboration with the hospital and the Ontario Nurses' Association, we created a harmonized role of case management/transition planning. Tremendous duplication was eliminated and system navigation was enhanced. Patients in the hospital now receive support from one person with an integrated role—it's client-centred and more efficient. The CCAC of London-Middlesex is exploring these opportunities as well with their London hospital partners.

A plan is evolving to have case managers become a part of family health teams in Waterloo region and also in London-Middlesex; they are integral to community health centres currently. The potential role of case managers in system transformation ensures that clients do not fall between the cracks. We believe this is very significant.

Investing in community-based services: The region of Waterloo is comprised of 490,000 people and is one of the fastest-growing areas in Canada. In 2005-06, with a budget of $47 million, it is projected we will help more than 22,000 individuals and their families, providing approximately 230,000 nursing visits, more than 550,000 hours of personal support and homemaking, and more than 72,000 therapy service visits. In addition, the CCAC of Waterloo Region will assist 2,500 people with the process of transition to long-term-care homes. London-Middlesex is similar in size to Waterloo and serves a comparable client base.

Over the past year, both the CCAC of Waterloo Region and the CCAC of London-Middlesex have experienced caseload growth of more than 15%. As further integration of services continues and community-based alternatives to acute care are expanded, continued growth in the investment in home care is important. It is also important to realize that the aging population and the current strategies to divert hospital admissions have increased home care caseloads.

As acknowledged by the OACCAC in its presentation yesterday, there have been significant investments in CCACs over the past two years to avoid and substitute for hospital services, to reduce wait times for hip and knee replacement, expand access to peritoneal dialysis service, increase access to post-acute home care, expand end-of-life care and develop a consistent client screening and assessment process. These investments will have to continue as the health system transforms. We have the studies and data to prove that making these investments reduces hospital admissions, ER visits and return rates and reduces hospital length of stay.

We understand that there is a significant multi-year federal funding agreement specifically committed to home care for acute and palliative clients which will result in base budget increases for the next several years.

The plan to allow LHINs to redirect savings from integration activities noted in subsection 17(2) is also an opportunity to provide the additional resources that will be required to meet increasing demands for home care and community-based services.

1150

Amalgamation of CCACs, part VII of Bill 36: An important component of Bill 36 is the amalgamation of CCACs within LHIN boundaries in Ontario. Once again, as identified by the OACCAC yesterday in its presentation, "There is a significant level of support among CCACs for consolidation and alignment." The CCACs of Waterloo region and London-Middlesex are part of that significant support and have advocated for CCAC consolidation for more than a year. Our analysis has identified the following benefits that derive from amalgamation:

(1) provides clients with consistent and equitable access to CCAC and community support services within the LHIN boundaries;

(2) supports the development of an integrated risk management strategy to effectively identify and manage potential areas of risk such as communicable disease, community emergencies and disasters;

(3) potential to redirect efficiencies resulting from consolidation to enhance client care and to fortify unmet need such as specialized geriatric services;

(4) uses existing networks to improve access to specialized resources such as restorative justice;

(5) aligns with already established and developing networks such as the regional cancer centre, regional cardiac centre, hospice palliative care network, stroke strategy, hospital networks and numerous other LHIN-wide initiatives;

(6) leverages and facilitates broader expansion of best practices and excellence in community care;

(7) builds on existing complementary vision and values of neighbouring CCACs;

(8) stabilizes community-based human health resources resulting from RFPs issued over a broader geographical area. The resulting economies of scale benefit clients, provider agencies and staff working in this sector;

(9) creates a community-based, system-wide platform:

—to promote dialogue leading to a common set of community-based performance indicators and care maps;

—to identify and meet health needs of populations served;

—to facilitate accountability to the LHIN for community services.

There are decided benefits in amalgamation, particularly in light of Minister Smitherman's commitment that

local presence will be maintained through the local community- and hospital-based offices of the CCACs.

Mr. Enns: Mr. Chairman and members of the standing committee, once again thank you for the opportunity to present our thoughts to you. In closing, I wish to reiterate our support for this legislation and would urge you to proceed with the passage of this bill. This will ensure that CCACs are amalgamated across the province within LHIN boundaries and will result in an enhanced client-centred system of community health care.

Mr. Mercer, Ms. Coleman and I are happy to answer any questions you may have.

The Chair: We've run out of time, but we do have a few minutes because somebody cancelled. Do you wish to go for a minute each? Why don't I start with you, Mr. Arnott, seeing as they are from your area.

Mr. Arnott: Your presentation is very comprehensive and self-explanatory, but I do want to thank the board and staff of the CCAC of Waterloo Region for the outstanding work you do here.

Mr. Enns: Thanks, Ted.

Ms. Martel: I have a question. On page 8, you say, "The plan to allow LHINs to redirect savings ... noted in subsection 17(2) is also an opportunity to provide additional resources." So I go to subsection 17(2) in the legislation and I see it says the following: "When determining the funding to be provided to a local health integration network ... for a fiscal year, the minister shall consider whether to adjust the funding to take into account a portion of any savings from efficiencies that the local health system generated in the previous fiscal year and that the network proposes to spend on patient care in subsequent fiscal years in accordance with the accountability agreement."

You choose to read that as saying that the LHIN is going to get its budget and the savings. I read that to open the potential to the savings being deducted from the budget. What guarantee do you have from the minister that the reference to savings is in addition to the budget and not a subtraction from the budget in that fiscal year? The legislation doesn't say "in addition to."

Mr. Mercer: In responding to that question, there is no guarantee in the budgetary process, and we all know that from experience as you develop a budget. But in the spirit of the legislation—we're looking at the objects of the LHIN, and we're assuming from the objects of the LHIN that we are seeing a philosophical shift occur in health care, being promoted through the legislation, that would allow the creation of innovative opportunities that do create efficiencies and those efficiencies being reinvested in areas that are identified as being deficit in a particular LHIN area.

The Chair: Mr. Leal, the last question.

Mr. Jeff Leal (Peterborough): I just want to follow up on that line of questioning, because it's certainly my understanding that the minister has been very clear that any LHIN savings within the geographic area of a specific LHIN would be used to fund those priorities that the LHINs themselves identify. For example, in my area of Peterborough, we have a high degree of seniors, and the CCAC in my community is very excited about the LHIN legislation and getting those extra dollars to put in to address the priorities, particularly of home care, in my community, which has that large seniors population. Could I just get you to comment on that?

Ms. Martel: Where is it in the legislation?

Mr. Leal: I'm asking this gentleman a question, Ms. Martel.

Mr. Mercer: The other component, reflecting on your question, is that the reality is that the LHIN is going to be developing an annual plan that they submit that will define the budget for the given LHIN area. Once again, reflecting on the objects of the LHIN, we believe we're going to be part of that process and we're going to be able to put forward the efficiencies that we identify, and then we'll be able to reinvest those in the program areas that have been identified.

Mr. Leal: And improve patient care.

Mr. Mercer: Absolutely.

The Chair: I thank you all for your presentation.

We are breaking until 1 o'clock, when we'll be back in this room to continue the presentations.

The committee recessed from 1155 to 1305.

The Chair: Can we start the meeting, please? We are a few minutes late.

ONTARIO NURSES' ASSOCIATION, LOCAL 100

The Chair: The first presentation comes from the Ontario Nurses' Association, Local 100, London. You can start any time. There are 15 minutes in total, and any time you don't use will be available for questions and/or comments.

Ms. Vicki McKenna: Good afternoon. My name is Vicki McKenna. I'm the first vice-president of the Ontario Nurses' Association and a member of Local 100 here in London. With me today is Lawrence Walter. He is ONA's provincial government relations officer.

I'm a registered nurse and have been nursing full-time since 1979. I've been nursing in London in the day surgery/day medicine units, caring for adults and children, for 20 over years now. I did work in the United States for one year as a new graduate, and I can tell you that I came back to Ontario as quickly as I could. I don't want nursing in Ontario to ever operate like it often does there for patients and for nurses, where profit motivations impact on patient access and the quality of care that can be delivered.

I want to start by telling you that we have more than 7,000 members in the London area, what we refer to as region 5 within our structure within the Ontario Nurses' Association, and the surrounding two local health integration networks, or LHINs. We have registered nurses and allied health professionals working in all sectors currently included under Bill 36, including hospitals, community care access centres, long-term-care facilities, and public health, which is excluded from the legislation.

Yesterday in Toronto the committee heard three overriding concerns from ONA's president, Linda Haslam-Stroud, key reasons as to why ONA does not support the approach to integration set out in Bill 36. I won't repeat those concerns, but I do want to repeat to you that ONA leaders are speaking out on Bill 36 precisely because nurses are vitally interested in a positive outcome for health care reform in London and in communities throughout Ontario, not only for our professional interests but for the patients we care for.

Registered nurses know too well the consequences of not getting health reform right. Nurses work daily in life-and-death situations. Mistakes in health care design also have very serious consequences. We agree with the minister that we have to do this right.

Today I want to review additional issues for nurses relating to effective and meaningful collaboration with input from the community and front-line health care professionals and their representatives.

We are concerned with the lack of adequate provisions in Bill 36 regarding input and collaboration in the establishment of local integrated health services plans; input from the community and front-line workers into the LHINs integration decisions and funding decisions; a meaningful oversight of integration and funding decisions, which will have an enormous impact on both the patients we care for and the health care workers themselves; and insufficient accountability into the ongoing provisions of health care services under the LHINs.

We believe the purpose of the bill should be to implement seamless health care. Legislated mechanisms for effective input from employees and their representatives can assist with this transition and, we believe, avoid disruptions in the continuity of care for our patients and the working conditions for the staff that deliver that care. Under Bill 36 as currently drafted, this puts in place a framework for the consolidation of services and disruption in service delivery which undermines patient accessibility, service provision and quality care.

First, we would like to comment on the appointment process for the LHINs boards, which has been conducted entirely under ministerial control. Our members ask why a democratic process for an elected board could not have been implemented which would allow for real community input and representation into the integration decision-making processes undertaken for their area. Rather, what we see is the ministry retaining a tight control on the LHIN board through the appointment process. From the very first act related to the establishment of LHINs, control has been set up to be exercised from the top down, not through community involvement.

We will also be making proposals regarding conflict-of-interest guidelines for LHIN board members that will ensure consistency from network to network, including oversight by the provincial ethics commissioner.

Let me turn to the provision in Bill 36 that currently sets out a requirement, in subsection 16(2), for the creation of a "health professionals advisory committee" by each LHIN. You might think this would be a requirement that would hold some appeal for registered nurses and allied health professionals who belong to the regulated professions. However, after a closer review of the requirement, you might note that there is no definition as to the composition of the committee except that it's to consist of members from the regulated health professions as the LHIN determines or as prescribed. There is no process for the selection or appointment of these members of the regulated health professions.

We've had some experience with health care committees where health agencies have appointed who sits on the advisory committee. I can tell you that the experience has not been very productive or very conducive to a collaborative relationship. "Why?" you might ask. Well, for one thing, often senior nursing managers are appointed to such committees to represent the interests of front-line nurses. This, of course, never really works out very well since, by definition, they don't really have current knowledge of front-line nursing issues from the perspective of front-line nurses themselves. In addition, this requirement does not set out the roles for the advisory committee or the obligation on the part of the LHIN.

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Accordingly, our proposal is that this advisory committee needs to be made up of front-line professionals and that they be given a meaningful role in decision-making, including advance notice of meetings, disclosure of relevant information and planning documents, and the opportunity to actually be heard.

In addition, we believe that restricting input to an advisory committee of regulated health professionals excludes the constructive and welcome input from the non-regulated group of health care workers. For nurses, who are used to working in teams every day, this exclusion seems unwarranted and unhelpful to this commitment of collaboration. Therefore, we'll be proposing that there should also be a health sector employee advisory committee.

I would like to turn now to the requirement for each LHIN to undertake community engagement in the development of a local integrated health service plan and in the priority-setting process. From the perspective of health care workers and their unions, this provision is extremely weak. It does not set out specific requirements for each LHIN, nor does it set out any common requirements across LHINs. We believe it's important to ensure that a process is set up that mandates a consistent public process with clear guidelines.

As currently drafted, Bill 36 does not give unions a role in the decision-making process that flows from the local integrated health service plans, even though integration decisions made by health service providers or imposed by LHINs or by the ministry can have a huge impact on union members, both in the way we deliver care to our patients and in our rights and working conditions.

It's our view that all interested stakeholders—the community and health care employees and their unions—should be given notice of intended integration decisions,

with the opportunity for input, before the decision is finalized. In addition, we're proposing that unions be given notice of final integration decisions by health care providers, LHINs, the ministry or cabinet, if our members are affected, well in advance of the implementation of those decisions.

I'd like to move at this point to what we believe is a failure of Bill 36 to provide a meaningful oversight or review function of integration and funding decisions determined by each LHIN. Currently, the bill does not provide a mechanism to review integration or funding decisions. We'll be making proposals that a review process be established. At the moment, Bill 36 provides for a health service provider to request reconsideration of a decision by the LHIN itself, and for review by the courts.

In our proposal, we believe an independent body such as the Ontario Health Quality Council could be charged with reviewing integration decisions against the criteria of public interest. We believe the Ontario Health Quality Council is well positioned to take on this review function, given the nature of its work and its access to information. This review process would allow for closure for a community that disagrees with the integration decision determined solely by the LHIN.

The final area of concern we'd like to address today relates to accountability agreements and subsequent compliance reports. Currently, Bill 36 provides for accountability agreements between the minister and each LHIN to be made available to the public at the offices of the ministry and the LHIN. This is appropriate, but we believe that all accountability agreements should be made public. However, accountability agreements presently being established between the ministry and health service providers will not be made public. Furthermore, once the LHIN takes over funding in 2007, there'll be no requirement for the next round of accountability agreements between the LHIN and health service providers to be made public. The main point here is to ensure an open and transparent process during health reform decisions and during ongoing accountability for implementation.

Contrary to the minister's views expressed yesterday in Toronto, our intention is to improve the health reform being undertaken, to get it right, so that it provides a firm foundation to build a genuinely integrated health care system. For that reason, collaboration, effective input, oversight and public accountability are all key elements to ensure a successful health transformation in the public interest. But, as is the case in most things, the devil is in the details. We believe Bill 36 requires that much more attention be paid to the details of quality patient care, community input, and local accountabilities.

Thank you.

The Chair: Thank you. We have about three minutes available, Ms. Martel, if you wish to start.

Ms. Martel: I just want to focus on your point that the accountability agreement should be public. From the broadest possible perspective—and I appreciate that suggestion—I agree with that and I can tell you that we've had some problems even with the current accountability agreements and getting information. We've been trying to get information from the ministry about the people who were hired through the CCAC process—what agencies actually got information. We've been told we can't get that because accountability agreements are only between the ministry and the actual CCAC. We have gotten nowhere, to date, trying to get really basic information about which agencies got public money through the CCAC. So I agree with you entirely in terms of the broadest possible public notice, so to speak, of who is dealing with whom and who is getting what. That's really what needs to be done, because we're talking about public money here, and that should be available to the taxpayer.

I just want to go back, though, to your appointment process. Why are you concerned about the current appointment process as it stands, which is essentially ministry-directed and ministry-controlled?

Ms. McKenna: We believe that this is fundamentally the most radical reform of health care in our province and that, if it is truly to be locally focused, then there needs to be true local representation there. The size of these LHINs is so vast that just by calling it local does not make it local. Therefore, we believe that there are people in our communities who are interested, who have the knowledge and skills and should be people who may well be represented by their communities and supported to be on their LHINs.

This appointment process is not about the people; this is about the process. I think that that needs to be an important point: that this is not personal; this is just the way a democratic, clear transparent process should happen. We don't believe that it is even close to that in the current structure of the LHINs.

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: Thank you very much for being here. I just wanted to pick up on that issue. One of the things that we're trying to do in this process is to learn from the experience of other jurisdictions that have gone through similar processes. I just wondered if you're aware that Saskatchewan, Quebec and Alberta all have moved away from elected boards because they couldn't find people who wanted to stand. It just wasn't working out, so they've moved to an appointment process. What we're suggesting is an appointment process that has the community nomination aspect to it, that the LHINs will be expected to get community nominations for people who would be able to represent the community and stand for appointment.

Can you just comment on that? Because it really is something that we're trying to improve on from other jurisdictions.

Ms. McKenna: I don't know the details of all the issues; however, I'm surprised that they couldn't find anybody who was interested in health care. That surprises me a lot. However, I don't know the total situation and will certainly be looking at that. The reality is that I don't really even know of any school boards where you can't

get people who want to run on school boards. We have municipal elections; we rarely have to fall back to appointments. Occasionally it happens, but health care is the number one priority in Canadians' minds and Ontarians' minds, and I'm very surprised that there wouldn't be people who would be interested.

Ms. Wynne: That's just the experience; that's what's happened.

The Chair: Thank you. Mr. Jackson, please.

Mr. Cameron Jackson (Burlington): I appreciate your presentation. The committee has heard some of the concerns you've raised. One of the aspects that is troubling me—I have spoken with two people who were appointed in the LHIN in my backyard, which is from Niagara to Brantford to Burlington. One of the comments that was made was that the minister indicated at the first meeting of people who had been appointed to the LHINs that he really wasn't looking for people with experience in health care. That troubled me a lot, because we are going to be making a substantive leap. These LHINs are extremely powerful and are going to be making decisions about service integration and the delivery of services, actually even trimming some services. Are you concerned about this concept that, that if you don't have a lot of experience in health care, you'd make a better candidate for the LHINs? I'm just following on the comments from the Liberals with respect to learning from other jurisdictions. But I thought we should have health professionals inside the tent, not outside the tent.

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Ms. McKenna: That's perplexing to us as well. It's a bit of a mystery. I can't say that I know the details of all the experiences that were spoken to and I'm not even going to guess how that came about. But yes, it's perplexing. It's a mystery to me why you wouldn't have people who might have some experience or knowledge of health care design, health care delivery, health care provision, actually planning health care. That would be where we would be going. However, it is a bit of an oddity in our minds, yes.

The Chair: Thank you very much for your presentation.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 260

The Chair: The next is the Ontario Public Service Employees Union, Local 260, Owen Sound/Markdale. Are Mark Weston and Christine Coughlan present?

Mr. Mark Weston: Thanks for this opportunity to speak. My name is Mark Weston. I'm an addiction counsellor employed at the withdrawal management service in Owen Sound. I represent the service workers from OPSEU Local 260, at the Grey Bruce Health Services corporation in Owen Sound and the five outlying community hospitals in Grey and Bruce counties.

Our service workers are well-trained, hard-working individuals who are dedicated to providing quality services such as housekeeping, maintenance, kitchen, laundry workers, registered practical nurses etc. Our workers support families and the local economy by spending their incomes in our communities. If the legislation is passed as it now stands, the future of these workers' employment will be uncertain. Entrepreneurs will see this legislation as an opportunity to rob our workers of their current standard of living while padding their own pockets with money. Eventually the quality, well-trained workforce we currently have will drift away to work elsewhere, free from the uncertainty and downward-spiralling incomes in health care. We will be left with a transient, unskilled workforce that is only committed to their employer until something better comes along.

The new era will bring in a centralized system that is not easily accessible by the aging and low-income population in our counties. Patients will have to travel vast distances to access treatment that traditionally was available locally. We will see patients die alone, distant from their families and friends. When consumers become disenfranchised from the delivery of health care, who will they complain to? Where are the checks and balances? Will they become trapped in yet another layer of a bureaucratic quagmire? Today, consumers can deal with issues quickly and efficiently at their local level. When the money and power become centralized in a dense urban community such as London, what becomes of rural health care in a community such as Owen Sound? We have already seen this happen on a smaller scale with all the hospital amalgamations. The outlying hospitals and consumers certainly didn't feel they were better off. Their resources were taken to balance the budget of the larger regional hospital.

In Owen Sound, we can't attract doctors. It will become even more difficult to find doctors when many of the services are located elsewhere. What would be the enticement to come to Owen Sound to work long hours with too many patients and to have to give up their care when they send them to London for treatment?

The majority of people in our province do not even know what LHINs are all about. The government has done a poor job of informing the people about the proposed legislation and its implications for consumers. Health care takes the biggest bite out of our tax dollars and therefore deserves to be given the scrutiny and transparency it deserves to all the people of our province.

Ontarians have made it clear that they want quality health care and they are willing to pay for it. They do not want "to the lowest bidder" health care.

Ms. Christine Coughlan: My name is Christine Coughlan. I work at Grey Bruce Health Services as a medical lab technologist at the Southampton site. We're one of the small rural hospitals that, when we were forced to amalgamate, did not go quietly. Our town is a resort town, a beautiful town on the shores of Lake Huron. We have a major employer, Bruce Nuclear Power Development, down the road. We are expecting an increase of employees, up to 1,500 contract workers coming in for the restart. We have a lot of retirees retiring to our area. Our hospital is very important.

Medical lab technologists are very vital to the health care decisions that physicians make. Last night, I was on call. I had to stay late, until 4:30, for a cardiac patient. The results were fine, normal; they sent him home. I went home and got called twice more, the second time, at 12:30, for the same patient for 4:30. This time when I drew his blood work, they were elevated. If our hospital or the lab weren't there as part of the decision-making, that patient could have died or would have had to drive another 40 minutes to get to the closest hospital, which is Southampton in our area.

The other four hospitals within our corporation are Tobermory, which is two hours from us; Wiarton, which is 45 minutes, with Meaford and Markdale over an hour's drive from our sites. Our site, with all these people coming and the influx of visitors and holiday tourists in the summer, being a very small hospital, has the second-busiest emergency department in our corporation, second to Owen Sound.

As medical lab technologists, we have guidelines to follow. We run controls. We have to make sure that our results are the correct ones for the patient. We are obligated to be in quality control programs from the government, some that we pay to go into. These are all so that the patient care is the best that we are able to do. From what I see about the LHINs, they are not accountable to anybody. Medical lab technologists are accountable to the doctors, to the government, to my boss and ultimately to the patients, who are the ones that matter the most. These LHINs do not seems to be accountable to the people they are serving. They are there for the patients, but there is no recourse for any patient or community if a decision is made that is not to the benefit of our community; there is nowhere for them to go to lodge a complaint or to have some input in this. There seem to be no checks or balances for the CEO or board members of the LHINs.

All these hospitals have foundations and they all seem to have people interested in running for these boards so they can keep the upkeep of these hospitals, so I find it hard to believe that there is nobody in these areas that would have the experience to be on these boards of the LHINs. The LHIN CEOs, from what I can see, report only to the minister. If that's the case, there is nobody else who can go to them, and that sounds like a dictatorship to me. Isn't that how scandal and corruption occur, when one person has too much power and has the ultimate decision on where it goes? Coming from a small community, that can spell a death knell for us.

These LHINs are modelled after other programs that don't seem to have done very well, so why are we as Canadians using this? Do we not have enough brains and thinking power to develop our own system? I cannot believe that, in all of our government, we do not have our own program that can take the health care, which people in the outside countries want to have—why we can't do this. When we adopted one of our children from an international adoption, there was a choice of giving him to a Canadian family or to an American family. The organization was told to give him to a Canadian family because he had a correctable handicap and, in the States, they might not be able to afford to correct the handicap. It was very simple surgery, but in Canada, because of our health care, we were able to give this to our child. He is now able to run, skate and do whatever, whereas in the States and where he was from, Haiti, he would not have been able to do this.

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Politics seems to be very risky business, with democracy and voting and whatever. I did not go into politics. I wanted job security for my family and for me, so I went into health care, thinking that would be a good choice, that I could make a difference as a medical lab technologist because I see the patient every day. When I run my tests, because it's a small hospital, I know this patient X belongs to this result, and I know the history of these patients who come in because we see them a lot. For us, to have job security is really important. When the amalgamation came in, it was awful. The insecurity of not having a job is not very nice.

Our hospital, with all the different departments, is a vital link to our community, and we would like it to be there to help the patients, who are our families, grandparents and neighbours. Thank you.

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

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, SOUTHWESTERN ONTARIO

The Chair: Next is the Ontario Public Service Employees Union, southwestern Ontario, Ron Elliot. Good afternoon. You can start any time you're ready, sir.

Mr. Ron Elliot: Good afternoon and thank you for holding these hearings in London. I am Ron Elliot, OPSEU regional vice-president, and I will be making this submission on behalf of the 15,000 OPSEU members who will be affected by the proposed LHIN legislation and who live in the geographical areas covered by the Erie-St. Clair and the South West LHINs. Of the 15,000 members, 5,400 work in health care.

Today I'm going to talk about how the LHINs have been implemented with little community consultation, an apparent lack of comprehensive planning and under the veil of secrecy. For example, we're here today to discuss legislation that guides the formation of the LHINs, while in fact we know the LHIN boards have been appointed, CEOs and senior staff have been hired, and the 14 LHIN offices have opened.

We believe the government has put the cart before the horse: Change the health care system to show you're making change, without a plan and with as little public debate as possible. The LHINs are an old idea, which has been rife with problems in Great Britain and in Canada in provinces such as British Columbia.

Fourteen huge, unaccountable, unelected bureaucracies are being set up that will take at least $55 million

out of the health care system. From last night, we now know that is a low figure, because the ministry has published figures that show that for 2005-06, $40 million will be spent on LHINS, with practically no staff hired; they're not even up and running. Before this came out, our best estimate was $55 million, but we were way under. The resulting chaos in our health care system will directly affect all Ontarians.

The district health councils were told in January 2005 that they would be closing. By March 2005, the workers were fired. District health councils were made up of members from the community and helped plan health care in local communities in Ontario. Effectively, there has been no health care planning in Ontario for over one year. About $21 million was spent to fire the workers. The government has yet to report how many health care dollars were spent to cancel office leases and on other costs.

The ministry set up seven Ministry of Health and Long-Term Care regional offices in 1999-2000. The purpose was to plan, manage, fund and monitor the system of health care programs. These offices were staffed by professionals who came from the public service and health care services. These regional office public servants were accountable to the minister and the public. MPPs could request information from the minister, and ministry employees would provide the answers: a directly accountable system. Now the minister will be able to pass the buck and tell the MPP to go to their LHIN for answers.

On January 18, 2006, the seven regional offices were told they would close within 12 to 14 months. The staff learned of their precarious position by watching a video supplied by the ministry. The staff were effectively fired by video.

During the last provincial election, Dalton McGuinty promised to restore successor rights to public servants. He also stated that he valued our work. Well, we still do not have successor rights, and clearly he does not value our work. After being fired, our members in the ministry regional offices were told their jobs would not be transferred to the LHINs. We cannot understand the government turning their backs on trained, experienced and knowledgeable workers.

The seven regional offices will be replaced by 14 LHIN boards. At this early stage of the LHIN boards, the government has already cut their legs out from under them. The 14 LHIN CEOs were hired—appointed—by the government, not the LHIN boards. The South West LHIN CEO appointment is questionable at best. Did the government do any research prior to appointing the LHIN CEOs? A simple Internet search reveals a quote from a Deloitte and Touche inquiry into the North Bristol British National Health Service, managed by the new South West LHIN CEO, stating the executive group "was conducting its business in a dysfunctional, uncoordinated manner." The trust was plunged into a £44-million deficit in 2002-03. The report further said that a "culture of fear" had prevented senior finance staff from speaking out. What a start to the LHINs.

The 14 LHIN CEOs are each being paid about $230,000 per year in salaries alone, twice as much money as each of the seven ministry regional directors. The LHIN CEOs have been in place since August 2005 and have not contributed one thing to health care. Again, those are dollars out of the health care system for a new, expensive bureaucracy.

Further, there will be changes to the CCACs: 42 CCACs will be slashed to14. Can you imagine what kind of service the CCACs will be able to provide in your home community, considering the huge geographic area covered by a LHIN? For example, you live in Long Point, located in the South West LHIN. One of your parents requires a bed in a home for long-term care. Suppose there's no space in the Long Point area, but there is space in Stratford. Will your parent be forced to move out of their community, leaving family and friends behind? Currently, as the population ages, there is no plan to build more homes for long-term care. We also know that long-term-care beds are not necessarily located in the communities where they're needed.

We question the LHIN boundaries. The ministry stated that they were set up along patient referral patterns. We can tell you that patients from Sarnia-Lambton, now in the Erie-St. Clair LHIN, are usually referred to London, located in the South West LHIN, for tertiary care. They are not referred to Chatham or Windsor, the other major centres in the Erie-St. Clair LHIN. As a matter of fact, when the ministry published the LHIN boundaries, they left some smaller hospitals off the map. Was this a mistake or future planning?

1340

The minister has stated that people will be able to cross LHIN boundaries for health care services, yet each LHIN will receive a specific amount of dollars to fund the services contained within their geographic boundaries. It does not take much imagination to foresee citizens vigorously guarding their LHIN-allotted health care dollars and questioning why citizens from other LHINs are using those dollars.

LHINs are not local. "Local" is a misleading term at best. The South West LHIN is made up of the following counties: Elgin, Middlesex, Oxford, Perth, Huron, Bruce, and parts of Grey and Norfolk counties, from Long Point to Tobermory.

The LHINs will pit community against community. In competing for health care dollars within the LHIN, we will see smaller hospitals, supported by the community with community funding, close. Employers want to locate their businesses in communities with hospitals. Hospitals are very important to communities. People identify with their hospitals. Community members provide valuable assistance to the health care system by doing volunteer work at hospitals and other health care services located in their community. Will they want to volunteer for organizations that are not based in their community?

Let's look at the LHIN mandate in the legislation. The LHINs have a legal requirement to continually re-

structure health care within their geographic boundaries. Health care has been going through restructuring for the past 20 years. There is a shortage of health care workers. Who would want to work in a system that is under constant change and turmoil? Health care workers have been beaten down enough. Morale is at an all-time low. For health care workers, restructuring means continuous worker turnover, with no job security.

The minister will be the grand puppet master of the LHINs. The legislation requires the LHINs to sign accountability agreements and follow the ministry's strategic plan. The minister determines the funding levels, the minister can veto or order integrations, and the minister approves bylaws and sets salaries. The minister has the power to add any health service to the LHINs. To us, this sounds like a job for the ministry.

With the minister and ministry in effect retaining control, why spend millions of health care dollars on the LHINs, which will not provide one additional health care service to Ontarians? Recommendation: Stop the LHINs now, before one more health care dollar is wasted.

Every citizen living in Ontario should be alarmed about $21 billion of the provincial budget being transferred to the LHINs, nongovernmental organizations, the leadership of which is appointed by one person.

I want to thank you for listening to me. If you have any questions, I'd be pleased to answer them.

The Chair: Thank you. There is less than a minute each. We'll start with Ms. Wynne, please.

Ms. Wynne: Thank you for coming, Mr. Elliot.

A couple of quick points. The issue of the CCACs: I just wanted to make sure you were aware that, although there will be amalgamations, the 42 offices will remain open. So in terms of local service, that will remain.

Mr. Elliot: The legislation does not say that. They've already told the CCACs that the executive directors will be competing for their jobs.

Ms. Wynne: In terms of the administration, yes, there is going to be an amalgamation. I'm talking about the storefront. The offices will remain open. So in terms of service to people, people will still have access. I just wanted to make that point.

Mr. Elliot: Does the legislation say that?

Ms. Wynne: Well, the legislation doesn't have all of the implementation that will be rolled out as this goes forward.

Mr. Elliot: When will we see the rest of the legislation?

The Chair: There is one minute each, please.

Ms. Wynne: It won't all be in legislation; the implementation won't all be in legislation.

I think I've run out of time. I'll leave it at that. The service to the communities will remain because those offices will be open.

Mr. Elliot: How could the service possibly remain in the communities?

The Chair: Mr. Jackson.

Mr. Cameron Jackson: Thank you, Ron. I appreciate your presentation. I agree with a lot of the concerns you've raised.

When you talk about accountability agreements, are you concerned that they will also include confidentiality agreements? One of my concerns: My hospital just closed 10 beds on the weekend. I said that we'd need to tell our community. The CEO said, "Cam, the agreement we signed with the Ministry of Health, under Bill 8, says that I can't talk to the media." I said, "Does that include your board?" He said, "Yes. It covers all of us. We're not allowed to tell the public about these cuts."

Are you recommending that we have an override for these confidentiality agreements? I think they are as problematic as any of the accountability agreements.

Mr. Elliot: I think you hit the mark right on, Mr. Jackson. How the hell are we going to have a health care system that's secretive? It's the most important service to Ontarians. We just can't understand what the government is doing. If you look just at district health councils, $21 million out the window. I don't know how many million bucks out the window for the regional offices; I don't know how much money out the window for CCACs.

The unions estimated this to be a $55-million program, but already we found out it's a $40-million program, although we've yet to determine how much the Liberal advertising agency, Avant, has taken of the $40 million. Those are our health care dollars, for no services, which everybody in this room is interested in.

The Chair: Madame Martel, please.

Ms. Martel: Thank you for being here today. I think you're right. When I spoke about this legislation on second reading, I said that for most people, what is of most concern to them is getting the health care service that they need close to home, as soon as possible, by the same health care provider, on a continuous basis. There's nothing in the legislation that will ensure that the LHINs can do that. Frankly, that is a function of how much money is going into the system. That's determined by government. That's also a function of government policies and regulation: Who gets services, where, how much service they get in a CCAC. That's all done by regulation by the government. So the establishment of the LHINs will not change any of those basic concerns for people.

My overriding concern with the legislation continues to be the minister on the one hand saying that this is about local control and local communities making decisions, when, if you look at the legislation, it's all about even more excessive central control of every facet of health care. The LHINs are local in name only. They are appointed by the government. They serve at the whim of government. Their decisions have to be essentially in line with what the government dictates.

Given that that's the case, do you really see a whole lot of people on the ground having some ability to influence health care decision-making, when in fact the LHIN board members, for example, are accountable back to the ministry, not to the people whom they're designed to serve?

Mr. Elliot: Like I said in the presentation, it's going to affect volunteers; it's going to affect community spirit.

And they are going to close the smaller hospitals, as they are continually whittling them down. You know, some of the hospitals were left off the map of the LHINs. How would you like to come from those communities?

As legislators, you have to be concerned that $21 billion is going to be shipped out of the provincial budget to what the minister states are, and this is a quote from the minister, "non-governmental organizations." Surely we have to be very concerned about that.

The Chair: Thank you very much for your answers and your presentation.

Mr. Elliot: Thank you.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 4186

The Chair: The next presentation is the Canadian Union of Public Employees. Is anyone here from the Canadian Union of Public Employees Local 4186, London? Yes.

You can start. You have 15 minutes. I'm just going out for five minutes, but Mr. Ramal will chair the meeting.

The Vice-Chair (Mr. Khalil Ramal): Go ahead, please.

Ms. Rosemary Van Niekerk: Good afternoon. I want to thank you for providing this opportunity. My name is Rosemary Van Niekerk. I'm a daughter of an aging parent, I'm the wife of an athlete, the mother of three children, and a grandmother. All of the family are active sports enthusiasts. I've come to appreciate my local health care services that are provided here in my community. But I'm also professional support staff. I work with special-needs children. I'm also the president of Local 4186, representing support staff employed at the London District Catholic School Board.

1350

We understand that the government wants to transform health care and some social services. The proposed Bill 36 will create a have and have-not split. This will undermine our public health care and public social services.

The legislation proposed at this time would allow for the creation of 14 local health integration networks, LHINs. The boundaries for these 14 areas were established over the past year. The local health integration networks referred to will encompass the planning, integration and funding for hospitals, nursing homes, homes for the aged, home care, addiction treatment centres, child treatment facilities, community support agencies and mental health services. Bill 36 is going to give our government and the LHINs an expansive and controlling power, all the power that will be necessary to restructure our local public health care and social services.

The LHINs will not be local decision-making bodies. They won't take into consideration our communities, our communities' wishes or our communities' needs. Bill 36 would grant little power to our community. The LHIN's board would decide when, where and even if a service is warranted. The legislation will transfer the control of our community service providers to the minister and the cabinet or its agents, the directors of the local health integration networks. This process will take away our local autonomy. Bill 36 will grant unprecedented authority to the Minister of Health and the cabinet. This could completely restructure our health care. In fact, we know that community care access centres that play such a valuable role in our community would be consolidated and possibly turned over to for-profit corporations, with no consideration of community input.

The proposed legislation suggests local services, but the districts are far from local. The local health integration network will not deliver service directly and so will not be accountable for the shortcomings of services that will befall our community; the ministry would not be accountable, as they delegated this responsibility to the LHINs; and the local service provider won't be accountable, as they had to follow the direction given by the LHINs, and around we'll go: no accountability.

Bill 36 will create a purchase-provider split that will undermine our public health care. The proposed boundaries of the LHINs have been formed based on supposed hospital referral patterns. These boundaries are not local, they don't represent community interests, and they lack political coherence. How could a local health integration network adequately represent such a diverse and varied constituency? In fact, it couldn't. Even if the members of the local health integration network board wanted to take into consideration the local residents' needs, it simply wouldn't be possible.

With Bill 36, the cabinet may create, amalgamate or dissolve a local health integration network, with the boundaries ever-changing. The LHINs are governed by a board of directors appointed by the cabinet and will be paid at a level determined by the cabinet. The government will decide who will sit as chair and vice-chair of the boards. You will hold your seat and position on the board only as long as the cabinet dictates.

The government will control the funding for local health integration networks. The LHINs integration would have to fit the government's provincial strategic plan. As I understand it, the government may unilaterally impose an accountability agreement, with no input from the local communities. The LHINs will be responsible to the provincial government. There is a long history of public health care and public social services in Ontario. When the previous government attempted to cut funding to local health service communities, our community pointed out the problems that would be created. They engaged the public locally, and the government reconsidered. The proposed cuts were not implemented and the hospitals were allowed to meet the needs of their local communities. Public health care is still very much underfunded in Ontario.

One has to ask if Bill 36 is an attempt to silence the criticism of underfunding. The LHINs proposal replaces community service boards with government-appointed boards. We know that the community care access centres

were taken over by the provincial government in 2001. There was an immediate cessation of public outcry. That has resulted in dramatic cutbacks to those services. The most vulnerable in our communities—the elderly and disabled people in Ontario—have lost much of their home support services.

We know that government-controlled regional agencies are a poor model for the delivery of both health care and social services. They are neither transparent nor are they user-friendly. There is a very real perception that the LHINs are being orchestrated to insulate the government from future decisions that will privatize many of our public services and further cut back on the services that are currently provided. The local health integration network would become the scapegoat for unpopular decisions made by our provincial government.

Unlike the government, the LHINs would not be able to increase funding to provide or maintain services. Smaller communities would most likely be the first to see their local services integrated into larger communities. We're very fortunate living here in London. We have an amazing public health care system. It's world-renowned—both our medical practitioners and our facilities. Yet when my mother needed orthopaedic surgery, our health care community couldn't meet her needs. We had to go to Kitchener. But we were really fortunate: She only had a six-month wait, and the surgery was successful. But there's much pain and suffering in our community still. I know of one member injured at work two years ago who is still waiting for surgery. She had to go to Guelph to get diagnostic services that weren't readily available here in our health care community. And this is London: a major, well-known health service provider.

The LHIN structure will raise significant barriers to the control of local health facilities. It is likely that the decisions will take a bottom-line mandate, and the communities' service needs will be dictated by that bottom line. Yet the local health integration network will not be accountable to the community affected by its decisions.

Perhaps the ministry could consider approaching this proposed legislation from a slightly different perspective and include some of the following provisions:

—local health integration network boards would be democratically elected by all in the geographic area;

—selection of the chair and vice-chair would come from within the board;

—each local health integration network would be inclusive of a mandatory health sector employee advisory committee;

—the legislation would provide the right for a full judicial review and reconsideration by any person or trade union of any local health integration network;

—the legislation would ensure that no public service positions would be privatized;

—competitive bidding will not be recognized as a way of conducting business;

—language would be included that would prevent the further privatization and contracting out of our public services for profit.

1400

The seamless care that the LHINs proposal suggests will not be realized. This legislation will further fracture the delivery of service, as there will be increased competition for health dollars. Services will be cut. We all know that cutting back support services puts us all at greater risk and often mandates that higher-paid staff assume the responsibilities formerly carried out by support staff workers.

The government's endorsement of the plan to turn over the clerical services and the supply needs of dozens of hospitals in the north to a new employer—the NOHBOS—is alarming. In Toronto, I understand that the same approach is being endorsed.

My experience with the London District Catholic School Board has taught me that if the legislation or the collective agreement doesn't speak specifically to "no contracting out," you'd better be forewarned because that's probably the intent that's going to present itself. At the London District Catholic School Board, contracting out was approved as a cost-saving measure so as to better enable the school board to serve the needs of students. The health care providers—the LHINs—will use the same arguments, suggesting that these jobs aren't essential, and they are.

Thank you.

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

CAREWATCH SARNIA-LAMBTON

The Chair: The next is Carewatch Sarnia-Lambton; four presenters. There's a fifth person. You're all welcome. We need one extra chair there. There will be, I believe, 15 minutes total for all of you. You can start whenever you're ready. Good afternoon.

Ms. Marilyn Cliche: Good afternoon. Mr. Chairman and members of the committee, thank you for the opportunity to present our concerns with respect to Bill 36, a piece of proposed legislation. The proposed legislation does in fact provide control throughout a locally centralized health care system by government regulation. This legislation explicitly defines LHINs as an agent of the crown which will act on behalf of the government. The governing body of the board of directors will be appointed by cabinet. As you know, the minister will have significant control inclusive of accountability agreements and funding allocation, and all 14 LHINs must develop their plans in accordance with the timing and framework as set out by the minister.

When the Liberal government was elected, we the people were promised transparency and accountability. The level of control this minister will have over our health services, we believe, is not in keeping with this promise. The legislation does not appear to provide for democratic control or public input, and the public has not been adequately informed with respect to the managerial details of this legislation. However, we do note that the

legislation provides indemnification for everyone but the service providers.

Without having been passed, albeit through second reading, LHINs management and some staff have been retained by the government, and office space, equipment and protocols appear to be in place, without the full implications and costs of establishing yet another bureaucracy being known.

In our opinion, democratic control, public input, public notice and principles need to be addressed. Provisions for communities to appeal and requirements for public notice must also be met. The legislation provides unprecedented powers to the minister and cabinet to completely restructure the delivery of health services, including the power to turn delivery of services from non-profit over to for-profit corporations.

In spite of the so-called accountability agreements to allocate funding, the legislation is wide-scoping and broad, and we are concerned with the basic definitions found under subsection 2(1) and clause 25(1)(a), in particular "'integrate' includes." The minister and LHINs are given extreme powers to order any non-profit health service that receives funding to close or amalgamate non-profit health service providers, of which we have three in our community; transfer all of the operations of any non-profit health service providers from one to the other or to a for-profit corporation, including but not limited to clinical services; issue compulsory integration decisions, co-ordinating services, creating partnerships with other persons or entities, whether public or private, not-for-profit or for-profit, and so forth.

LHINs have been given the power to veto voluntary integration and agreements under section 27(1) and transfer those services to another person or entity. Restructuring of this magnitude, we believe, may also create many expensive legal issues and challenges.

There is nothing in this legislation to prevent: immediate cuts in all clinical and non-clinical service areas; overcharging of services, exorbitant costs and out-of-pocket expenses to be incurred by consumers; and time limits for patients' travel or services and/or refusal of services, therefore driving the public to seek out private care, which many will be unable to afford. It appears to promote privatization and allow hastened managed, competitive bidding throughout the entire system, and it appears there is no protection of public health. We are gravely concerned about this plan.

As mentioned, each individual LHIN—there will be no requirement for consistency in accountability. Accountability agreements, confidentiality agreements, terms and conditions of those agreements, access to equal care, co-ordination of the level of care and services will all be at the minister's discretion. We respectfully request an amendment to the legislation with language that clearly set outs the terms and conditions for all LHINs with respect to accountability agreements. We must have equal and pan-provincial accountability.

We also note that our physicians have been excluded from this legislation. Why? I live in LHIN area 1. My physician and dentist are in another geographic LHIN area. Should I have a medical emergency, I can say without reservation that I want and expect my personal physician of 18 years involved in my immediate medical care. He should have the right and authority to medically intervene on my behalf, give instruction to a LHIN 1 ER physician and have the authority to transfer my care to another facility. We hereby request that the legislation be amended to include physicians, dentists and dental surgeons as primary service providers.

Although the Canada Health Act calls for accessibility and universality in public administration, the managed competitive bidding system for health services will, in all likelihood, result in fewer hospitals providing services and, based on age and growth population statistics, create greater inequalities in local access to health services. Patients will become nothing short of inventory. Profit is profit, and that is what patients will be reduced to: inventory.

All one needs to do is look at the anti-trust hearings currently taking place in the United States with respect to integrated health networks and the profit and corruption they have created. In fact, the US is facing the same wait times dilemma and staff shortages that we in Ontario are experiencing. So, does an integrated health network really solve health care problems?

Will the LHINs really be accountable to the public they are supposed to serve, or only to the health minister and cabinet? Is it being created to act as a buffer between the people of the province and the government, or is it being established as a monetary scheme similar to the integrated health networks in the United States? What is the actual cost of funding the LHINs? How many people will they employ, at what salary levels? Will the LHINs, to create a cloak of secrecy, simply amend their bylaws, which they are entitled to do under this legislation? How will privacy legislation affect the public's right to know, with respect to this legislation and the operation of the LHINs? Too many questions are unanswered. The public requires and is entitled to full disclosure.

We're also concerned with the word "entity," which appears in this legislation. In particular, we take notice of "entity" meaning a person who operates under the Public Hospitals Act or the Private Hospitals Act.

There is no exclusion provision for a Shriners hospital. Why? If the children in our province requiring specialized burn or orthopaedic care should ever be fortunate enough to benefit from a Shriners hospital, the members of our group, who are wives of Shiners and raise the money, believe that this government should take an absolute hands-off approach and provide an exclusion in this regard.

1410

Additionally, Carewatch continually receives telephone calls from patients in our area, and we visit homes of people in our community to assist them in receiving the level of care they are entitled to receive under the ministry guidelines. Prior to the establishment of CCACs, a physician and discharge planner determined the level of

care a patient would require upon returning home. As a result of previous health care amendments, patients are subjected to dealing with persons unknown. We have a concern that the sustainability program between the Ministry of Health and the CCACs will again be implemented. We do not want to see for-profit nursing homes being permitted to be subsidized by the government for an 80% bed level capacity. It cannot happen. We cannot have the CCAC dumping our seniors into any for-profit nursing home to sustain an 80% bed level capacity in order to receive funding from the ministry through the LHINs.

Is the government choosing to find itself in a tragic situation? We hope not. We know that inspectors have already been cut from the budgets and we are gravely concerned, as you will note from the pictures in your brief. These are conditions which we found locally in a nursing home. We took the issues to certain elected bodies and persons. Some of the issues have been rectified; some others are still ongoing. Inspectors are a requirement. These are our senior citizens, the people who fought to give us the right to sit before you today. We must take care of our seniors. Inspectors are a necessary requirement. To off-load that service from provincial to a for-profit inspection agency is unacceptable to our seniors, particularly in the Sarnia and county of Lambton area.

We find it sad when the government of the people is not consulting with the people, and by that we mean the actual health care providers—not managers, supervisors, accountants, economists or hospital funding consultants. We mean the women and men who know first-hand the needs of these seniors and the people in our community.

We also have a concern with respect to downloading of funding and where the funding in our local community is coming from and going to. As a Shriner's wife, I can assure you that our local Shriners raised and donated hundreds of thousands of dollars to our hospital for a burn unit. The hospital took the money; there isn't going to be a burn unit. Shriners raised and donated money for a burn unit for our community, which has Chemical Valley. There isn't going to be a burn unit, but the hospital took the money and put it into general revenue. That's unacceptable. Confidentiality agreements have to go. We need accountability.

Our city and county levels of government, as well as taxpayers and community service organizations in Lambton county, have been funding our local health care system. We need to know if Bill 36 will require the citizens of Lambton county to continually subsidize our local health care system. How much more money will this minister expect from the people of Lambton county? Will we have to continue to pay extra money once our hospital is built or after our hospital is built? Our hospital has given out $1.8 million in interest-free loans, repayable from 2006 to 2010. How will that type of financing, interest-free, affect our funding from the LHINs?

Under the previous government, hospitals were allowed to generate revenue through the bonding program, and our hospital is no exception. They have an interest in a joint venture and an interest in a subsidiary corporation. However, the majority of persons associated with these corporations have no affiliation with our community; in fact, two persons are non-residents of Canada and live in the Netherlands. Where is the money coming from and going to?

We are requesting amendments in this legislation that monies coming from the ministry being downloaded into our hospital system or from the LHINs be accounted for. This is your money; this is our money. Whether or not a hospital has a side business, which they are permitted to do, we have a concern that hospitals may incorporate and add subsidiary companies to generate revenue by having all of the non-clinical services themselves. So we're looking for some accountability. Confidentiality agreements need to go, period. This isn't just a separate little corporation; this is everybody's money, everybody's interests in our community.

I think I will leave it at that.

The Chair: You are right on the 15 minutes. Also, I need you to identify yourself. Could I have your name, please?

Ms. Cliche: I'm sorry. My name is Marilyn Cliche.

The Chair: Thank you, Ms. Cliche. We thank all of you, and we do have what you said in writing, so I'm sure the ministry and everybody else will take note. Thank you.

RÉSEAU FRANCO-SANTÉ DU SUD DE L'ONTARIO

The Chair: Our next presentation will be done in French. All of us, I believe, have a translation machine if we need it. I would ask the Réseau franco-santé du Sud de l'Ontario—or close; I didn't take any direction from the assistant here. How good was it? She can speak French.

Bonjour. Bienvenue. That is all I can say in French. I can say a little more than that. But you can start any time you wish. You have 15 minutes total.

M^me^ Marthe Dumont: Monsieur le Président, mesdames et messieurs membres du comité, nous aimerions d'abord vous remercier d'avoir accepté de nous entendre aujourd'hui. La transformation du système de santé ontarien entreprise par le ministre Smitherman et le gouvernement de l'Ontario, et le projet de loi 36 qui en découle, sont d'importance capitale pour les francophones. Ils représentent des occasions pour la minorité franco-ontarienne de prendre la place qui lui revient dans le système de santé transformé.

Permettez-nous d'abord de vous présenter le Réseau franco-santé du Sud de l'Ontario.

Le réseau est un organisme sans but lucratif qui oeuvre à l'amélioration de l'accès aux services de santé en français dans le sud de l'Ontario.

En 2001, un comité consultatif a déposé à Santé Canada un rapport sur la question des services de santé en français pour les francophones hors Québec. Les

résultats font réfléchir: 55 % des francophones en situation minoritaire au Canada n'ont pas accès à des services de santé en français.

Cela a mené à la création de la Société Santé en français, puis en 2003 de 16 réseaux au Canada, dont le Réseau franco-santé du Sud de l'Ontario. Le réseau a tenu son assemblée de fondation le 23 avril dernier.

Le Réseau franco-santé du Sud de l'Ontario vise une concertation des forces vives du milieu pour améliorer, en bout de ligne, la santé des francophones. Le réseau regroupe donc différents intervenants dans les domaines de la santé et de la francophonie, dont des professionnels de la santé, des établissements de santé, des organismes communautaires francophones, des établissements de formation postsecondaire, des membres de la communauté francophone, des autorités gouvernementales et d'autres partenaires. Il compte jusqu'à présent plus de 140 membres individuels ou corporatifs.

Le réseau dessert un vaste territoire qui s'étend de Penetanguishene au nord jusqu'à Welland au sud et de Peterborough à l'est jusqu'à Windsor à l'ouest. Ainsi, le réseau compte sur son territoire 10 des 14 réseaux locaux d'intégration des services de santé.

Le réseau est gouverné par un conseil d'administration formé de neuf bénévoles issus de différents secteurs et milieux.

Le réseau s'est donné comme principaux objectifs : d'être le porte-parole des francophones dans le domaine de la santé auprès des instances gouvernementales et associatives; de promouvoir activement les services de santé en français auprès des membres de la communauté, des intervenants et des organismes de santé; de favoriser l'engagement communautaire; d'établir les partenariats nécessaires dans le but d'assurer l'accomplissement de son mandat, ce qui comprend, entre autres, participer à l'évaluation de la situation des services en français, à la détermination des besoins, à la planification des services et à l'élaboration de stratégies de recrutement et de maintien en poste des professionnels de la santé; d'assurer la mise sur pied d'initiatives francophones pertinentes et d'appuyer, de diverses façons, des projets à l'échelle locale.

1420

Permettez-nous maintenant de vous dresser un portrait de la communauté franco-ontarienne de l'Ontario et, en particulier, de celle du sud de l'Ontario.

On compte 548 940 francophones en Ontario. Cela équivaut à la population totale de Terre-Neuve et Labrador et à près de quatre fois celle de l'Île-du-Prince-Édouard. Dans le sud de l'Ontario, on trouve près du tiers de tous les francophones en Ontario, soit 174 870 francophones. Près de 65 % des francophones sont nés en Ontario, près de 25 % au Québec et 5 % à l'extérieur du pays.

Le deuxième rapport sur la santé des francophones de l'Ontario révèle que les francophones en Ontario sont, en proportion, plus nombreux que les anglophones à se percevoir en moins bonne santé. Ils ont obtenu un score plus faible sur l'indice de l'état de santé fonctionnel.

Le taux d'usage quotidien du tabac parmi les francophones à faible revenu familial est deux fois plus élevé que le taux de l'ensemble de la population.

Il y a une plus grande proportion de francophones que d'anglophones qui souffrent de maladies cardiaques. Les femmes francophones sont plus portées à souffrir de maladies cardiaques que les femmes anglophones.

Suivant l'adoption de la Loi sur les services en français en 1986, les conseils régionaux de santé ont identifié 172 organismes de santé pour offrir des services de santé en français dans le sud de l'Ontario. Or, ces organismes, dans les meilleurs des cas, offrent à l'occasion seulement des services très limités de santé en français. De plus, de ces 172 organismes, neuf seulement ont demandé et obtenu une désignation totale ou partielle en vertu de la LSF. Cependant, il n'existe aucun mécanisme pour vérifier que ces organismes offrent véritablement des services de qualité dans les deux langues officielles, après leur désignation.

Les seuls services sur lesquels nous pouvons vraiment compter sont ceux des deux centres de santé communautaires francophones. Malheureusement, ces centres offrent uniquement des soins de santé primaires et ne peuvent desservir à eux seuls l'ensemble du territoire qui est le sud de l'Ontario.

Lors de l'adoption de la Loi sur les services en français, les francophones ont fondé beaucoup d'espoir et ont travaillé avec le gouvernement Peterson afin de mettre en place des services qui leur permettent de protéger leur langue et leur culture. Vingt ans plus tard, ils n'ont toujours pas accès à des services adéquats en français. Presque partout dans la province, la qualité et l'accessibilité des services en français ont dégradé. La communauté franco-ontarienne n'a pas été protégée.

M^me^ Nicole Rauzon-Wright: Jusqu'à maintenant, la prestation de services de santé en français a été laissée au bon vouloir des organismes. II n'y avait aucune mesure de rendement, aucune mesure incitative, aucun mécanisme de responsabilisation. Voici donc quelques exemples pour illustrer la situation des francophones en Ontario.

(1) Dans le sud de l'Ontario récemment, une adolescente dont la mère est victime de violence est traumatisée par la situation familiale. Ces deux femmes sont seules, sans soutien familial, leur deuxième langue est le français, et elles ne comprennent pas un mot d'anglais.

Alors que des services en français sont à la disposition de la mère auprès du centre d'aide aux victimes de violence sexuelle, aucun service n'existe pour venir en aide à cette jeune fille en français.

Au fil des semaines, la situation s'aggrave. La jeune fille perd du poids. Elle est déprimée. Elle ne veut plus aller à l'école et se replie sur elle-même. Le psychologue anglophone, provenant d'une culture qui accepte la violence, ne peut communiquer avec elle et ne lui offre aucune sympathie.

La mère est désespérée. Elle ne sait vraiment plus comment se sortir de cette situation. En plus d'être pauvre et violentée, elle ne peut aider son enfant.

Tous les efforts pour trouver des services pour venir en aide à la jeune fille se sont soldés par un "Sorry."

This would be unthinkable in English. Why is it acceptable in French?

(2) Ailleurs dans le sud, une dame nouvellement arrivée du Québec, lors d'une consultation, apprend de la bouche d'un anglophone qu'elle a le cancer. La dame panique, ne comprend rien et croit qu'elle va mourir. Il n'y a personne autour pour la rassurer et lui expliquer la situation dans sa langue. On cherche partout dans l'hôpital pour trouver finalement une personne capable de lui parler dans sa langue et lui expliquer les démarches à suivre.

Just picture a person you care for being in this kind of situation, with absolutely no help.

(3) Cancer centres are being expanded and new ones are built across the province, and until we brought the bilingual situation to the attention of Cancer Care Ontario, nobody had thought about the provision of services in French.

Here in London, the cancer centre welcomes new patients with orientation material and a calendar for treatment follow-ups. There are great tools for the English-speaking patients; however, French-speaking patients are given an outdated, 10 years or more, French orientation text, with only an English calendar. The sad thing is that there is money that could be used to translate and update the French through special funds that in no way would have affected the budget of the hospital.

Furthermore, the only services available in French are those of the receptionist, even though there's a sign posted at one of the clinics stating that services are offered in both official languages. Accountability is essential. We must work together to fix situations like this one.

Ailleurs dans le sud, une enfant d'à peine trois ans doit subir une intervention chirurgicale dans un hôpital identifié, dans une région à forte concentration de francophones. Malheur, elle ne comprend pas ce qui lui arrive et aucun membre du personnel ne peut la réconforter et lui expliquer la situation.

Picture yourself as a parent watching helplessly your terrified child crying her way to surgery. Would you accept that situation if the roles were reversed?

En terminant, l'exemple sans doute le plus explicite : une personne se présente à l'urgence en se plaignant d'avoir mal au coeur. « J'ai mal au coeur » can be literally translated as, "My heart is aching." So heart professionals start the whole intervention, thinking they're dealing with a heart attack victim. This time, the patient had an upset stomach.

As funding members of this country, the Franco-Ontarian minority do not wish to be considered an afterthought or cause the system undue expenses. The community wants to work with you. It believes that French-language health care services are part of the solution, not the problem.

Toutes les décisions qui touchent la planification et la prestation de services de santé en français à la communauté franco-ontarienne doivent être prises par la communauté franco-ontarienne. C'est non seulement une question de meilleure pratique, c'est aussi une question d'équité, de droit. Il doit donc y avoir une reconnaissance du rôle de la minorité franco-ontarienne à cet égard.

Il est important de comprendre que la communauté franco-ontarienne n'aspire pas à un système de santé séparé. Elle recherche plutôt un moyen d'intégrer le système de santé transformé de façon à répondre aux besoins et aux attentes de la communauté franco-ontarienne.

La minorité franco-ontarienne et la majorité anglophone ont des statuts et des droits égaux comme peuples fondateurs de ce pays. Ils ont droit à un accès égal à des services de santé dans leur langue.

Les RLISS doivent en tout temps agir dans l'intérêt public. Ils ne peuvent pas prendre de décisions qui causent des torts irréparables à la communauté franco-ontarienne. C'est pourquoi il est indispensable de rendre responsables les RLISS et les pourvoyeurs de services de la prestation de services de santé en français de qualité par la mise en place d'ententes d'obligation de rendre des comptes.

How can we help you to ensure that there is accountability for integration and sustainability for quality French services in health? We're looking forward to working with you for the better health of all Ontarians.

Thank you for allowing us to express our views. We welcome your questions.

The Chair: Merci beaucoup for your presentation. There is about a minute left. Why don't we give you 30 seconds each if you want to ask a question? We'll start with Mr. Jackson. Thirty seconds, please.

Mr. Cameron Jackson: You are concerned, clearly, that the French Language Services Act of 1986 will not override any other concerns in this legislation. Or are you looking for something in the legislation that sets out those rights that you currently are entitled to?

M^me^ Rauzon-Wright: We're actually looking for something in the legislation. As the LHINs are being formed throughout the province, although we acknowledge that a few French-speaking people have been appointed to certain LHINs, we certainly don't have full representation. In the south of Ontario, we have 10 of the 14 LHINs, so we need to have something quite spelled out.

Mr. Cameron Jackson: I thought you said nine in your presentation.

M^me^ Rauzon-Wright: No, 10.

M^me^ Martel: Merci d'être venue cet après-midi. J'ai vu à la première page que vous dites : « Ils représentent des occasions pour la minorité franco-ontarienne de prendre la place qui lui revient dans le système de santé transformé. » Mais j'ai vu le projet de loi. À mon avis, il n'existe rien qui va non seulement protéger les services qui existent pour les francophones en ce moment ou améliorer la situation pour la plupart des francophones qui habitent en Ontario. Alors, qu'est-ce que vous voulez

voir dans ce projet de loi qui peut vraiment améliorer la situation?

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M^me^ Rauzon-Wright: On a beaucoup lu le projet de loi. Pour la première fois dans un projet de loi—corrigez-moi si j'ai tort—on fait mention de la Loi sur les services en français. À ma connaissance, 25 ans en Ontario, je n'avais jamais vu ça. Alors, on est content qu'on reconnaisse, qu'on parle dans le projet de loi des services de santé en français. On voudrait qu'il y ait dans le projet de loi quelque chose qui garantisse à la francophonie un droit de regard sur ce qui va se passer. Puis on veut travailler en partenariat avec les autres personnes de la province.

M. Ramal: Merci pour votre présentation. Je pense que c'est vrai, c'est plus important pour notre ministre et ministère que chaque personne qui habite en Ontario tienne les services en français, en anglais, parce que notre ministre ouvre le dialogue avec la communauté francophone à travers la province pour établir un mécanisme pour bien servir chaque personne qui habite en Ontario.

M^me^ Rauzon-Wright: Oui. J'ai siégé sur un comité consultatif de M. Smitherman, ce qui fait que je suis au courant. On a soumis un rapport qui devrait sortir bientôt.

The Chair: Merci beaucoup for your presentation. We thank you again.

LONDON HEALTH COALITION

The Chair: The next presentation will be the London Health Coalition. Is someone from the London Health Coalition here? Good afternoon. You can start any time you're ready, gentlemen.

Mr. Peter Bergmanis: Good afternoon. I'll introduce myself. I'm Peter Bergmanis. I'm the co-chair of the London Health Coalition. The London Health Coalition is a chapter of the Ontario Health Coalition, from which I believe the committee has already heard a brief. The gentleman beside me is Jim Reid, a member of our chapter here in London as well as a representative of the Local 27 CAW.

At the core, this bill is essentially a health restructuring act vesting the Minister of Health with unprecedented powers designed to facilitate the restructuring of health care in the province. Unfortunately, the legislation as currently constituted contains few, if any, democratic checks and balances to ensure that population need and the principles of the Canada Health Act are paramount.

The health care system of Ontario has been in perpetual turmoil since the 1990s. During its tenure, the hospital service restructuring commission ordered the amalgamation of 45 hospitals into 13 and closed 29 hospital sites. Hospitals were thrown into a state of chaos, experiencing forced amalgamations, bed closures, staffing cuts, emergency room overcrowding and serious backlogs for clinical procedures and diagnostic tests. London's health care institutions were no exception. They were shrunk down to only two. Today, those would be St. Joseph's Health Care and the London Health Sciences Centre. The St. Thomas Psychiatric Hospital and the London Psychiatric Hospital were both ordered closed. Emergency services have been transferred to only two sites: the Westminster and University campuses of London Health Sciences.

Forced to comply with the unrelenting demands of restructuring, and without commensurate funding support from Queen's Park, hospitals have been drained of their financial reserves. To this day, hospital restructuring costs continue to mushroom, without provincial guarantees to assume operating costs that have incurred. London's hospitals are millions in debt. Another costly round of restructuring will do little to alleviate their current financial plight, much less any further financial woes.

Furthermore, the term "local health integration network" is actually quite misleading. There is very little local or integrated about the entire model. As previously noted, the LHINs legislation is a health restructuring act, centralizing more powers than during any other restructuring in the history of Ontario's health care system. Rather than moving decisions closer to communities, real power will reside with the health minister and cabinet. The repository of new powers will include: the ability to transform or order services, personnel, property and funding with limited compensation or opportunity to appeal; the ability to order the closure, merging and transfer of all operations of any non-profit service provider; a new structure for the health system established unilaterally by the health minister's strategic plan; enforcement of these new powers by court order.

The scope of the legislation encompasses all hospitals, some mental health facilities, charitable homes for the aged, community health centres and a host of government-funded health service agencies. Glaringly, doctors, private diagnostic clinics and labs are excluded. It is telling that legislation which purports to integrate, improve case management and provide a seamless continuum of care somehow ignores the system's key players.

Bill 36 also suffers from a real democratic deficit. There are no traditional democratic checks and processes set out in the legislation. LHIN boards are appointed by cabinet and exist at cabinet's pleasure. Cabinet is endowed with the inexplicable power to exclude any persons or classes of persons from LHIN membership. Yet the qualifications for board membership are decidedly tipped in favour of business and administrative elites, with no corresponding prevention of a revolving door adjoining membership in the for-profit health industry and the LHINs. An overly cozy relationship with the for-profits can open the door to potential scandal.

The LHINs are yet to be up and running, yet problems with how their membership is constituted are already emerging. The newly appointed chair of the South West Local Health Integration Network, Tony Woolgar, comes from the United Kingdom under a cloud of allegations of financial impropriety and claims of "cultivating a culture of fear." This is from the Bristol Evening Post, dated

back in October 2003. Evidently, the LHIN's exclusionary clause does not apply to anyone of the calibre of Mr. Woolgar.

The bill contains no protections against secret, in camera meetings of the LHIN board, no public process for access to timely information regarding restructuring proposals, and no process for public input or appeal. In effect, the very people the health system was designed to serve—patients—are shut out.

With the lack of proper democratic oversight, the threat of privatization intensifies. The legislation facilitates privatization in several ways: The LHINs are endowed by the Minister of Health with the power to move funding, services, employees and some property from non-profits to for-profits, not the other way around; cabinet may order the wholesale privatization or contracting out of all support services in hospitals; the minister may close or amalgamate non-profits—again, the exclusion of the for-profit sector from such draconian measures fuels new market opportunities as the numbers of non-profit providers shrink; there is no prohibition against delisting of OHIP services, leaving people at the mercy of out-of-pocket expenses for services which the for-profits will be all too eager to provide and charge for at a handsome cost.

Again, no discussion of forced privatization of a public service like health care would be complete without mention of the introduction of market competition. Under the guise of the wait time strategy, the McGuinty government has elevated market competition to a whole new order of magnitude. The same devastating policy for which the previous Conservative government was blamed for destroying home care, the McGuinty Liberals are now prepared to unleash upon the hospital sector. That would be competitive bidding. Under this model, a pricing system is created, and services such as cataract surgeries are tendered for bid to health care providers, both profit and non-profit. The provider that bids under the government-set target price wins the contract. Government funding would flow to the successful bidder.

Such pricing and competition regimes are fraught with pitfalls: administrative inefficiencies which suck money away from patient care; competition fragments providers, converting colleagues into competitors. Results include constant personnel turnover, lack of continuity of care, low wages, a shortage of skilled workers, high costs, and an ever-increasing shift to for-profit delivery. Consolidation of services into specialty hospitals undermines the efforts of civic-minded citizens and leaders who have worked hard to improve local access to services.

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London, as a major centre, may fare well under such a regime, but when the enormous geographic size of a LHIN that stretches from Tobermory to Long Point is considered, how onerous will it become for patients requiring to travel further in order to access health care services? Loss of local accessibility will only exacerbate inequalities of access to care, since some individuals would not have the means to travel long distances.

To conclude, Bill 36, as constituted, poses an enormous threat to the survival of the public health care system Ontarians cherish. An unprecedented power shift into the hands of the Minister of Health without any corresponding democratic checks and balances belies the true intent of this legislation, which would be forced health restructuring driven by cost containment and not patient care needs.

Not only does the government risk another expensive restructuring boondoggle, whatever cost savings may be enjoyed are questionable. Additional tiers of administration from the LHINs onto the hospital oversight of private contractors will be added on without any benefit to bedside patient care. A workforce without stable, long-term job security, forced to seek alternative employment, would leave the high-stress environment of the public system, further contributing to the erosion of medicare. Demoralized health care providers cannot deliver top-notch quality care.

The increased incursion of transnational, for-profit health care corporations will open medicare to challenges under trade agreements, which could forever change the health care landscape of Canada. Ontario is in danger of degenerating into the morass facing the National Health Service of the United Kingdom, rife with its scandals and hospital closures due to the introduction of market forces.

In the opinion of the London Health Coalition, at best, Bill 36 should be scrapped. At the very least, the most odious elements of the legislation should be revamped. Real democracy, proper safeguards for public accountability, stakeholder participation, and commitment to the overriding principles of the Canada Health Act need to be carved into this flawed legislation. Ontarians deserve no less.

With that I submit my brief and invite the panel for any questions.

The Chair: Thank you. We have about three minutes. I'll start with Madame Martel, please. One minute each.

Ms. Martel: Thank you for being here today. My first question is this. In light of some of the information that you've provided in the brief and that we've heard before about the democratic deficit—i.e., members of the LHINs being appointed by the government, serving at the behest of the government; that the LHINs themselves in the legislation appear as agents of the government; that there's nothing in the legislation that talks about how the community will be engaged in any concrete term; that the board members themselves only have to sit four times a year, etc.—how confident are you that the community interests are really going to be served under that kind of framework and that kind of set-up?

Mr. Jim Reid: One of the concerns that we see with the legislation is that it duplicates the oversight of hospital boards. We won't see the ability of local communities, especially outside major health care centres like London, to have any input into the process of how health care is delivered in their local communities. The duplication of the administration: At this point in time, the province has spent over $40 million to set this process up

and it's not benefiting one patient in the province. The problem that we're going to get into here, quite honestly, is that without that local oversight, we're going to end up with everything that the right wing complained about the medicare system in the United States: that it's a top-down bureaucracy. Here, we've concentrated the control in the hands of the minister, with a few designated sub-lieutenants across the province who are going to dictate how health care is delivered in local communities. That is a significant issue that I see across the province.

The Chair: Mr. Ramal.

Mr. Ramal: Thank you for coming and telling us about your concerns. I share your fear about the government, especially from experience with the past government. When they tried to reconstruct health care, they closed a lot of hospitals; they closed a lot of facilities across the province of Ontario. But don't you think that yesterday the Minister of Health, in his opening statement, was very clear in terms of two-tiered health care and hospital closures that clearly, to all the people in the province of Ontario, he is against closure; no two-tiered health care in the province of Ontario?

Mr. Reid: What we've got is privatization from the inside out. That's what this legislation effectively is: It's privatization from the inside out, at least speaking on behalf of the workers I represent in the two major hospitals in London. We're seeing non-clinical services—and basically, these are fast-tracked and wholesale changes that are going to be allowed to turn over the work and the services that those workers provide to the private sector. So really, what we're seeing are not the cut-and-slash policies of the previous government; what we're seeing is the slow erosion of the health care system by this government. This is part of this legislation, and I believe that this is part of the overall plan by the Liberal government in Ontario: to erode public access to the health care system.

The Chair: Mr. Jackson.

Mr. Cameron Jackson: Thank you for your presentation. You have a working knowledge of some of the other legislation. One of the concerns I have about the net effect of this bill is that, in terms of the role for MPPs raising questions, it's going to be very hard for us to raise health care questions in the Legislature, and I'll tell you why. This legislation is constructed in the same context as workers' compensation legislation, and I recall that because I used to work at Queen's Park when it was being constructed. Essentially, it says that if there's this agency out there that's responsible for injured workers, you can't ask the minister a question on the floor of the Legislature because there is this arm's-length agency that deals with it.

My worry here—and I think you've been alluding to it—is not only the lack of transparency, the confidentiality agreements, the gag orders on talking to the media; it's that, even as MPPs, we're not going to be able to raise specific questions, because the minister will be able to say, "Look, that's not my responsibility. I've given them their envelope. That's what they manage. They're accountable." If he's going to end up saying that, where is the true accountability? I see this as a huge loss for the last voice you have at Queen's Park, which is the person you elected to go there and speak up for you. Even that is being taken away in this legislation because of the manner in which it's scheduled. That's the technical word we use in legislative terms for an agency that is scheduled, which determines how much you can discuss it on the floor of the Legislature.

Mr. Reid: We're on that same page. Obviously a LHIN can act as a bulwark against any kind of political flak that may come from decisions that the minister may take, or that the LHIN board may take because they're at arm's length, as you note. Then all of the consequences or any political fallout will just fall on them.

The Chair: Thank you very much for your presentation.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 260

The Chair: We'll move on to the next group, and that is the Ontario Public Service Employees Union, Local 260, Markdale. You can start anytime, madam.

Ms. McIllwraith: My name is Jill McIllwraith and I have been an RPN working in Ontario's health care system for the past 32 years. I am currently president of OPSEU Local 260, Grey Bruce Health Services, in the South West LHIN. I represent 934 health care workers in an amalgamation of six hospitals. I also sit as an executive on the health care divisional council and as chair of the health care support sector.

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In 1998, under Bill 136, our six hospitals voluntarily amalgamated to form the current corporation. Before the hospital cutbacks in the 1990s, our six hospitals had a total of 800 beds; our current corporation has 140 beds. Long-term care was removed from our hospitals, as well as a complex long-term-care unit which took care of patients who were not requiring an acute hospital bed but did need care above a level that could be provided in a nursing home. The replacement beds were not put into the communities to cover the number of beds that were closed. This has had a major impact on wait times in our region, as more than 50% of our medical beds are taken up by patients who are awaiting placement in a long-term-care facility.

Under our amalgamation, the board of the corporation has attempted to move services around within our communities. This has been met with strong resistance from the doctors and surgeons providing these services, who did not want to move to a different town to practise in their field of expertise. Under the restructuring of the LHIN, we may lose many of the professional services, and the doctors and health professionals who provide these services, if they are relocated from one area to another. We cannot afford to lose any doctors or professionals from our area, as we are already facing a critical shortage.

What of the impact on the patient and their family? Who pays for flights, hotels and time off work to assist patients to travel to distant cities for treatment? For those who cannot afford these expenses, we are creating a two-tier system. What is the difference between charging user fees and creating conditions whereby access to health care is dependent on high personal expense?

If services are to be moved out of our area, then what is the impact on the employees? Workers are not always as portable as the government would like to believe. Two-income families are often faced with a dilemma when the workplace for one is suddenly shifted to a location hundreds of kilometres away.

The impact on employees during the restructuring of the new amalgamation was very stressful, as bargaining agents had to vie for representation rights. It left most employees feeling uncertain as to the role they would have in a much larger workplace than they had originally been hired for. There have been layoffs every year in the past six years, and job security has become a thing of the past to most of the employees of GBHS. Workers are tired of all the changes. When workers feel under threat of job loss or major change, morale plummets. This can't help but have an effect on patient care. Health care support workers are a very dedicated group of people. In our smaller communities, we take pride in the work that we perform and the services to our fellow community members.

During the same period of this restructuring, while front-line workers were reduced in proportion to the bed reduction, there was no comparable reduction in management personnel. More managers now direct fewer workers. Might I be so bold as to suggest the possibility of significant cost savings potential going unaddressed?

We now have the food that we feed our patients outsourced. While we are assured that it is nutritionally complete, I would have to doubt that a patient is getting the proper nutrition when many meals are returned to the kitchen uneaten, as the food is unpalatable to ill or elderly patients. It is unpalatable to relatively healthy people, and only those with a strong constitution and well-anchored teeth are able to consume it. We cannot understand why non-clinical services are being targeted by the government under section 33 of the bill.

Dietary and building maintenance are inherent parts of the health care system. Other health systems have made these services the focus of privatization and restraint, creating more hospital-borne infections and increasing the likelihood of the transmission of viruses in the health care environment. The issue of hospital infection has been well documented in our media, yet the LHIN restructuring thinks that a private, for-profit service would be able to do an adequate job. Our staff have been well trained and know the necessity of keeping a high-level watch on the hygiene of our buildings, with the ever-present germs that live in a hospital.

Our staff take pride in their work, but their numbers have been cut so much that it is a battle that is not always won in controlling the spread of infection. I do not believe that a third-party, for-profit company taking over the responsibility of maintaining the cleanliness of our hospitals is going to do as well as the dedicated staff who now do it. It is another case where the government's idea of integration is contrary to the good functioning of the health system. The added stress of having to compete for your job every time the competitive bidding process is renewed can only result in less focus on the job for the employees.

Five of our six hospitals had no deficit at the time of our amalgamation. Now we all enjoy a yearly deficit and the most common topic is budget: How can we trim more from supplies; how can we do more work with fewer people? There has been no financial advantage to our amalgamation, and if the hospital is believed, the ministry did not take into consideration the vast distances between our sites, there being more than a 100-kilometre spread from one end to the other. Our LHIN has a major centre, the city of London, but we are at the opposite end and need to have our rural issues addressed. While it may be efficient from a delivery standpoint, it is not efficient from a user standpoint. Again, who pays for flights, hotels and time off work to assist patients to travel to distant cities? What is the difference between charging user fees and creating conditions whereby access to health care is dependent on high personal expense?

We will see fewer nurses, fewer MRI technologists, fewer cleaning staff, fewer pharmacy technicians, fewer RPNs, fewer dietary staff and fewer clerical workers. Smaller communities and medium-sized ones will likely lose those services. In most of our communities, the hospital is the largest employer. There would be an impact on our communities by further downsizing or the privatization of our services, leading to economic loss. Our small towns and businesses depend on having our services close to home.

Patients will have to travel further. In our counties, winter travel is not always an option, and we do not have the necessary public transit. It simply does not exist. Under fiscal pressure from the government, the LHINs could very well rationalize many health care services under the integration plan, forcing patients to travel hundreds of kilometres for services we presently receive in our local community.

The local health integration networks are being presented as the solution to problems in our health care system. Ontario's health care system is not broken and does not need such a massive and costly reorganization. In fact, the risks outweigh any potential we can reasonably see that would emerge from this restructuring.

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. Drugs costs are the fastest-growing expenditure in health care, yet pharmaceuticals are left out of this structure. The large number of P3 hospitals the government has embarked upon also poses a serious threat to future health care funding, as does the rising cost of equipment.

We have been waiting for approval of a new hospital in our amalgamation. The community raised its portion

of the money, $13 million, and we have not yet heard if we can go ahead with it.

Lacking in the LHINs legislation is any real human resources strategy. I wrote the report on the human resources issue for the South West LHIN. One point that was clear with all the stakeholders I had contact with during the information gathering for that report was that a human resources plan was needed and should be put in place before any restructuring begins. While the rules do provide a forum for unions to battle out representation issues, the process is going to create retention and recruitment problems. We already face difficulties in recruiting health care professionals in small rural areas. Speculation about amalgamations and transfers is going to enhance the existing problems of bringing needed health professionals to our communities. Who is going to relocate to a more remote community when the likelihood of having the service transferred to another centre is rumoured or imminent?

The province needs to develop human resource adjustment plans, taking into account existing collective agreement language where applicable. It should also be willing to substantially fund these plans. Human resources plans will need to be negotiated, and will need to include, at a minimum, retention and recruitment policies, layoffs as a last resort, measures to avoid layoffs, 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 convened. No legislation should go forward without a human resources plan. Without health care workers, you have no health care system.

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The Chair: There's about minute and a half left. I'll start with Mr. Fonseca; 30 seconds, please.

Mr. Peter Fonseca (Mississauga East): Thank you very much. Jill, I understand your concerns, and I believe that actions speak louder than words. The previous government, as you said, closed hospitals, fired nurses, downloaded public health to our municipalities, mismanaged SARS. There's such a long list against the previous government in terms of what they did to our health care system.

Let's look at the actions since we've come to government and what we've done as a government under Minister Smitherman. He has driven health care into the community; he has put $260 million more into home care and community support services; he has uploaded public health to the province; he has hired over 4,000 new nurses; we have funded the health care system by more than $5 billion. All these actions by Minister Smitherman over the last two years are about bringing health care to the local community and making sure we have the best health care system possible.

The LHINs are an evolution in making our health care system sustainable and better for all Ontarians for the future.

The Chair: Thank you. Mr. Jackson, please.

Ms. McIllwraith: Was there a question there? I'd like to respond.

Mr. Fonseca: The question—

The Chair: Excuse me. Anyone has the option to make a statement or ask a question. Because of the time limit, I was going to go to Mr. Jackson. You can answer as you please.

Mr. Cameron Jackson: Thank you, Mr. Chairman. I will yield my moment to the deputant, and she can respond.

Ms. McIllwraith: The cutbacks I'm talking about did not happen under the previous government; they happened under George Smitherman. I am talking about a year and a half ago, when the complex care unit was closed but nothing was put in our community. I keep hearing statements about health care going to the community. I've looked in the phone book, and that community is not there. Nobody is there taking care of those patients when they go out. There has been no increase in funding there; there has been nothing. I come from a rural area. We don't see it. I can't say I wholly blame the last government—yes, they did a lot—but this government is really riding the same rocket.

The Chair: Madam Martel.

Ms. Martel: I'd like to thank you for coming today and for raising your concerns. It's too bad that the legitimate concerns you raised weren't addressed by the government. For example, why doesn't the legislation include a human resources plan? It is very clear from the definition of what the LHINs can do, and the government and the cabinet, that major restructuring is going to take place. It's going to have a major impact in hospitals, loss of services into the community and those services will not be going into the community after all.

You wrote a report for the LHIN about why this was needed. Nothing appears in the legislation. Do you want to raise with us again your concerns, both as a health care worker and as someone who could be a patient and whose family could be patients, about the fact that there is nothing in this legislation that talks about what's going to happen to all these folks when the chaos starts?

Ms. McIllwraith: We have seen what has happened in the past when chaos hits, again without anything in the legislation. I communicated with almost every stakeholder in this LHIN. It was clear that the first issue was getting human resources, and nothing has been done about it.

The Chair: Thank you for your presentation and for your answers.

LONDON INTERCOMMUNITY HEALTH CENTRE

The Chair: We'll move to the next presentation from the London InterCommunity Health Centre. You can start any time you're ready, madam. You have 15 minutes.

Ms. Michelle Hurtubise: My name is Michelle Hurtubise. I'm the executive director of the London

InterCommunity Health Centre here in London. Although our provincial association is making a presentation on the concerns of community health centres across the province, today I'm focusing on some of our regional issues, which are certainly echoed across the province.

We believe that community health centres play a critical role in fostering health system transformation. We deliver cutting-edge interdisciplinary primary health care, illness prevention, and health promotion services to hundreds of thousands of Ontarians, many of whom face significant barriers in accessing primary health care. Excellence in interdisciplinary health care and support has also led to their identification as a key vehicle for the implementation of municipal/provincial primary health care strategies such as diabetes care. In fact, the diabetes program at the London InterCommunity Health Centre is recognized as a best-practice model for ethnocultural communities by the Canadian Ethnocultural Council as well as a demonstrated cost-effective delivery mechanism for at-risk communities.

Our services improve and sustain individual health outcomes, and result in an overall reduction on the burden to the province of avoidable high-cost acute long-term-care services. This is a community-based program and needs to be nurtured under a community governance model.

Within LHIN 2, there are currently two community health centres, one in London and another in West Lorne, with London having two sites within the community, as well as there also being an aboriginal health access centre with sites in London and Muncey. Within the next three years, there are three more community health centres scheduled to open in Woodstock, St. Thomas and Markdale.

Our review and what I present to you today results in the development of some specific recommendations geared toward either amending or refocusing some key provisions. We see four overarching principles as critical to the success of LHINs and ask the committee to consider Bill 36 through the lens they provide. These principles are: that Ontario requires a culture of health service integration, not merely a system navigation mechanism; that the ongoing and broadly defined "community engagement" by LHINs is the key to achieving true local integration; that a continuum-of-care approach for health service coordination and integration is critical to ensuring that services reach all clients, particularly those facing barriers in accessing services; that the provincial health system standards, including standards for all primary health care models, are necessary to ensure equity in the system and effective planning at the LHIN level and across LHINs.

In terms of Ontario requiring a culture of health service integration and not merely system navigation, we believe that every door is the right door to services. LHINs should facilitate the ongoing dialogue among all levels of care provision through opportunities not limited to the HAPS process. It needs a multi-sector approach grounded in a focus on the broad social determinants of health: health promotion, education, housing. Integration needs to be properly resourced. CHCs and others have been doing this work for a long time because it's needed for client care, but, like multidisciplinary teamwork, there is a cost to it that needs to be appropriately resourced.

One of our concerns about an approach of system navigation is that many people with multiple and chronic physical and mental health needs require intensive care management within an integrated system. The capacity to perform this function exists with many different types of organizations—home and community care service providers, mental health and addictions and community health centres—and they need to be resourced as such.

We feel strongly that health care providers in various sectors assisting a client to receive the appropriate care they need is the outcome of an effectively coordinated system, not the role of an individual sector, organization or individual. Each has a role to play in the outcome.

One of our main concerns related to the ongoing and broadly defined community engagement is that we think this is critical for any true change. Community cannot be exclusively defined as a health service provider. Client and client group engagement has to be ensured. There needs to be support for ongoing community governance as a method of ensuring rich client and community engagement processes. Integration orders and institutional changes in services need to be undertaken through a filter that ensures that clients are able to access these services and that resources follow clients to new service locations.

Community governance cannot mean governance of all health services by a regional board. For example, we don't support the Quebec model of community governance whereby all health services in a health region, including hospitals and long-term care, are managed by a single board. We believe, in supporting that community base, that it needs to allow a 90-day period, not a 30-day period, to challenge integration orders to allow community-based organizations an opportunity to respond effectively.

Community governance encourages and fosters volunteerism. So to remove this governance model impedes the critical cost-efficient component of this system.

I do have in my written proposal, which I'm not going to review because I wanted to cover some other points, some specific wording related to ensuring that community engagement is a component of the legislation. There is a clause related to that, that no integration order will result in the elimination of community governance structures except where there is a single health service provider with another single health service provider, but that the community governance model is maintained.

We also strongly recommend that "community" be added to the definitions that are there, which includes that all clients receiving services are captured, the residents in a geographic area, and that the full complement of health services providers is part of that process as well.

Within the continuum-of-care approach for health services coordination and integration, we want to ensure

that proximity of services does not necessarily mean duplication. Barriers to access need to be borne in mind to ensure that services reach diverse target populations. A one-way valve provision is needed, and a provision protecting community groups from hospital deficits is needed.

Related to that in terms of some of the items is funding of health service providers, specifically part IV, subsection 19(1): "A local health integration network may provide funding to a health service provider in respect of services ... in or for the geographic area of the network." One of our concerns is the transient nature of many of our clients, particularly in community health centres that span the boundaries. This is a major issue in LHIN 1, where the Grand Bend area CHC is located, but their catchment base and the clients who are accessing the services are predominantly located in LHIN 2. Planning needs to accommodate for that.

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Provincial health care system standards, including standards for all primary health care models, are necessary to ensure equity in the system and effective planning at the LHIN level and across the LHINs.

We recognize that there are certain HR anomalies within the LHIN scope of authority. For example, all other primary care models, except for community health centres, are outside of the financial planning of the LHIN models, which means that our physicians who are employed by us as health service providers are outside that consideration. We are concerned about equity across primary care models within that kind of framework.

We are also concerned, in terms of the representation, that health professionals advisory groups should ensure that there is representation from the different models, and there are specific recommendations related to the clauses in the submission ensuring that that representation is happening both from the health services provider level as well as within the health professionals advisory committee.

We also want to ensure, in terms of the minister's duty to develop a provincial strategic plan, that a subsection should be added that the minister shall engage the public in the development of that health system and consult reports of the Ontario Health Quality Council in preparation for this plan. It should describe the processes and results of the minister's public consultations and highlight the role of the Ontario Health Quality Council reports and recommendations in guiding his policy and planning decisions.

In general, London InterCommunity Health Centre supports the intention behind the local health integration act. We hope this legislation will ensure that the broad determinants of health are taken into consideration in its consultation process, planning and implementation. Every door must be the right door to service. This means that the processes for community engagement need to be broadly defined and include more than just health services providers and organizations. It also means that all models of primary health care need to be included in the planning process, as well as the communities that they serve. The planning process also needs to ensure a continuum-of-care approach for the coordination and integration to ensure that services reach all clients, particularly those facing barriers in access and services. We are quite concerned that populations facing access barriers are often further marginalized in the planning process that only considers the global population health perspective.

The Chair: Thank you for the presentation. So one minute each. We'll start with Mr. Jackson.

Mr. Cameron Jackson: Michelle, thank you for your presentation. I share your concern about—this is a crude way of putting it—those who are outside the tent and those who are inside the tent. Mental health seems to be the biggest loser here, in particular children's services. Without getting into a lot of the technical stuff—and I appreciate that you've raised a couple of items that we haven't had presented to us—do you have an overarching comment you could share with us with respect to how we can have a truly integrated system if so many are outside of this model that should be patient-focused and case-managed?

Ms. Hurtubise: I think one of the primary concerns related to that is when you're looking at a community consultation process that's only looking at service providers. The clients we serve are not health services providers; they are people who don't have access. So community governance is a critical component in ensuring that those voices are coming forward, a community governance that is reflective of the community it serves, that engages its clients in a planning process. Some of the other references related to human resources planning that ensures that, in particular, the community organizations are not going to have to bear the brunt of hospital deficits within a LHIN planning process are critical.

The Chair: Ms. Martel.

Ms. Martel: I wanted to follow up on the community governance because, frankly, the bill is pretty well void of any kind of framework with respect to how the community is going to be engaged. From my perspective, while the minister on the one hand talks about this being a process to respond to community needs, there's zero in the bill in terms of showing how the community is going to be engaged. Worse, if you look at a number of the provisions, it just really centralizes that control, not bringing it down to the community level. So what kind of ideas do you have around community governance as part of community engagement to really ensure that people are actually going to have some say?

Ms. Hurtubise: I think community health centres are a good model of community governance, where they draw their governance structures from the clients they serve, the communities they serve, on their boards of directors, as well as having part of their planning processes engaging those community groups in that process.

The HAPS process is an example where service providers were engaged—sort of—in terms of, there was

a plan presented but there wasn't a lot of opportunity to, quite honestly, really influence that much. It was presented for feedback rather than in the development of, and I think there need to be mechanisms so that community and community-based groups are involved in developing those plans, and that as part of accountability mechanisms there are plans for how the community is going to be engaged in the planning of health services and the impact on its community.

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: I actually want to pick up where Ms. Martel left off, because this was one of the issues I raised with the minister before we embarked on this exercise: whether we could try to draw out from these committee hearings some of the specifics around what some of those mechanisms might be. You've talked about the community health centre model, you've talked about a plan being presented to a community, but what are the mechanisms that you think should be used to engage people in not just giving feedback, but actually being part of developing that plan?

Ms. Hurtubise: One of the pieces is ensuring in the accountability agreements that there are clear expectations that health services providers are engaged in their communities. I think there's a number of mechanisms. Certainly within our centre we use focus groups, we use client surveys, we look at our health outcome data for our clients in developing our programs and services. I think those are all critical pieces that develop that community governance and respond to the community needs of the clients. We have a voice through responding. Our client community council takes a look at quality service issues and provides that feedback. If that's a mechanism in an accountability agreement both within the LHINs and the health services providers, that they are demonstrating those kinds of mechanisms for community voices to be heard, I think that's one step along the way.

The Chair: Thank you very much for your presentation.

ONTARIO HOME CARE ASSOCIATION

The Chair: The next presentation has been cancelled, so we'll go to the 3:30. Is anyone here from the Ontario Home Care Association present? Susan VanderBent is the only name I have. Could we have the name of the other?

Ms. Susan VanderBent: Margaret McAlister.

Good afternoon. Thank you for inviting us today. My name is Sue VanderBent and I'm the executive director of the Ontario Home Care Association and also chair of the Ontario Home and Community Care Council.

The Ontario Home Care Association is an organization of home health and social care service providers. Ontario Home Care Association members provide a range of home care services, including nursing service, home support services, personal care, physiotherapy, occupational therapy, social work, dietetics, speech language therapy and medical equipment in the home.

Ontario Home Care Association members are contracted by all three levels of government, community care access centres, insurance companies, institutions, corporations and private individuals.

The Ontario Home Care Association thanks the standing committee on social affairs for the opportunity to present the Ontario Home Care Association perspective on the LHIN legislation.

Our association has long been a supporter of the transformation agenda and a systems approach to the delivery of health care in Ontario. The ministry's transformation team is to be congratulated on the comprehensive and thorough development of the LHIN system and its support to the new LHIN chairs and CEOs.

My association supports the fact that the proposed local health integration networks will improve patient care by allowing communities to plan and coordinate local services. This move will allow people to receive care at the right place and the right time, increasing access to local providers and home care service provision through realigned community care access centres.

The OHCA is pleased that the legislation requires the LHINs to jointly develop strategies to integrate services using a process of community engagement, thus enabling the emergence of a systems approach to health care. The LHIN legislation supports local citizen engagement and encourages accountable and equitable decision-making related to funding for care needs. Identifying local care priorities, planning for local health services, and integrating and funding local health services are important levers embedded in the legislation to move health care in Ontario into a true systems support for health care.

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We have some recommendations on the legislation. My board supports the stated intent of the legislation that prohibits LHINs from delivering care. The OHCA believes that the success of this made-in-Ontario solution to reorganizing care at the local level will rest on the fact that the LHINs always maintain a focused planning and integrating role.

The board of the OHCA wishes to ensure that an agenda of inclusivity is maintained by the LHINs, ensuring that all service providers, both transfer payment and non-transfer-payment agencies, be at the tables where discussions are held regarding service provision and the creation of integrated service plans. The input of these providers is important and necessary in order to ensure good ongoing care for people in Ontario. Stronger language in the legislation to reinforce this direction would be useful. I point directly to part III, section 16, subsections (1) and (3).

OHCA recommends that the LHINs create health advisory committees that are broadly inclusive of all types of professions, stakeholders and sectors. In this way, the LHINs will get the best advice from many different perspectives and avoid recreating silo thinking and silo attitudes.

OHCA recommends LHINs pay particular attention to enhancing the role and value of the home care sector in

supporting the overall goals of the broader health system reform. The LHINs must have clear indicators that measure better transition planning and home care integration. In a few minutes I also want to speak a little bit to a paper that the Ontario Home and Community Care Council presented.

OHCA recommends that the LHIN boards seek out members with a deep appreciation of the role and value of home care service and its important role in the health care system. OHCA is particularly supportive of a broader role for the realigned CCACs. An expanded role will allow the CCACs to take a central place in the LHINs in demonstrating leadership related to the growth of home care. This will support an enhanced home care system in its focused growth as an integral part of the broader health care system at both the local and the provincial levels.

OHCA believes that the government's transformation agenda rests on the need for a strong and stable home and community care system. It is for this reason that the OHCA strongly advises and recommends that the transition team maintain the same careful planning process to ensure a smooth and effective transition and realignment of the CCACs' boundaries within the LHINs.

OHCA recommends that LHINs broadly support the design and development of a chronic disease management continuum based on local population health needs. The home care sector plays a large role in the support and management of individuals who have lifelong illnesses. This would also include an end-of-life and palliative care system. Current work by the Canadian Home Care Association national partnership project suggests that home care has a significant role to play in proactive chronic disease management.

From the patient-client perspective, the LHINs will be successful when integration occurs at the point of care. Since structural changes alone will not necessarily lead to seamless care delivery, a results-based accountability system is also needed to support and monitor the effects of transition planning by the LHINs. To support transition planning, the Ontario Home and Community Care Council suggests that we need to identify key system-wide quality processes for information exchange and determine system performance indicators and outcomes. There are very few, if any, areas in Ontario where system-wide key quality processes related to transition planning or system performance outcomes are being tracked or reported. It is essential to the Ontario integration agenda to support and encourage health care providers to communicate with each other across complex organizational boundaries.

The current investment in e-health and electronic information exchange currently under way in the province will be a great support to the integration agenda. However, the Ontario Home and Community Care Association believes that the process of improving communication related to transition planning can begin at the local level prior to the full implementation of electronic systems. Most health care providers understand that in the present delivery of health care services, it is the consumer who is vulnerable to the lack of coordination and communication between different sectors in the system. The Ontario Home and Community Care Council believes that the key quality processes of routine discharge planning from acute care to primary care and community care must be expanded to examine the need for a new function within the health care system called "transition planning." Transition planning can be defined as the management of a complex, two-way interface between and among institutions and community-based providers. Transition planning is particularly important for those persons of all ages who require ongoing systems support due to long-term mental or social illness.

Strong working relationships between providers and willingness to share timely and relevant information in all parts of the health care system are required to support good transition planning for people. Particular emphasis in transition planning is placed on the need for continuity and quality of information exchange as people receive care and move back and forth through the permeable boundaries of all parts of the health care system. Key quality processes for transition planning between health care providers are necessary. Key quality processes can be defined as those activities which assist organizations in effectively meeting consumer demands and are the basic building blocks of communication between health care providers in the system. The clear articulation of key quality processes in transition planning will shed new light on system performance outcomes such as decreasing unplanned readmissions to acute care for both mental and physical reasons.

Further research work needs to be done to identify outcome measurements which appropriately capture the increased efficiency and effectiveness of the LHIN. The Ontario Home and Community Care Council believes that tracking the movement of specific, identifiable subpopulations of clients may be a useful place to begin to understand how the system can be improved to give more coordinated care. Tracking movements of persons as they seek health care is greatly supported by the current investments in e-health and privacy legislation, which are now underway in Ontario.

In conclusion, the Ontario Home and Community Care Council believes that when specific system performance outcome indicators related to improved communication have been identified, data about current system practice can be measured and baseline levels of system function can be set. Once current baseline data are in place, measurable time targets for system performance improvement can be identified by all service providers. Each health care provider in a LHIN plays an important role in supporting new system performance indicators that are collectively, and not individually, shared and managed.

Annual reporting in a balanced scorecard format would showcase the success of each LHIN as they move toward the achievement of a truly integrated system of care for people at the local level.

The Chair: There's about a minute and a half, so 30 seconds each. Madame Martel, will you start, please?

Ms. Martel: Thank you for your presentation today. I'm not sure I understood the function of the transition planner. I'm assuming that's different from the system navigator proposal that has come to us. Maybe you can just explain the differences to me.

Ms. VanderBent: I'm not sure. Can you be clearer about the question?

Ms. Martel: I know you're not here representing CCACs, but CCAC has talked about a system navigator approach.

Ms. VanderBent: And you're asking what we think about that?

Ms. Martel: You can respond to that to me as well, but I wasn't very clear on what the difference was between that and your—

Ms. VanderBent: And transition planning?

Ms. Martel: Yes. Which would be a transition planner?

Ms. VanderBent: No. I implied that; I wasn't clear.

Ms. Martel: That's my mistake. Sorry.

Ms. VanderBent: That's all right. It is not a noun; it's a verb. Transition planning is the responsibility of a system and should be embedded in the policies, processes and practices of organizations as they help people to move across systems. It should not ever be embedded in one person, because if you give that role to one person, what you do is take away the responsibility of the system to actually look at how it manages its transitions. If I'm sending a person to you as a sending caregiver, I should be very aware of what you need in order to look after that person. I shouldn't have an intermediary to do that work. As the sending caregiver, I should know what you need as the receiving caregiver and make sure my work that I'm sending to you meets your needs, because you're the person who's going to be carrying on the care.

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That's what we do not have, really, in our system at this present time. We send people out from all kinds of organizations, back and forth. People do move back and forth nowadays because they often have chronic or lifelong illnesses. But the sending and receiving of information is not well done, and that's what we have to do better as a system and as a group of providers.

The Chair: Ms. Van Bommel.

Mrs. Van Bommel: Just to take that a little bit further, you were talking earlier about palliative care. In an earlier presentation, we heard from a group who were concerned about the erosion of palliative care at their local hospital. Where do you see the future of palliative care? Is it something that would be provided through home care? Should it be provided through the hospital? Or should it be something, as you're mentioning now, that moves back and forth? Where do you see palliative care going?

Ms. VanderBent: I was a palliative care social worker for three years at St. Joe's in Hamilton, and I think there's a need for many different doors to support people who are dying of cancer or any other disease. There is a need for a hospice, there's a need for home care, there's a need for acute care and there's a need for long-term care. People die in many different places, and families and people have many different needs. I personally think the legislation in this system will provide a better opportunity for people to die with different types of options that will better support families and better support people.

The Chair: Mr. Jackson.

Mr. Cameron Jackson: Just on that point, however, there will be a distinction between the three palliative care options, two of which are not covered under the Canada Health Act. So yes, we may get increased patient choice, but there may be fees attached to it, which can occur outside of a hospital setting.

I want you to put your hat on with the Ontario Home Care Association. My question to you, Sue: Have you had any indication from the current government about how much of the community support envelope will be transferred to the LHINs and how much, if any, may be retained? I remember that, when I was the minister, staff recommended, "We should really be getting out of this business, Minister." It was just politically too untenable, so I said, "No, we're going to continue to do Meals on Wheels. We're going to do a whole series of supports." But you have municipalities getting community envelopes now for public health and regional health units, and that envelope has expanded. Have you had any discussions with the government to look at the community support envelope to say, "These are a couple of things that we're going to mandate to the LHINs," and therefore Meals on Wheels—I just pull that one out of thin air—will now be decided by the LHIN, or it'll be outside? Have you had discussions at all, in any kind of detail, so that we have a clue as to how this integrated—because that's your whole point: You're looking at the whole patient's needs, whether it's nursing, physiotherapy and so on.

Ms. VanderBent: I'm sorry, I haven't had those conversations, so I don't know the answer.

The Chair: Thank you for the answer. That's what he was looking for. Thank you for your presentation.

LONDON HEALTH SCIENCES CENTRE

ST. JOSEPH'S HEALTH CARE, LONDON

The Chair: Next there will be two together, the 3:45 and the 4 o'clock. London Health Sciences Centre and St. Joseph's Health Care, London, wish to do half an hour together. Are they both present?

Interjection.

The Chair: They are outside? Can they please come in quickly? They're exchanging some ideas outside.

We are asking for the London Health Sciences Centre and St. Joseph's Health Care, London. Mr. Ramal, are both groups represented here?

Interjection.

The Chair: Okay. Thank you.

You can have a seat. We are going to have both presentations as a group. You have up to 30 minutes, half an hour. Whatever time is left will be available for questions and comments from the membership.

Mr. Peter Johnson: Thank you. I'm Peter Johnson. I'm a board member at LHSC. With me is Graham Porter, who is the chair of St. Joseph's hospital, and Diane Beattie, who is chief information officer and integrated vice-president of health information management and strategic alliances at both LHSC and St. Joseph's. What we're going to do in the form of our presentation is, first, address some issues within the bill; second, some specific issues with respect to LHSC; and then Graham Porter is going to address certain issues with St. Joe's as a faith-based hospital.

One of the unique things, I think, in the province is that in London, the two hospitals here and the surrounding community have been very, very active integrating the services with the region for a number of years. I think it would be worthwhile to apprise you of that and the things we've done, which really feed into the concept of the LHINs.

One of the distinguishing features of and the challenge for the LHINs will be to distinguish between the role of an academic centre and the community hospitals. It's been a continuing challenge for the academic hospitals to receive the appropriate funding for the additional level of activity they have as academic health sciences centres. As we know, there is going to be an increased desire on behalf of the government and the public for educating more health care practitioners, doctors etc., and that is the role of the academic health sciences centre. That is an issue that needs recognition within the LHINs: that there is a difference between the needs of an academic health centre and a community-based hospital.

The second issue is with respect to integration. As I said, Diane is going to speak to you at greater length about integration and its benefits. We clearly believe that, in order to provide the best health care for the citizens of southwestern Ontario, it has to be an integrated service model between the academic health sciences centres, the regional hospitals, the community access centres. We certainly support the concept of an integrated delivery system and have done a lot to do that.

Specific concerns with respect to Bill 36 include the fact that integration decisions do not require consultation with the hospitals. At present, there's a lack of criteria or guiding principles for integration decisions, and there's a lack of due process or mechanism for hospitals to appeal integration orders. Those are some specific concerns that we have with the legislation.

With respect to funding, that has continued to be the bane of our hospital's existence for many years. I've had a long relationship with the hospital, being chair of the Children's Health Foundation back in the 1980s, being on the Victoria board around 1990, doing the legal work on the mergers of the hospitals in London and the mergers of the research institutes, and just recently having rejoined the board, so I've seen it from inside and out. The funding issues are a continual problem. We have had monitors, observers, outside consultants come in and review our operations inside out. All of them go away and say that it's a well-run facility, and still we don't have money to operate—

Interjection.

Mr. Johnson: Yes, and those cuts are being announced today.

That is a major issue, because as we transcend from the current situation to the LHINs, there are legacy issues we are faced with, enormous financial issues. I don't know how that transition will be made and whether they will get lost in the shuffle, but that is an issue.

At present, 60% of the patients at LHSC reside in London-Middlesex, 31% are from communities within southwestern Ontario throughout the LHIN, and 9% are from across the province and the country.

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Specifically with respect to Bill 36, our concerns in that regard are a lack of clarity as to how LHINs will make funding decisions in a geographic area or across areas representing the national scope that we have; secondly, the fact that our budget planning process has been so challenging, and the interminable delay in getting any resolution from the ministry for that.

With respect to the governance, one of the things that has made London so strong—and I can say it as a new board member tooting my horn, because I wasn't a board member when this was done. But having seen the work done by the boards in London over the last 10 years—I'll give you a small story. Back in 1990, when I was on the Victoria board, I suggested that the hospitals work together to do the best for our community. I was viewed as a heretic at that point in time because there was a Vince Lombardi attitude that each institution should be fighting for the dollars and fighting for the patients and not co-operating with the others in the city. London has changed dramatically over that period of time. We had Victoria Hospital and LHSC merge; we had the research institutes merge. We have integrated vice-presidents. We now have an integrated CEO. We've done a tremendous amount, and that has been due to the wisdom and leadership at the CEO level and at the board level.

I think the challenge for the government will be to ensure that they populate the LHIN boards with the same degree of talent that exists at the hospital boards, because they have a very, very challenging job and it's a very complex role. We would like to hope that the LHIN boards would be populated with people with expertise, community interest and an ability to do a very, very demanding job.

A point on my briefing notes is, "Establish criteria for when LHIN boards may meet in camera." Perhaps that will be dealt with in Bill 123, so we'll see what happens there.

In summary, just to end my remarks, LHSC supports the aims and principles of Bill 36. We're optimistic about it and we are prepared to take a leadership role, working with the South West LHIN, the other hospitals and health

care providers to improve the delivery of health care in this region. We believe it has to be done on an integrated model and support that. But we do join our peer hospitals in Ontario in advocating changes to the legislation that offer hospitals an explicit role in the consultation process for integration orders, greater clarity around funding issues, especially for academic hospitals, and a commitment to skill-based LHIN boards with local representation.

Mr. Graham Porter: My points, not surprisingly, will echo to a great extent what Peter has already said, particularly, unfortunately, around funding. However, we do want to thank you for the opportunity to present to this committee, because we at St. Joe's and also at LHSC view Bill 36—as we know this government does as well—as a pivotal piece of the legislation to transform our health care system.

Particularly with respect to this bill, I want to concentrate today on some of the themes that Peter has spoken about, as I said, as well as stressing St. Joe's faith-based mission, which is obviously of a great deal of importance to our board. But I also wanted to speak briefly about voluntary governance and the teaching and research components of both of our hospitals, which are critical to advancing health care in the province, and funding, of course, to support the continuum of care in our community.

The first thing I did want to touch on was the voluntary governance. We view it as critical—and we join the Ontario Hospital Association in supporting this position—that local representation is an important function for the LHIN boards, so that the LHIN board members understand the needs of the region and that we get the appropriate knowledge and skill set on the boards. First of all, we want to congratulate the people who have been appointed. Our board views the appointees as good choices, who have the appropriate knowledge and skill set. Our board looks forward to working with them in the southwest LHIN. As well, our hospital sees great opportunities to work across LHINs since, for both LHSC and St. Joe's, a number our patients, as Peter alluded to, are drawn outside our LHIN. We have a larger catchment area than just the physical constraints that were placed on us.

The next important point for St. Joe's is the faith-based mission. Ontario's health care system was founded, and continues to be stewarded, with substantial leadership and support of faith-based organizations. As a hospital in the Catholic tradition, St. Joe's has always tried to respond to the diverse needs of our communities while upholding accountabilities to our sponsors and to the government. We particularly have distinct guidelines which we uphold, in keeping with the Catholic health ethics guide of Canada, which corresponds to the objects of our owners, the St. Joseph's Health Care Society, and our bylaws and our values, listed in our strategic plan, of respect, excellence and compassion. This is fairly difficult in an era of integration and shared services, but we're proud of the collaborative models of leadership and care delivery we've established with our partners while maintaining and strengthening our distinct mission. We believe that our entire community becomes stronger, and our Catholic mission becomes more valued, through shared understanding with our partners.

The next point I wanted to touch on was system integration. As Peter discussed, a major success story, in our view, in London and in the region has been continued sharing of services, sharing of CEOs, sharing of vice-presidents and resources. I think it's fair to say that London has been on the cutting edge of a lot of the significant sharing of resources and integration. And it's gone beyond London: We work with all the other six hospitals in the Thames Valley Hospital Planning Partnership. That deals with health care delivery, technology, patient records and supply chain initiatives. It extends not just to hospitals but to other service providers and care partners throughout the region, and not just the LHIN but southwestern Ontario. We've demonstrated that a variety of models, including joint ventures, shared services agreements, integrated functions and leadership structures can successfully and voluntarily be applied. The thing that I think St. Joe's is proudest of is that we've done a lot of these things on our own initiative.

As Peter said, the LHSC and St. Joe's boards work remarkably well together, in concert, with a view to the best interests of the community that we serve, and we're committed to continuing this approach. The one thing we would like to point out is that we're a bit concerned that Bill 36 doesn't establish enough of a framework for consultation about the integration decisions. We think guiding principles and establishing pre-set criteria for integration are vital. These are things that could be considered going forward. Alterations along these lines would be positive additions to the legislation.

I also wanted to touch on the mandate of academic hospitals. This is particularly important for London since some 3,700 medical and allied health students are taught in London's two academic teaching hospitals. Obviously, we're proud of our long history of teaching and research, and we want to make sure that this continues to be an important driving force in London and the region.

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I want to underscore the need to recognize the unique roles of Ontario's handful of teaching hospitals. While the government has rightly increased the number of university enrolments, our concern is that there has to be corresponding support for academic hospitals to reinforce the increasing number of health care professionals. In particular, St. Joe's capacity to offer rising student numbers the space and supports for learning is at a bit of a critical point and might even threaten the viability of some of our accredited programs.

Finally, I just want to touch on the funding issue. As always, the London hospitals are concerned about money. In London, there have been seven financial reviews in the past eight years, including a comprehensive review conducted in 2003, which was done in partnership with the Ministry of Health and Long-Term Care. These

reviews have basically failed to resolve the necessary funding levels identified for both hospitals. Obviously, we continue to work with the ministry on an ongoing basis to ensure full funding and to meet what we will consider our obligations under the HAPS for this fiscal year and next, and obviously, we have no issue with the concept of signing hospital accountability agreements. But we need to make sure we have dealt with the unresolved funding commitments; otherwise, we might have to deal with substantive reductions in patient care volumes or access to care, which obviously none of us wants.

We are concerned that the existing processes may become even more ineffective and burdensome if funding decisions are not clearly delegated to the LHINs or if somehow the accountability is not clearly passed from the ministry to the LHIN. There has to be clarity about how the LHIN boards will assume regional funding decision responsibility.

In summary, we want to continue to be an active leader and partner in transforming health care in London and to improve health care for all Ontarians. I think we've demonstrated our capacity and desire to continue to change and integrate, but we need to ensure that there's representative knowledge and skill-based LHIN boards. We want to ensure that there is good consultation and principles and criteria for integration, and we want to ensure that academic hospitals are given unique recognition. Finally, we want to make sure there is a framework on criteria for funding decisions.

Ms. Diane Beattie: This afternoon, I'd like to just give you a little bit of history on the integration model we've been using in London and how that has worked. As you look at the title "LHIN," I think the key and operative word for us is really "integration" and starting people to think about systems and how systems work.

If you go back 10 years, we had five independent organizations managing hospitals in the city. Today we have two hospitals on 10 sites. There's a resolve amongst the hospitals and the hospital boards to embrace what we're doing as a community resource and look at it as one community working together. Why the change from what Peter said was the Vince Lombardi approach of the previous generation? As you look at what we're trying to do and how we're working, there is a real need to understand that our human resource shortages are going to drastically change how we work together and why we need to work together.

The average age of a nurse in our community is 48. In London, we grew up with Freedom 55, and on the ONA side, there is 30 and out. So if you look at the number of nurses who will leave the profession over the next period of time, the expectation is that for every five who leave, there is only one in school coming behind. The Globe and Mail had an article about 18 months ago that actually said that for every eight and a half who leave across the country, there's only one coming in from school behind that group of nurses.

You don't have to look at just nurses. You can look at lab techs, you can look at radiologists, you can look at every group of professionals in health care. So if we don't start to think about how to integrate and how to do things differently, we are not going to be successful and we will not have the health care system we need moving forward. As we've gone through this process as well, I think we've found that there have been significant efficiencies and better ways, and we've learned to do better things and to work together differently.

We started out in 1995 with the merger of three hospital campuses, which were then Victoria Hospital and University Hospital, and then we went into the HSRC directions in 1997. Through that time frame, the two London hospitals have been guided by 13 principles, and those 13 guiding principles are used today. We've followed them and watched what they're doing. The most critical of those guiding principles can be paraphrased: "Follow the patient's journey." If you follow how the patient flows through the system, then looking at integration and how to adjust your services and work forward is much easier.

Both Graham and Peter mentioned the integrated leadership model that has been put in place. I think, as you look at that, it's really important that you may have different missions but very much a common vision of where you're going and common values of how that needs to work. What we have, actually, is cross-appointment on our boards of directors, so the vice-chair of the LHSC board sits on the St. Joe's board and vice versa. I think it is really effective and has made a significant difference.

The key thing we're learning about integration, though, is what we call the C3 umbrella: Connect the continuum of care. In that, we've really invested in information technology to support the larger geographic region. Right now, we're working on all of Thames Valley, where we have everyone on the same digital imaging or PACS system. We've put everyone on the same hospital information system to create an electronic patient record. We've gone to what we call video care, which is telemedicine, so video conferencing from location to location, and we're actually sharing a lab system as well, which will dovetail into the EPR. You have to have a framework for people to share and a way for people to share. What we've found is that building that technology really makes a difference.

In the handout you'll see several places where, across southwestern Ontario, we have learned to share and collaborate in a number of things we've done. You'll see the referral patterns and the referral centres across our area.

I think the couple of things we would like to share, particularly with this committee and the LHIN boards, are the lessons we've learned about integration. First of all, it's tough to let go. Independence is cherished. We have to improve the way we make decisions collectively and bring more of a systems perspective—systems thinking is very difficult to get started; develop ways of working together that allow us to focus on the people, or patients, we collectively serve; demonstrate to the public,

our stakeholders, that we are working together to coordinate the delivery of care; apply best practices across that continuum of care; and the final lesson is, relentless effort to find the best ways to make collective decisions takes time and an awful lot of energy, and we really need to make sure we're focused in that perspective.

Our five critical success factors are: building trust and credibility of the players, so it's a people thing and a relationship thing first; perseverance—this is not something for the faint of heart; the old adage "communicate, communicate and then communicate again" is absolutely essential because, in a void of communication, people always understand and take the worst, never the best; you have to creatively develop your partnerships and then really make progress toward system planning and systems thinking. As we go forward, if we're going to be successful, I think the operative word in all of this is "integration."

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The Chair: Thank you. We are just at the end, but I'll allow one minute each since it was a long presentation. Mr. Ramal, please.

Mr. Ramal: I have no questions. First, I want to thank you for coming this afternoon to do a presentation. I had the chance, over the last two and a half years, to meet with you on a regular basis and see your job. No doubt, to my mind and to many people in London, you are the leader of integration. You did your best to integrate all the hospitals in London and work together—not just in London but all around the Thames Valley area. Hopefully, you'll continue working with the LHIN in the future and try to integrate and consolidate service between yourselves, in Thames Valley and London, and in other communities and health providers in the LHIN boundary.

I also want to tell Graham about his concern. If you go back to the bill, to speak to your issue, your concern, I think clause 26(2)(f), if you go to it, will answer your questions.

The Chair: Mr. Arnott, up to a minute.

Mr. Arnott: You've given us a lot of information. I don't have any specific questions but I'm certainly looking forward to hearing from more hospitals as the hearings continue across the province. Your advice is very thoughtful and well presented.

The Chair: Thank you. Madame Martel.

Ms. Martel: Two of the three of you focused on funding as a major issue. I assume we'll see in the papers today what the result is of the deficit-cutting exercise that's going on. The reality is, though, that even if how money gets transferred down to the LHINs is sorted out or clarified in some way, if essentially the same amount of money is transferred down, your funding problem is not going to be resolved. It's only going to be resolved at the expense of other players in the system who would lose money in order for you to gain money to put you in a better position. The reality is, the funding issue is under the control of the government, not the LHINs. So if this is not resolved already, and this legislation is before us, where do you see yourselves in the next two or three years as the transformation takes place, with essentially the same pot of money being downloaded?

The Chair: It's your choice; only one, please.

Ms. Martel: It's not a trick question.

Ms. Beattie: I think it's very, very important over the next short period of time that the funding issues that have been identified across the London hospitals, in particular, and the number of reviews we've gone through get resolved prior to the LHIN taking responsibility for the funding piece. If it doesn't, it's just going to cause a lot of heartache and discomfort for a group that needs to figure out how to work together. They will be diverted in their attention to looking at dollars and cents versus figuring out how to improve the care that we deliver.

The Chair: Thank you very much for your presentation.

CHED ZIVIC

The Chair: We'll move to the next presentation, which is from Ched Zivic. Mr. Zivic, you have 15 minutes total for your presentation and potential questions and/or comments. You can start at any time.

Mr. Ched Zivic: Thank you very much. I'd just like to make some comments and express some concerns.

Bill 36 represents a fundamental shift in how our health care system will function in Ontario. I have very serious concerns with respect to local autonomy, privatization and workers' rights. While it's widely acknowledged that financial and fiscal anxieties will always persist, we must, as a society, do the most civilized thing and put the welfare of the sick and the people who work on behalf of the sick in front of all other considerations. If Bill 36 is designed to use economic planning to serve the moral purpose of improving our health care system, why is an act of Parliament sabotaging this responsibility? This legislation raises some serious concerns with respect to where the fundamental sovereignty lies in our democratic society. Thankfully, today's forum will promote frank and open discussion. These proceedings will truly ring hollow if this legislation passes without serious consideration being given to the valued scrutiny of concerned health care workers, consumers and their unions.

Bill 36 exiles civic-minded, elected volunteers in favour of a paid bureaucracy of detached appointees who will be motivated by nothing more than a fiscal agenda. This will spawn the privatization of health care services. Moreover, the bargaining rights and collective agreements which took years to forge will be threatened, as well as those who contribute to the welfare of our young and our aged.

With the privatization model, for-profit providers fall beyond the scope of the Public Hospitals Act and are not accountable to the health care consumer because private business practices would restrict public access, and audit quality of service as predicated on cost savings, not

quality of care. The experience of P3 hospitals in the UK confirms that substantial reductions in service often occur in the P3 environment.

We have been excluded from providing input into what constitutes the parameters surrounding these accountability agreements, which are essentially fiscal targets set by the honourable minister. In turn, his authority is given to the LHINs, and they can create partnerships with other persons or entities, transferring, merging, dissolving and so on. When the 14 LHINs are up and running, hospitals will be forced to adopt fiscal targets and dictates set out by the network. Again let me stress that it is unclear what formula or model is used to establish this target, and there is no transparency, oversight or accountability.

Because I live in a small community, I fear that the larger urban centres will have a big advantage, because the larger centres represent a greater population and have entrenchment and long standing within the health care system. I suspect that the small institutions simply cannot compete or will not be allowed to compete. Regional inequalities will become a greater systemic problem because, when cost-cutting is the primary motivator, the most vulnerable will be affected. Rural Ontarians have a lot to be concerned about with this legislation. We always seem to be the recipients of made-in-Toronto solutions, and there exists a very real disconnect between urban and rural Ontario.

I've been a rural paramedic for 26 years and have seen first-hand how the value of numbers has driven policy with respect to service delivery. It is my understanding that ambulance services have been excluded from this bill, and I received an e-mail from the director of emergency services assuring me that the land ambulance will remain a municipal responsibility. But for how long?

In closing, I respectfully urge you to remind the government that it has the privilege and a responsibility to protect our health care system. If it chooses to go down this path, we will all become casualties of a distant, uncaring bureaucracy driven by a rationalized sense of immunity in pursuit of a balanced budget. The chasm will become an abyss if the architects of this legislation choose to ignore the concerns of the speakers who have stood before you today.

Thank you very much for letting me speak.

The Chair: Thank you, sir. We have up to two minutes for each group for comments or questions. Mr. Arnott, maybe you want to start.

Mr. Arnott: Thank you very much for your presentation.

Mr. Zivic: Thank very much you for listening.

Mr. Arnott: I have a lot of concerns about Bill 36 from the perspective of the opposition and from what I'm hearing. But I also agree that, generally speaking, the government needs to look within its means. If there's a health care budget, we need to stretch those available resources as far as possible so as to benefit patients. If we can find efficiencies and savings in the health care budget, that in theory should be driven into better frontline services. I don't think you'd agree with any of that, would you, in terms of a general assumption?

Mr. Zivic: The notion of living within your means definitely falls within the scope of prudence and sensibility. I am not for one moment suggesting that we just recklessly go out and borrow billions and billions of dollars to sustain a system that is completely unsustainable.

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My basic problem with this legislation is that the democratic process has been somewhat usurped and that all members within the House have got to have some input into this process. More importantly, I think it is crucial that the confidence in our democratic system and our elected representatives remains sacrosanct. We have had scandals at the federal level. We have had scandals at the NHS in Britain, where this template was taken from. In 2000, Minister Clement went over, studied this model, brought it back, put a made-in-Ontario stamp on it, and now here we have to live with it.

That being said, I think it's incumbent upon the legislative process to acknowledge the needs and requirements to sustain and maintain a sensible level of health care, but not at the expense of the people who work within the system; the people who, every day, put their lives on the line—I can only speak of myself and my own profession—to deliver a system of health care. When you start opening the door to privatization, to the bidding process, there's automatically an entrenched mentality of these private providers that there has to be a 15% to 20% profit margin. But at what expense?

The Chair: Thank you. Madam Martel.

Ms. Martel: Thank you very much for making the presentation today. The opportunity for privatization in the bill exists in a number of ways: number one, the very real potential, to my mind, that cutthroat bidding or competitive bidding is going to be used as the mechanism for LHINs to purchase and acquire services; secondly, section 33, which allows the minister to decide which non-clinical services in a hospital are going to be contracted out, because "contracted out" means privatization; and the third area, where the minister can essentially shut down not-for-profit entities and transfer those to other areas, which could well be for-profit entities. So there's discrimination there, but a real potential for further privatization.

My concern around all of this is that if you have a limited pot of health care dollars, to my mind, it should be used on patient care, not on profits of big corporations or small. I don't know if you want to respond to that.

Mr. Zivic: Well, I can respond to that, because one of my biggest concerns—I sat on the hospital foundation in Hagersville, which is where I used to work before we were downloaded by the ministry to the municipality. We worked extremely hard to try and mobilize our community to support our hospital. We raised money for vital equipment. In fact, it seems that the hospital has come to rely on those funds to operate at a proficient level.

One of my concerns is, if this legislation goes through and we become the servants of this over 500-member

bureaucracy, which I think will be detached and not really serve the needs of the community to the same extent, what is that going to do to fundraising? What is it going to do to foundations that work within hospitals which are going to be seeing their services cut, where they're going to be seeing decisions made outside of their previous jurisdictions? I think that's very problematic. I think the perception will be that they have absolutely no control or no input, and no say, into how their hospital will serve them.

As I alluded to in my presentation, I think it's important to acknowledge the fact that smaller service providers, smaller hospitals, run the risk of being victims of this legislation, because when you try and centralize a big system like health care, they're going to look at cost-efficiencies. Part of that will be to streamline services, and privatization. Privatization is already here. We have Aramark. We have Sodexho. We have companies that do provide services to institutions. That's the loss of some very important jobs to the union workers. I think that will be reflected in the quality of care and the quality of service.

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

Ms. Wynne: Thank you. I just wanted to make a couple of comments, and then Ms. Van Bommel has a question. First of all, thank you for coming. I just want to say that Minister Smitherman has talked to a lot of people about this legislation, but Tony Clement is not one of them. I'm quite sure that Mr. Tory and Mr. Clement would not be in favour of this legislation because, in fact, it doesn't extend competitive bidding. Section 33, which Ms. Martel referred to, has its own clause embedded in it that would repeal that section once the processes that it's intended to complete are completed. I think those folks would not be happy with this legislation, because it actually does preserve the publicly funded system and that's its intention.

On the rural-urban issue, I really believe that this legislation is even more important for rural coordination. As an urban member and an urban resident, I don't think I worry about provision of service and coordination as much as people in rural areas, so I'm going to ask Ms. Van Bommel to comment on that and ask you a question.

Mrs. Van Bommel: Thank you very much. I want to just carry that further, because as a rural member, and having been involved in health care in my community in the past, I certainly know some of the difficulties that we experience in trying to coordinate the care.

We talked earlier and we've had different opinions expressed about the formation of these boards. Under the current legislation the membership of the boards is appointed, but we've had other people talk about an election. Now, if you look at the system, at the LHINs, how do you think rural communities would fare if we were to have elections of board members?

Mr. Zivic: I can only speak to my own experience. My wife sat on the board at the hospital and she was elected. I think it's important that we observe around this table that we live in a pluralistic, democratic society. I think all groups within that society have to be equally served. One of my concerns with respect to this legislation is that the rurals could be balkanized, could be absorbed, especially those rurals that are very close to larger centres. I can speak to emergency rooms. A number of years ago there was a proposal put forward that our emergency room should close in my small community. The community mobilized; it stayed open. I think what's going to happen here is, if a community is threatened, or their hospital is threatened—because you have to realize, in the small communities, it's not just a hospital; it's a hub within that community. It provides jobs, it provides a very essential service. A lot of times, communities put their own hard-earned blood, sweat and tears and equity into that hospital decades ago to build it, to make sure they did have access to health care.

This legislation, I think, jeopardizes that. I really think that we can be lost in the shuffle. I think this bureaucracy can be very detached. I think you have influences that come to bear behind the scenes, and we all know that the way politics works is that the biggest stakeholder will get the loudest voice. I don't see any guarantee in this legislation that the rural hospitals will be given a fair and level playing field.

Mrs. Van Bommel: But if you look at the situation now where LHINs such as the one we're in right here and you have a centre like London, how do you think the rural communities around London would fare in an elected process?

The Chair: A quick answer, please.

Mr. Zivic: You know what? I'm really not exactly certain what you're asking. We're talking about process here, and as laudable a concept as that is to discuss, I think it's very important that we never lose sight of what this legislation is all about. I think that the way the hospitals were set up, the boards were set up, these were very dedicated individuals who really wanted to see the hospitals improve, move forward, provide a high level of service. Prior to this legislation, I think that that was happening. I'm not sure that would be maintained under this legislation.

Thank you very much.

The Chair: Thank you very much. We just went over the time; otherwise, I would have allowed—but that's fine.

Mr. Zivic: I appreciate that, thank you very much.

The Chair: We appreciated your comments and your presentation.

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WENDY MANZIE
JADE CAMPBELL

The Chair: The next one is from Wendy Manzie and Jade Campbell. Thank you for coming, both of you. I understand you're making a presentation together. There is a total of 15 minutes.

Ms. Wendy Manzie: I'll be brief. I'm Wendy Manzie. I live in Sarnia. I'm not as familiar with the

forum as many of the other speakers today, so I'm just going to go ahead and read my statement.

According to the ministry's release on the proposed Bill 36 draft, "The purpose of this act is to provide 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 by local health integration networks."

The geographic areas of the proposed network are prescribed through the local health integration network maps. Erie-St. Clair, or LHIN 1, residents are here in London today because the ministry is not holding these public meetings in each of the new geographic regions. This may have been an opportune time to introduce the public to the new boundaries.

Coming from Lambton county, I believe the ministry has to recognize that the separation of London Health Sciences from this part of southwestern Ontario is not a user-friendly move. While the bill allows for "no restriction on patient mobility" and is directing that each LHIN therefore "not enter into any agreement or other arrangement that restricts or prevents an individual from receiving services based on the geographic area in which the individual resides," the bill does not provide assurance for funding for the mobility; that is, the transportation of patients and/or their families or support systems.

To name a few of the objects of this bill, and I've taken chronological liberty with these:

(a) to engage the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal channels for the community input and consultation;

(b) to ensure that there are appropriate processes within the local health system to respond to concerns that people raise about the services they receive;

(c) to undertake and participate in joint strategies with other local health integration networks to improve access to health services and to enhance the continuity of health care across local health systems and the province;

(d) to enter into agreements to establish performance standards and to ensure the achievement of performance standards by health service providers that receive funding from the network.

Does this mean that the intention of the bill is to take direction and input from local taxpayers, or just lip service of an intended, yet-to-be-established process that no ordinary citizen would be able to successfully navigate? Are we to assume that current hospital follow-up in long-term and diagnostic services will be available within reach of our current local public transit systems? Will the members of each community be properly informed, let alone have some true input on the health care services provided within their communities? Will there be an additional tax, not unlike the recently implemented provincial health care premium, just to maintain present levels of service, or will residents have to adjust or lower their expectations?

Ontarians, as both health care workers and potential health care consumers, should not be subject to a disconnected health care system. The proposed bill calls for us all to rely on the kindness of strangers to provide our most intimate, essential health care services. This is potentially going to leave many of our most vulnerable people unable to access or feel comfortable with an unfamiliar, potentially transient health care system. For workers, this legislation will potentially discourage current experienced providers from continuing in their field of expertise if it means they will have to disrupt their lifestyle and livelihood by commuting long distances and no longer having a sense of being valued by and for their community.

That sense of belonging will be nonexistent for new workers, thus drastically changing the climate of caregiving. Future health care workers are less likely to commit to an education that will require more time and money than their desired field of expertise will justify, considering the competitive bidding process and its inevitable lack of job security, low wages and undetermined term contracts.

Does the current provincial Liberal government have a template of the proposed performance standards agreement included in Bill 36? Are the citizens of Ontario to accept that our health care services are for sale to the lowest bidder? Can we afford to give such an all-encompassing piece of legislation our sleepy seal of approval? Considering that each individual LHIN may determine what services it deems financially feasible in any given geographic area, this inevitably will lead to a two-tier system. The for-profit clinics have made their intention clear—to take advantage of the opportunity to fulfill the demand for convenient one-stop health care services—while the proposed LHIN system will have patients traveling across the countryside to access health care services.

The current provincial government should take notice, as the former federal Liberal government has recently experienced, that Canadians are not prepared to accept a plutocratic system for our tax dollars. Will this proposed legislation just create another layer of bureaucracy, and at what cost to our health care system, which is already bleeding out from excess administration costs?

The proposed bill includes 14 government-appointed executive boards to consist of not more than nine members, including a director or chairperson. The office space has already been rented, and there is an allowance for an undetermined number of office staff, whose salaries have not yet been disclosed. Executive board members will have a term of three years initially. The board of directors and committee member selection process will be controlled by the minister, with the minister's discretion as to their renewal.

The potential for conflict of interest on these boards is undeniable, yet the bill allows that they will develop their own policies. The bill calls for all meetings of the board of directors of each health integration network and its committees to be open to the public, except if the

Lieutenant Governor in Council prescribes otherwise. What specific criteria will be used for this discretion?

While the objectives of this bill may be well intentioned, in its current state there are too many opportunities for system failure. The reorganization of health care in this province is in order, but Bill 36, as proposed, is not the catalyst for positive reform. Without proper inclusion of the unions representing health care workers to create a positive realignment of health care services for the people of Ontario, there can be no improvement to the health of Ontarians. The unions have a long, successful history of advocating not only on behalf of the caregivers, but for the vulnerable in our communities as well.

The Chair: Thank you very much for your presentation. There is about a minute for each group, and we'll start with Mr. Fonseca.

Mr. Fonseca: Thank you very much for your presentation. Just before you presented, we heard from a number of groups, two of them being St. Joseph's hospital and the Ontario Home Care Association, both local entities. One is a large hospital; the other is really care in the community and in the home. They addressed the LHIN legislation and, yes, they made some recommendations, but they said it is so needed to provide that continuum of care, especially at those transitioning points. Today that's not working very well in many instances in the province when someone is post-op or whatever it may be and getting care in the community.

Do you believe that we can better our system by the LHIN legislation, that we can bring our standards higher, so we can see what's happening in Ottawa or what's happening in North Bay or what's happening in Windsor and be able to take the best, like what's happening here in London, and transplant that around the province so we can raise our level of care and provide the best care for 12 million Ontarians?

Ms. Manzie: I would like to be optimistic about the intention of the LHINs, as drafted, but I don't see that patient care, bedside—the consumer of health care—is going to be served by this legislation. I understand that there is duplication of administrative services, but I also see, as I pointed out, that the private sector has spotted—and there are the clinics that are proposed for Ontario where it is one stop. People don't want to have to go to emerg and then come back to another ambulatory care half an hour away. It would be nice if every community could have the services available.

In the rural and smaller communities across the province—Sarnia isn't really rural, but it is considered one of the smaller areas—there is a really hard time enticing general practitioners, family doctors, to those areas. If there is not the support in those communities for those family doctors to give to their patients, we will not have family doctors and everybody will be travelling.

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The Chair: Mr. Arnott.

Mr. Arnott: Thank you very much for your presentation. Would you ideally want this committee to recommend that Bill 36 be withdrawn?

Ms. Manzie: Ideally? As it is presently? Yes, absolutely.

The Chair: Thank you. Madam Martel.

Ms. Martel: Thank you very much for the presentation. I wanted to focus on the assurance that people will be able to access health care services outside their LHIN. We had a presentation this morning from a group from Petrolia, who, at the end of their presentation, quite clearly told this committee that—and I don't know the circumstances; I'm assuming someone's going to find out about this—they could not get health care service in London, even though the minister had said that you could go outside your LHIN boundary to get service. I remain very concerned that while the minister may say this, at a certain point in time, if funding isn't shuffled around so that you get service outside of your LHIN boundary and that service is paid for, sooner or later you will only be able to access service in your LHIN area. Given some of the geography here, and the fact that the referral patterns don't make sense in so many of these LHINs, that's going to mean an incredible hardship on many people who may have to travel very long distances in order to get care, or be getting care from specialists that they previously could see before the LHINs and now cannot because they're outside of that LHIN boundary.

Ms. Manzie: Yes, absolutely. I happen to be a paramedic, and with the downloading of the ambulance five years ago, it was supposed to be seamless and boundaryless and all of the rest of it, as far as municipalities go. The municipalities do bill each other when there is overlap, and I can see that the tax base for the LHINs will be done the same way. But at the same time, we don't have any assurance within the LHIN legislation to state that there will be the temporary cost-share, if you will. I'm not familiar with how exactly it would be administered as far as billing the other LHIN and whether or not they would have access to the ministry to get extra funding for those services.

I'd like to point out as well that an hour from Lambton county is one of the best services for health care in the world. When we look at different types of illnesses, as far as head and chest and different illnesses and injuries and neonates, they cannot travel by helicopter, they cannot travel by air. Going to Windsor, there is no straight road from Petrolia, Sarnia, anywhere. It's very rural, and it's dangerous with the trucks. We've all heard about all the accidents on the 401. Putting an ambulance, by land, on that road any more than we have to, because of just the shuffling for fiscal reasons, is insane.

The Chair: Thank you.

Ms. Campbell wanted to speak to us too. Why don't you give us your presentation, please.

Ms. Jade Campbell: Good afternoon, Mr. Chair, committee members and honoured guests. My name is Jade Campbell, and I am a health care provider and health care user. I live in Cambridge, Ontario, where I was born, raised and work. My parents were immigrants from China and built a family business in Cambridge.

As part of the sandwich generation, I've witnessed the evolution of health care first-hand. My parents and

godparents had to shoulder the cost of their health care in the 1950s. I remember my godfather as a single income earner paying his bills to the hospital every month. He did his doctor's landscaping on weekends to pay down his bill. My grandfather contracted tuberculosis and succumbed to the disease after a lengthy stay at a sanatorium. The bills for his care were borne by my family. My mother and father were the sandwich generation before there was a term for it.

I speak today to support a strong and accessible health care system that was a godsend for my parents and grandparents and to ensure that it remain a viable service for myself, children and their future generations.

I live in a small community, Cambridge, which has a growing population of 120,000 people. Presently, Cambridge Memorial Hospital provides its citizens with services that are essential in raising a family and taking care of its elderly.

The LHINs legislation has the ability to change the landscape of my community health care. I know that in my community there is mistrust of this government's ability to listen to our health care needs. In the fall, there was a great hue and cry from the Cambridge citizenry when our capital project was denied. Kitchener and Waterloo received approvals for their capital projects. From the Hansard of November 24, 2005, MPP Elizabeth Witmer responded to the Honourable George Smitherman: "For example, let's take Cambridge hospital. Maybe the reason the money is not flowing to Cambridge is because there is a secret plan in the minister's office to do away with Cambridge hospital and shift the services to one of the other Kitchener or Hamilton offices."

Despite petitions and pressure from our community groups, the government placed our project on hold. But just before Christmas, the Cambridge capital project was approved. Cambridge people were elated and duly noted that it was impeccably timed with a hotly contested federal election in our riding. What is the saying? "You can fool some of the people some of the time."

The proposed LHINs are not local. They are not based on communities and they do not represent the communities' interests. It will be very difficult for the people living within a LHIN to have a significant voice over the direction of that LHIN.

The autonomy of the LHINs from the government will be negligible. The provincial government appoints the LHIN boards, and LHINs will be required to sign memorandums of settlement and performance agreements with the government. So LHIN boards will be responsible to the provincial government rather than the local communities. It's a Senate-type thing, with some accountability. Without a code of ethics and conflict-of-interest blueprint, the potential for a train wreck remains to be seen.

This is in contrast with a long history of health care and social service organizations in Ontario, which as a rule are not appointed by the provincial government. For example, the provincial government does not appoint hospital boards, and they have effectively and doggedly fought for better funding for their communities with great success.

The LHIN structure puts up significant barriers to local community control of health care. Conflicts between communities within a single LHIN are likely. Small communities are particularly threatened. Too often rural communities have seen reductions in service shift with the centralization of services to the larger regional centres. Likely, the provincial government will respond to complaints by stating, "It wasn't our decision; it was a decision of the LHIN." Yet the LHIN will largely be unaccountable to local communities.

A key goal of this reform is to reduce costs by integrating services. But this also raises questions about cutting services. At first, the government talked only of integrating support services. But cutting back support services is (1) dangerous—a prime example is the SARS infection crisis and threats of pandemics; and (2) inefficient—as an example, the recent elimination of PSWs at Cambridge Memorial resulted in their patient assists being downloaded to our RNs and RPNs.

Major steps are now being taken to integrate support services on a regional level. New organizations are being established to take over and centralize support services formerly provided by hospitals, homes and other non-profits, with many of the services then contracted out to for-profit corporations. This is a major change in the structure of health care and social services that may have far-ranging consequences for workers and local communities.

The hospitals have balked at an exclusive focus on support services. Simply integrating support services cannot satisfy the cost savings demanded by the government; the savings would also require clinical cuts. I know that in my hospital there has been consideration for eliminating our pediatric and obstetric programs, its cancer clinic and laboratory services.

Certain populations in my community are going to be vulnerable and easily marginalized by decreasing the accessibility of services. These communities include: gays/lesbians, racial minorities, isolated seniors, the homeless, underemployed and underhoused, people with cultural or linguistic barriers, single parents, and those who are in a lower socio-economic group.

In Ontario, where distances are particularly large, this could add a lot of travel. But even where distances are measured in several miles rather than hundreds, specialization creates special problems for patients. Instead of being able to deal with all of their problems at one centre, their health care services are spread out over many health care providers, creating a real problem for those with multiple health issues, and especially for the elderly and the poor.

1640

The large, socially diverse areas covered by the LHINs also suggest that there will be significant conflict over resource allocation within the LHINs. With cost-cutting a key goal for the provincial government, the question will arise: What services will be provided in each area of the LHINs?

It is ironic that individuals in middle and upper socio-economic groups design programs that are intended to provide assistance to the lower socio-economic groups with little or no input from their target population. It is common knowledge that those individuals from lower socio-economic groups have a lower health status and a higher morbidity and mortality rate from most diseases.

We need (1) strong representation of all stakeholders from communities on the boards and committees to give voice to all citizens; (2) equitable access to services for smaller communities; (3) ensure that funding does not shift away from smaller communities; (4) transparency in board appointments so that the positions are based on skills and ability and not on a partisan political designation; and (5) focus on community needs as opposed to cutting services.

We need to address (1) inadequate acute care programs; (2) easy access to services for patients who have ongoing chronic care illnesses which reduce their ability to live in their own communities; and (3) providing the proper funding to promote health and prevent illness.

In conclusion, the Canadian health care system is founded on principles of universality and accessibility. The state of our health care is significantly compromised if services in our community are integrated or cut. I would like to refer the committee to the five principles of the Canada Health Act, which is committed to ensuring that all levels of government uphold (1) comprehensive coverage of all medically required services; (2) universal coverage for all Canadians regardless of income; (3) accessibility to all residents uninhibited by user fees; (4) portability of coverage from province to province; and (5) public administration of health care on a non-profit basis.

I thank you kindly for providing me with the opportunity to make this presentation.

The Chair: Thank you very much. There's no more time for any questions. We thank you for both presentations.

STUART JACKSON

The Chair: We have the next person waiting on the telephone, I believe. The next will be a conference call. Can we start the process, please? Hello?

Mr. Stuart Jackson: Hello.

The Chair: This is Chairman Mario Racco and we are prepared to listen to your presentation, please. You have 15 minutes total. If you don't use the full amount, we'll be happy to ask questions and/or make some comments. Please proceed.

Mr. Stuart Jackson: Okay. I read the bill over the Internet. What I found is that (a) people who are on welfare, social assistance and other benefits from government will fall through the cracks if the bill goes through. The bill should not go through as a result of what I can see there; (b) I could visit rural areas in the summer—I know a town, Restoule, Ontario. There's not one public hospital anywhere in that area. The nearest hospital is in North Bay. I found that one out from a hunting trip. A hospital should be built in that area of Ontario; definitely, yes.

But when I look at other things within the whole bill, the answer to this question is, yes, we do need to modernize and bring our health care up to standard and up to par because the system has degraded somewhat since Harris took power. When Harris took power, it had degraded. Now, Harris is no longer in power. We need to come back up again, yes, but to come up at the cost of the federal and provincial governments, not at an actual cost to the rich people. I say, rich people can afford to pay to go to a hospital or to health care, and the poor, the needy people who are going to fall between the cracks, they're the ones who are entitled to the same benefits as the wealthy rich people are entitled to.

That sort of, to my sense, concludes the presentation, to keep it short and to move on to the next person.

The Chair: Thank you, Mr. Jackson. If you can wait there for a moment. Madame Martel, would you like to start, please? We have maybe a few minutes each, plus.

Ms. Martel: Thank you, Mr. Jackson, for joining us. In the first part of your presentation you said you had taken a look at the bill on the Internet and that you were concerned that people on social assistance were going to fall through the cracks. I think that's what you said. I'm not trying to put words in your mouth. Can you just expand on that thought for me, please?

Mr. Stuart Jackson: I can see in that bill where somebody goes to hospital, they present the OHIP card, and the hospital says, "I'm sorry, we can't accept that till we get verification." They will leave that person out on a stretcher, and that person's critical. The person who had the money gets treated quicker. On the OHIP card itself it should have ODSP so when it goes through the system, then the person gets in right away and is not stuck in a hallway to die.

Ms. Martel: Your reference is to ODSP, that there should be something on the health card that identifies someone who is on ODSP. Is that what you're saying?

Mr. Stuart Jackson: Yes, and also something on the health card that identifies somebody as being on welfare, like something identifying a person on welfare or a person who's on Indian Affairs benefits and other benefits.

Ms. Martel: In that way, you feel that it would make it really clear to people at the hospital that this is an individual who is entitled to receive health care services at that hospital in Ontario?

Mr. Stuart Jackson: That is correct.

Ms. Martel: Okay. Thank you.

The Chair: Ms. Wynne, please.

Ms. Wynne: Thanks, Mr. Jackson, for taking the time to talk to us. I just wanted to talk to you a minute about the issue of having to travel long distances. This has come up a number of times today, and I just want to clarify what we're trying to do.

By having these local health integration networks, we're trying to make it so that the procedures and the services that people need close to home and that happen

frequently are available to people. For the once-in-a-lifetime things, where you need a hip replacement or a knee replacement, there may be some travel involved. Because what we know is that if you go to a place where those things are done a lot, you're going to get better service. But for the things that you need on a regular basis, that's the kind of thing we're trying to keep close to home. That's why we're putting more money into home care and more money into procedures like dialysis that people need on a regular basis. We're trying to arrange it so that people don't have to travel for those things and also provide the best service.

Do you want to comment on that?

Mr. Stuart Jackson: Yes, I do want to comment. What I'm concerned about is—in Hamilton we've got some of the finest hospitals around, from McMaster Hospital down to Hamilton General Hospital and St. Joe's, but they do that service on a regular basis, on a day-to-day basis. But if you travel in areas like far northern Ontario—I visited the town of Restoule, Ontario, and there was not a hospital for miles in that area. So that is an area to build and construct a hospital, because in the summertime the town itself had employment from tourism, but in the wintertime they had nothing to keep the town going. So by building a hospital, not only would it generate construction jobs, but it would also generate employment because people have to be employed to work in hospitals. That means development in the town and business is brought into the town that basically doesn't do much in the wintertime.

The Chair: Thank you, Mr. Jackson. That terminates this presentation.

We will be able to move to the next presentation from the Ontario Health Coalition, the Canadian Association of Retired Persons, CARP, London chapter. Is anyone here for that deputation?

If they're not here, I'll see if someone from the Sarnia Health Coalition is here. Is there anyone from the Sarnia Health Coalition?

The next one would be the Ontario Medical Association, London chapter. Is anyone here from that?

Those are the last three deputations that we have on the agenda. We'll wait a few minutes because we are ahead at this time. What we can do is take a five-minute break, and we'll come back when there are people here.

The committee recessed from 1650 to 1705.

SARNIA HEALTH COALITION

The Chair: I believe Arlene Patterson of the Sarnia Health Coalition is present. If she is, would she please come forward? We have 15 minutes for your presentation and potential questions and comments. You can start any time you're ready, please. Thank you for coming.

Ms. Arlene Patterson: I've submitted my presentation in writing to you already. At this late time of the day, I'm sure that you have heard, so far, many points with regard to this proposed legislation. I certainly don't want to read verbatim the written submission. However, I would like to point out that we are the Sarnia Health Coalition and we are a part of the Ontario Health Coalition, which—

The Chair: As you said, we have your presentation, so anything that you may want to stress, the membership may wish to ask you a question on.

Interjection.

The Chair: We just received it. Am I right? Yes. So we haven't necessarily read it yet. Is there anything specific you want to underline that you put in writing for us?

Ms. Patterson: Well, I haven't been here all day, so I'm not really sure what other panels or other people have presented. Certainly we are 50 strong local health coalitions across the province and we're associated with the Ontario Health Coalition, who have over 400 affiliate organizations across the province. So we speak with some credibility in that we are not a small group, by any means.

I'd like to do two things in the 15 minutes: one, highlight some of the points that we're concerned about with regard to this legislation, but also talk about my personal experience as a patient within the system. I've been in the system as a patient for 14 years now and I've certainly seen many changing elements of our health care system. Some of them are of grave concern to me, as well as to other people I know who have also been in the system.

I'll start out by saying that this legislation, at its very core, is basically another health restructuring act. We've seen the restructuring that was done by the Conservatives. Most of that hit between 1995 and 1997. During its tenure, the Conservatives' Ontario Hospital Services Restructuring Commission issued final directions to 22 communities, affecting 110 hospitals. These directions amalgamated 45 hospitals into 13, and closed 29 hospital sites. The worst years were from 1995 to 1997 and immediately after, when the Conservative government withdrew approximately $900 million without warning from hospitals, cutting 9,000 critical, acute and chronic care hospital beds and laying off approximately 26,000 health professionals.

We find, quite similarly, that this legislation, if brought into being, certainly has some sweeping new powers to it, as did Bill 8 with the Ministry of Health.

Is the mike cutting in and out, because it certainly seems like I am.

The Chair: No, that's fine.

Interjection.

The Chair: We can hear properly.

Ms. Patterson: We see that this bill gives the Minister of Health central control, and also gives him major new powers in order to restructure and contract out. The main new powers include:

—the ability to order transfers of services, personnel, property and funding, with limited appeals and compensation;

—the ability to order the closure, merging and transfer of all operations of any non-profit, but not for-profit, service providers.

—We also find it disconcerting that a new structure for the health system ruled by the health minister's strategic plan is set unilaterally and enforced ultimately by court order.

—the ability to override protections and provisions in legislation covering civil servants, corporations, expropriation and the Statutes Act among others.

1710

This bill affects 10 other pieces of legislation, and one of our concerns is that this has not been reviewed very effectively in terms of the impact on that other legislation.

This bill empowers the ministry, directly and through the LHINs, to execute a new restructuring of the health care system. The legislation confers powers that expressly override previous legislation that set out processes for the disbursement of charitable or non-profit property, the guidelines for the civil service, compensation for expropriation of property, or processes for the enactment of statutes.

Centralization and the lack of democracy: The only thing I'd like to speak to there, other than what has been mentioned, is that there are no normal democratic protections against in camera or secret meetings. The public is shut out, basically. Yes, there is a provision here for notifying the public for meetings, but the wording is so vague, which makes us wonder whether they're actually encouraging the public to become involved or not. Why does this government envision a system in which democratic rights regarding the health system are less that those in any other sector?

Although this legislation does not directly state that they don't encourage privatization, just the mere fact that that statement is alluded to in this legislation would bring us to have some concerns in several ways. I will just list them as they are written:

(1) The LHINs may move funding and services from non-profits to for-profit services corporations.

(2) Cabinet may order the wholesale privatization or contracting out of all support services in hospitals.

(3) There is no definition in any Ontario legislation of what constitutes "non-clinical" services. Under this legislation, cabinet is given the power to define these services as broadly or as narrowly as they wish.

(4) The minister may close or amalgamate non-profits, but not for-profits. It is not difficult to foresee a shrinking set of non-profit providers while the for-profits continue and gain new market opportunities as the system is restructured.

The competitive bidding model, which we've seen in CCACs across this province over the past 13 or 14 years, has pitted non-profit and for-profit organizations and companies against each other. It has created a very unstable market. The costs here are huge in the duplication of administration costs.

But I would like to focus on the costs to the patient. That's where I leave my written submission. I would just like to say that there are those of us who are "sick," and then there are those of us who are sick. I speak in the latter category. I depend on this health care system, and I have for the past 14 years. Most of my treatment is conducted within the hospital. I know that while that's still possible, I'm covered under the Canada Health Act insofar as I'm not going to be expected to pay out of pocket for the treatment I receive. When this LHINs legislation is passed—and I hope it isn't, in the way it is written—what would it take for that whole question of outpatient services being put in the community and taking away our safeguard, and then being charged out of pocket for services that we have received in the past? That's a real concern, not only for myself but for many other people who, for example, receive IV therapy within the hospital. I have seen patients be approached by head nurses, unit coordinators, saying, "Your IV therapy has been discontinued. It has been delisted from the Ministry of Health. Therefore, either you pay for this drug or hope your insurance will cover the costs of the drug." What this does to patients is unbelievable, because we're not prepared for that. We didn't plan our retirements around making a specific budget line for medical treatment. We haven't had 30 years to work towards our retirement fund that would include those medical expenses.

Certainly we've seen the recent movement of the Copeman company, which wants to create private clinics with sort of social club fees for memberships. This is a very elitist move, and it's people like me, who are in need of treatment—I wouldn't be here if it weren't for my treatment. So what do we say to the people in the hospital already? We know that if this LHINs legislation is passed as it's written, the powers the Minister of Health has can, with the brush of a pen, eliminate, amalgamate or transfer any service within a hospital to the community. What that says to me is that the protection I have had while I've been in hospital—well, you shake your head. I've known people who would ask their physicians to be admitted into hospital so their drugs would be covered. As soon as you are categorized as an outpatient, there are certain costs associated with that. If you or a family member hasn't been in that situation—these things are done very insidiously, and they're done on a one-to-one; it's not a public piece of information that is out there.

The Chair: Thank you, madam, for your presentation. We've used the 15 minutes on the presentation. We also have in writing what you wanted to tell us. We thank you for coming and speaking to us on this very important topic.

Ms. Patterson: You're welcome.

STANLEY KORCHUK

The Chair: Could the Ontario Health Coalition and the Canadian Association of Retired Persons please come forward? Sir, you're next. You can start any time. There is 15 minutes total time that you can use to speak to us or for us to ask you some questions.

Mr. Stanley Korchuk: I'll probably take up all the time.

I'm a little presumptuous, perhaps, in saying that I represent these organizations, because I think I tend to be a bit off the wall on some of these things. However, I will report back on the results of this and I will present my paper. I haven't had time to present my paper to these organizations. I wanted to be a little more careful about what I say here as far as whom I represent.

Anyway, thank you for allowing me to appear before you. I'm 76 years old, and I guess the health care system becomes more important the older you get. What I learn, I intend to transmit, as I said. I hope too that what you will hear from me will be worthy of your attention and consideration.

The Chair: It is.

Mr. Korchuk: Thank you. Anyway, I've read through Bill 36, and there are a few ideas in there. I'd just like to summarize what I perceive about this, and I'll be very brief.

1720

It certainly exceeds the health restructuring commission of 1996, which I remember we had to cope with when I was on the hospital board up in Bracebridge. It's much more comprehensive. It covers hospitals, psychiatric facilities—a lot more things than the other one did—but it seems to exclude some other things. I kind of like the idea of integration, but not everything seems to be integrated.

New powers will be vested in these LHINS, as I see it, and the minister will be given profound power. I happen to have worked with the government, the same business you—not in health, but in education—so I know a little bit of its internal workings. I have a great respect—I didn't until I went to work, believe it or not. I developed a lot of respect for our government, but not until I got inside and got to work with ministers.

That LHIN service accountability agreements with health providers must comply with the minister's strategic plan, and compliance will be backed by court orders sounds a little authoritarian. Services may be contracted out, merged, transferred, etc—this is all old stuff for you; you've heard it 100 times. Property also can be transferred. Any current local control will be overridden. I liked the autonomy I used to have up in Bracebridge. I was in charge of the recruitment of physicians, and we took great pride in our hospital. I wonder if some of that is going to be subtracted. Of course, that's not all.

First, I wish to compliment the Minister of Health and Long-Term Care, his ministry and the government for conceiving and initiating legislation to create an integrated approach to the delivery of health care. It is a concept I identified and favoured when I served as a trustee on the board of the South Muskoka Memorial Hospital. But I also found, and I'm sure you will too, that it was not a very popular concept in the medical community. I had some awful battles: nurse practitioners versus doctors and stuff like that. All change is hard on the people targeted by change, especially when clumsily managed.

If this is not justified, please send one of these back to me and say, "You're wrong, Stan," or the paper is wrong, because there was a report on January 9 that 300 jobs were lost to health office closings and the workers were terminated by video. As a supervisory officer in education for many years, if I did that, I'd be fired. It's a very personal and very painful thing to go through for the recipient of the bad news.

The intent, according to the article, which quotes David Jensen, who I guess is a deputy minister of health, is to restructure health care in order to improve the system by closing 14 of the 42 community access centres. I think that was insensitive. One can expect only a big corporation to treat its employees in such a depersonalized way. I just want to throw that in, because I think a lot of other people felt that way in this city.

I do believe in an integrated, multidisciplinary organizational structure for the delivery of health care, but not one that is incomplete. I don't know whether you can overcome that. I know how tough that would be, and I can probably surmise why you didn't do it. Why were all the others left out?

I have a graduate degree in educational planning. I learned that there are principles of good planning that apply to all organizations. For example, included should be a clear expression of the goals and objectives and a precise identification of the advantages of the new over the old way of delivering health care. I know that behind the scenes this was all deliberated.

Nevertheless, the LHIN is a fascinating concept for me from a planner's point of view—I'm putting that hat on right now. It reminds me of the principle of subsidiarity. Do you remember? That was used in Europe when they developed and formed the EU. The principle of subsidiarity asserts that decisions—listen to this carefully—should always be taken at the lowest possible level, that the effectiveness of both the government ministry and an institution for which it is responsible is diminished by undue centralization, that consolidation can be a weapon of tyranny and that adherence to the principle of subsidiarity protects democracy.

I think Bill 36 touches on that violation of subsidiarity. But then the centralizing impulse is afflicting all modern democracies, everywhere you go, all over the world. There are exceptions starting up in some parts of the world, but I won't go into those; this is not the place to say that. I think the LHINs are a perfect example of that centralizing trend.

I would recommend to you a review of all levels of decisions and responsibility. Then I urge that all decisions and responsibilities be reassigned to levels in the government and in local and regional agencies consistent with the principle of subsidiarity. I know I won't get that, but I'm just throwing that idea out.

Public input, of course, is important. I said something earlier about objectives, that there weren't—there are objectives in here. As a planner, I can read through this and I know, when you write this, that there are objectives embedded that are quite clear. I'm not going to list them, because you know them all. One objective is to revamp the delivery of care, but the LHIN will not provide it; it

would just revamp it, as I understand it. Competitive bidding is important. For-profit health care corporations will be sort of integrated into that system—a potential dilution of the principles of the Canada Health Act, perhaps. At least it's not mentioned very much. Again, correct me if I'm wrong—not now, but maybe if I get one of these back. If you really disagree with me, I'd like to hear it, because I think my associations would like to hear about it, so bear with me a little longer.

The consolidation of hospitals into specialties troubles me a little bit. It's obvious to you, so I won't go into it. That those servers who bid less or more efficiently will be rewarded by more grants troubles me a little bit.

Public access to LHINS: The whole operation seems to be constricted, or at least constrained. Each LHIN will be accountable to the government and not to the public. It's really a top-down type of thing. I hate to say this, but maybe it's necessary at times.

These performance indicators really bug me. I came across them as a trustee. I'll tell you why they bug me. I've studied them all over the world, especially in England lately. They've got them in England, where quality is becoming hostage to the emerging private health care market and cost overruns. When you set up performance indicators, they become powerful tools for government control, but once you focus on a measure—and I have a physics background—the uncertainty principle moves in. I don't know if any of you have studied this, but the uncertainty principle is just a measure that doesn't mean anything. It's hard to swallow.

I just wanted to share that with you. I'm going to finish up. If you could do something for me: Make a few notes on this thing and tell me where I'm full of BS and where I'm not, and I'll pass the information on to the RTO and CARP members. Thank you very much.

The Chair: Thank you for your presentation. You're right on the 15 minutes, and I'm sure any of us may wish to take you up on that request. You may hear from someone.

Mr. Korchuk: I really would appreciate that, because it shouldn't stop with me.

The Chair: Thank you again for your presentation.

The last presentation for the evening is from the Ontario Medical Association, London chapter. Are they present? Those of you from London in particular, do you recognize anybody? No.

Having said that, they are scheduled for 5:45, and it's 5:30. To be fair, we should hang around another 15 minutes. Maybe we can have a walk. If they do attend, we'll start over again. Otherwise, we'll leave.

The committee recessed from 1730 to 1735.

ONTARIO MEDICAL ASSOCIATION, LONDON CHAPTER

The Chair: Can we resume again? It's the last presentation, and I understand that Dr. David Paterson is present. Dr. Paterson, if you can take a seat at the front, you'll have about 15 minutes to make your presentation. In any time left, we may be able to ask a question or make some comments. Start any time you're ready.

Dr. David Paterson: I can start now?

The Chair: Yes.

Dr. Paterson: Mr. Chairman and committee members, good afternoon. My name is David J. Paterson. I'm the past president of the Essex County Medical Society, and I've worked as a family doctor and an emergency doctor in Windsor, Ontario, for the last 30 years.

One of the reasons that I'm here is because I'm a front-line physician, but also I was a member of the Essex County District Health Council for about seven years and was directly involved with the restructuring process of health care in the Windsor area. This was the predecessor to the LHINs, and I want to make sure that you don't make the same mistake that some of the district health councils made.

Thank you for allowing me the opportunity to speak to you today about Bill 36. I warn you that I may stray from my notes because I just drove here from Windsor and I did some thinking along the 401, and you'll see me wander around my page with the thoughts that I had. My presentation will be brief; I suspect it has been a long day for everyone on this committee. I'll answer questions at the end if you so wish.

There are many positive aspects—am I coming and going on this?

The Chair: If you could move just a little farther from the microphone.

Dr. Paterson: I'm sorry. Is this better?

The Chair: Yes.

Dr. Paterson: All right. There are many positive aspects of this legislation, but there are also areas where improvements can be made. These improvements—actually, I just want to talk about one improvement, which I will speak about to you today, that will result in better and more efficient health care for all people in Ontario.

We're all aware that doctor shortages and wait times are chronic problems in the Ontario health care system, especially in family practice. Any government initiatives that may ease these problems and improve health care are most welcome.

Ontario is the last province or territory to regionalize. Local health integration networks will be an interesting challenge. Different areas of Ontario have vastly different needs and concerns when it comes to health care, so the LHIN concept may work very well.

The doctors of Ontario want to help our patients receive the best health care they can get. Doctors are intimately involved with every aspect of health care, from birth to death. We are the gatekeepers of the system. We have direct involvement not only with the patients, but with hospitals, nurses, home care, palliative care, all types of therapies—physical, mental, pharmaceutical—and every allied health professional, as well as local, provincial and federal politicians and the media.

Recently, the Ministry of Health and the Ontario Medical Association reached an agreement about physician remuneration. The majority of doctors applaud this

agreement. It would seem opportune to continue this spirit—this is where I go around my page—of support and co-operation. With the current shortage of physicians—this is expected to get worse through retirement and loss of physicians to other provinces and to the US—it would seem a very bad idea to end this period of public spirit and co-operation.

It is my understanding that doctors have no formal role in the LHIN process. We have an indirect opportunity to provide input to the LHINs via a health providers committee, one that I understand is comprised of all types of health care providers. This is insufficient and, in my opinion, quite dangerous because physicians are so intimately involved with all aspects of health care. Without direct input from local physician groups, LHINs seem doomed to failure. The result will be a profound waste of money and no improvement in care. A good analogy, to me: Starting a LHIN without direct physician input would be like amputating one of your legs before starting a marathon. It's that strong of an analogy and it's really true.

There is a role for all health care providers in this process. It's not up to me to decide where the other professionals will find their place. I can only speak to the role of the physicians and how crucial their input will be in the success of local health integration networks.

Recently in Windsor, we had a meeting of what they call OMA, district 1, which is physician representatives from Essex, Kent and Lambton counties, and our guest speakers were the CEO and the president of the LHIN representing our area. They spoke about their concept of LHINs and met with all the physicians and answered questions. They seemed very supportive of direct MD input and felt it would help both ways—LHINs to physicians and physicians back to LHINs.

If you get too far down the road without doing it right the first time, it will be very difficult to restructure and maintain the confidence of an already skeptical public who only want better care. And an election is not very far away. It is my suggestion, and a suggestion from the OMA's board of directors, that each LHIN have a standing committee of local physicians, both urban and rural physicians, that can provide the necessary input to allow LHINs to effect constructive, progressive and positive change. Without this input, it is impossible for LHINs to do their job effectively.

It was my experience on numerous occasions with the district heath council in Windsor that physician input was absolutely critical. Without this type of information, major errors would have been made that not only would have been costly but detrimental to the health restructuring process. I can give you examples of those. I'm trying to make clear that the health care problems unique to Windsor, Essex, Kent and Lambton counties are well known to the physicians who practise there on the front lines every day. This type of input is absolutely critical for the LHINs to work effectively.

Please change the LHIN structure to have a physician subcommittee that reports directory to the LHIN executive and make this a mandatory requirement. Without this change, the LHINs cannot function to their full potential. Doctors want this system to work. Many people think that doctors are trying to take control. This is absolutely untrue. We want to ensure that our patients have the best possible care. We want to see the waiting lists shrink and the pool of physicians grow. We want to be able to work more closely with other health care professionals for the betterment of our patients' lifestyles and well-being. We want to help you make Ontario the best place to give and receive care, and I think this is possible. Thank you for hearing me today.

The Chair: Thank you. We have about a minute plus for each. Can I start with Mr. Jackson, please?

Interjection.

The Chair: I'm sorry, I just looked at the name tag, not even the face. Mr. Jackson was here; he left. Mr. Arnott.

Mr. Arnott: It's the first time I've been confused with Cam.

Interjection.

The Chair: I like him; I think he's a nice guy.

Mr. Arnott: Thank you for your presentation. It was excellent. You indicated that the district health council that you were involved with had made a number of errors without the input of physicians, or would have made serious errors without the input of physicians. Can you give us a couple of concrete examples that come to mind?

Dr. Paterson: The restructuring involved going from four hospitals down to two hospitals. We were trying to rationalize where orthopaedics would go, where pediatrics would go etc. It's a very long process.

In combining the two hospitals and determining where the beds were going to go, the people on the district health council, without a physician, were unaware of the requirements of operating room time, of the way it worked in a hospital, and what would attract physicians to an area, what would keep them. From a surgical point of view, it's really OR time, and this is extremely difficult to obtain in the current system. The district health council was proceeding without this knowledge and making all kinds of grandiose plans that were not realistic. In that particular instance, I just simply pointed out that we cannot attract without having the necessary OR time.

We talked about changing pediatrics from one hospital to another. The problem with that was that neurosurgery was remaining at the hospital; pediatrics was leaving and going to a hospital that no neurosurgical backup. This is medical information input that they required before they finally made their last submission.

Mr. Arnott: When you pointed out those practical problems, you were able to—

Dr. Paterson: It wasn't from a selfish point of view. It was really to show what was happening.

Another example would be, there are fewer and fewer family physicians. From what I understand the LHINs do, care of people out in the community requires a CCAC etc., and this involves the care of a physician. If they

don't understand why family physicians are getting more and more scarce and work with the government of Ontario and the OMA to change that, no matter how many CCACs, social workers or whatever type of support work they want, it's not going to work. We're not trying to drive it. We're just trying to give them information so they can better arrive at a conclusion.

The Chair: Ms. Martel, please.

Ms. Martel: Thank you for driving up from Windsor today. I wanted to get back to your role at the district health council and then what you're proposing for the LHIN. Correct me if I'm wrong. You sat as a member on the district health council among a number of other consumers and health care professionals. Is that correct?

Dr. Paterson: Yes, I did.

Ms. Martel: So you weren't part of a specific physician subcommittee reporting to the district health council on proposals, ideas, changes etc.?

Dr. Paterson: No. I was on the executive.

Ms. Martel: You've already said to us that as a result of your role as a physician with, I would argue, a broadly based group of people, you were able to make changes, and important changes. Correct?

Dr. Paterson: I was able to give information so they would arrive at better—

Ms. Martel: Why wouldn't the same type of thing work on a LHIN? You were a physician sitting as a member of the district health council with other, I'm assuming, consumer members and members of other health care professions, and you were able to give your input that resulted in important changes. Why wouldn't the same thing work on a LHIN? If there were physicians sitting on LHINs with other health care providers, why wouldn't the LHIN recognize your input in the same way and make important changes?

Dr. Paterson: I was just handed a note, but I can't read it.

To be honest with you, I don't know. It seems like it's a point that doctors are not included on the LHINs, and I don't know why.

The Chair: Thanks very much. Ms. Wynne?

Ms. Wynne: Thank you very much for presenting to us. I wanted to ask you about the health professionals advisory committee. You're making a proposal that there be a separate committee of physicians, and we're suggesting that there be a combined committee. The question is, how workable do you think it would be—and I know you've said you can't speak for other health professionals—to have a separate advisory committee for every single health professional? Wouldn't it make more sense to bring the health professionals together and have them work out what the common advice should be? I'm a doctor's daughter, so I know the primacy of doctors, but I think what we're trying to say is that all those health professionals have a role to play.

Dr. Paterson: I have no doubt that they have a role to play, but physicians have the biggest role to play. If the role of allied health professionals was looked at as a pie, a big chunk of the pie is physicians. Because we're so intimately involved with this on so many levels and we represent the patients directly, that's why I think you need direct physician input.

I really can't speak for other health professionals. Nurses would be a big role as well. But other health professionals would be way down the line—and this is my personal opinion, not from the Ontario Medical Association. But if you do not have direct input from the physician group—I understand that LHIN 1 goes from Windsor right up north to Owen Sound or something; I don't know. But that's a huge, diverse area. If you did consider physician input, I would think that the doctors would have to get very busy in making sure they had input. I have no idea what the medical needs are in Owen Sound, and they don't know what we need in Windsor or Leamington. It would be up to us to provide a committee that would give you direct input.

Ms. Wynne: I'm being cut off. I just wonder why doctors couldn't provide leadership on those committees and work with the other health professions, but we'll probably have to discuss that more.

The Chair: If you could quickly, if you have a quick answer.

Dr. Paterson: I'm sorry?

The Chair: If you have an answer, that will be fine.

Ms. Wynne: About providing leadership on those committees, not having a stand-alone committee.

Dr. Paterson: I think the role of the physician is so unique. It's not a blend of working with a dentist or a physiotherapist or a social worker. The medical community is unique and extremely important.

Ms. Wynne: Thank you.

The Chair: Thank you again for coming all the way from Windsor.

Thank you to all of you for participating here in London. We appreciate your comments. We are going to Ottawa tonight so tomorrow we can get some more input in that area and do a better job. Thank you again.

The committee adjourned at 1752.

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