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Lundi 6 février 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

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 6 February 2006

Lundi 6 février 2006

The committee met at 0901 in committee room 151.

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.

The Chair (Mr. Mario G. Racco): Good morning. Today we will start right at 9. I welcome all of you to our fifth day of presentations. Today, tomorrow and Wednesday will be the last three days of presentations here in Toronto before we end this set of discussions with the community.

CITY OF TORONTO

The Chair: The first presentation this morning is from Toronto city council.

Mr. Joe Mihevc: Good morning.

The Chair: Good morning, Joe. How are you?

Mr. Mihevc: Good. How are you?

The Chair: Very well, thanks. Please have a seat. You have 15 minutes, as you know, and if there is any time, there might be an opportunity for questions and/or comments for you. Please start any time you're ready.

Mr. Mihevc: Thank you very much. We have a written submission as well.

The Chair: Yes, we all have it.

Mr. Mihevc: Great, thank you.

The city of Toronto is very pleased to take this opportunity to comment on and provide suggestions on improving Bill 36. My comments take place within the context of Toronto's knowledge of our city's diverse communities, our respective governments' responsibilities for the well-being of our residents and our developing culture of partnership—a culture of partnership between the province and the municipality based on mutual respect and co-operation, as embodied in the recently introduced Bill 53, the Stronger City of Toronto for a Stronger Ontario Act.

This government-to-government context provides the province of Ontario and the city of Toronto with an opportunity for achieving a common direction for the reconfiguration of local health services, a direction which is currently missing in the Local Health System Integration Act. As I said, the full document outlines Toronto's interest in a strong integrated health care system.

In my presentation, I will outline a number of recommendations from the city for making local health services integration work. Our most important recommendation is that the province recognize that the best possible solution for the city of Toronto is one local health integration network, or LHIN, whose boundaries correspond with those of the city of Toronto. If this model is not possible, and because right now Toronto is divided into five different LHINs, Toronto proposes that the legislation include a mandatory five-LHIN-city of Toronto collaborative table composed of equal representation from all five LHINs and Toronto to engage in joint decision-making about those services currently included in the LHIN legislation that are operated by or receive funding from the city.

What is our context? Toronto has a long-standing dedication to ensuring that city residents have access to appropriate health and social services. This requires careful planning and systems management as well as our share of funds to support the provision of high-quality, timely, effective and accountable services. In a sentence, we need to be able to also plan, develop and deliver city-wide services on a city-wide basis.

The main health services that the city funds, plans and provides are homes for the aged and its associated community programs, emergency medical services and, of course, public health. The city funds and directly operates both LHIN-funded and non-LHIN-funded health services. In one of the appendices here, you have a description of the full scope and role of these services. It should be noted that Toronto Public Health is a non-LHIN-funded service, and the board of health has adopted an official position that public health not be funded by—it isn't in the legislation now, but even at a future date—or report to a LHIN either now or in the future. Our feeling there is that it has been such a good relationship to link public health with the local provision of a municipal service, that that has been a long and great tradition in the city of Toronto. Toronto also funds a number of community agencies through its grants program. Many receive funding from the Ministry of Health and Long-Term Care and may be affected by the LHIN reorganization.

As Canada's largest and most diverse city, Toronto's health services must be prepared to meet the needs of city

residents from a wide range of income levels and linguistic, ethno-racial and cultural backgrounds. Because the city is a major urban economy which supports an extensive network of health and social services, it has a large population of people who are vulnerable due to income, age, recent arrival to Canada or disability. We give a sense of the demographics in the second appendix.

The city of Toronto supports and acts on the stated local health integration network goals of improved access to coordinated health care through effective and efficient local management. However, the legislation as currently written has significant barriers that will affect the city's ability to continue to achieve those goals, and at the same time will weaken our role as a government in funding, planning and providing services to people living here.

Our four main concerns, covered more fully in the complete document, are again:

The configuration of the LHIN boundaries: Toronto is served by five boundaries, as you can see from the map that I'll just show you here for a second. Only one LHIN is totally contained within the city's boundaries, the south central one. The other four LHINs have a reach far outside Toronto with areas that do not share the same large urban health and social service issues. As an example of impact, our homes for the aged and associated services will report through five separate entities for planning and funding purposes. This is going to be extremely difficult.

The second issue of concern is intersectoral planning and community development. At the local level, services do not operate in discrete silos but work in strong partnerships to provide health care and related services. For example, at present a municipal home for the aged in one of the four outlying LHINs of the city may collaborate with a service provider in a downtown LHIN for purposes of providing a particular type of program. In the new configuration, the home and the partner service provider will be in different LHINs. Similarly, partnerships may emerge between LHIN-funded and non-LHIN-funded service providers; for example, a public health unit and a community health centre.

Bill 36 is based on a direction of permeable boundaries which in practice should allow these relationships to continue. However, the legislation does not ensure that organizations will be able to collaborate or engage in joint service provision if the funding and planning for each resides in separate entities, or if one organization is funded via a LHIN and one is not.

The third issue of concern is community engagement processes and the community advisory committee. Although one of the activities of the LHINs is to engage the local community about needs and priorities, the only obligation currently in Bill 36 is that the local integrated health plan will be made public. This limited approach will weaken the community empowerment essential to building strong health care. Community involvement and outreach, such as that which takes place in our homes for the aged, makes service truly community- and consumer-focused. While there is nothing in the legislation that will prevent the continuation of community and consumer engagement activities, the city believes that this should be mirrored in the LHINs themselves.

In addition, Bill 36 provides the Lieutenant Governor in Council authority to add services to the LHINs without consultation, running counter to the language and presumably the intent of community engagement.

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The fourth major concern is the health professionals advisory committee. Although Bill 36 does contain a provision for a health professionals advisory committee for each LHIN, there is no requirement that these committees include experts in geriatrics and long-term care, public health and other associated non-LHIN-funded health and social services.

In summary, the proposed legislation impedes rather than promotes city-wide integration, diminishes Toronto's role as local government, and does not provide for sufficient community participation in decision-making. Toronto has sophisticated and detailed service plans in all sectors and needs the ability to implement them. There is also concern about potentially weakening the city's inter-sectoral and community partnerships, two of the pillars of our health services implementation.

How much time do I have left, Mr. Chair?

The Chair: About four minutes.

Mr. Mihevc: Okay. There are some other concerns that we have, but they're really basically in the written presentation. Maybe, because of time, I'll just jump to the conclusion.

The potential in a Stronger City of Toronto for a Stronger Ontario Act provides both governments with an opportunity to improve the direction set out in Bill 36. Communities are strengthened when public services have coterminous boundaries, hence Toronto's preference to be covered city-wide by one LHIN. We respect and support the intentions of Bill 36, and we believe that improvements can be made to strengthen community planning and service provision within the boundaries of the city of Toronto. We are of course prepared to work with you towards that end as an order of government.

The Chair: We have a minute each for comments and questions. Madam Witmer, would you like to start?

Mrs. Elizabeth Witmer (Kitchener–Waterloo): Yes. I'd like to thank you very much for an excellent presentation. You've certainly identified one of the concerns we have, and that is the fact that the city of Toronto, unfortunately, is broken up into so many different parts. Do you believe that the recommendation you have put in place will totally resolve that issue?

Mr. Mihevc: No, frankly. We—

Mrs. Witmer: What's your preference?

Mr. Mihevc: I think it would be a concession, knowing that the train has somewhat left the station, that a lot of the infrastructure has already been set up. That's why we put in the caveat that if this model of one LHIN for the whole city of Toronto is not possible, then certainly there has to be something mandated in the legislation to at least have the service providers of the five LHINs

covering Toronto working together so that our homes for the aged work and associated work in social services—so you have the same level of services, in quantity and quality of service, in Scarborough as you do in Etobicoke and North York and downtown Toronto. The best, of course, would be one LHIN. I think people see themselves as Torontonians, and the magnetic pull, say, for example, in Scarborough will be towards the east and as far away as Peterborough. From a Toronto perspective, that really doesn't make sense. However, if that is not possible—and I recognize the reality of what's before us—then certainly something needs to be mandated into the legislation to get the five serving Toronto at one table working on service planning for Torontonians.

The Chair: Thank you very much. Madam Martel?

Ms. Shelley Martel (Nickel Belt): Thank you for being here this morning. I want to follow up on that, because you're right: The train certainly has left the station. We're dealing with legislation when in fact LHIN offices have been established and people have been appointed as if the legislation were already passed.

The minister has tried to say that the boundaries are based on hospital referral patterns, except that we've heard during the course of the hearings that people would be travelling to hospitals that normally they haven't before. For example, people from Sarnia are now expected to go to Windsor, when in fact the referral pattern was to London, so that doesn't make much sense either. The legislation certainly didn't take into account at all referral patterns for community services that were already in place, for example city of Toronto community services. Can you just reiterate again the services that are already well-coordinated in a pattern within the Toronto boundary that could well be disrupted (a) if there's no change to one LHIN—and clearly there won't be, because the offices are already set up—and (b) if there is no really concentrated effort to ensure that those five LHINs within the city boundaries actually work together, bearing in mind that some of those LHINs have boundaries that are outside the city boundaries anyway?

Mr. Mihevc: I think the biggest area that will be captured in the LHIN system for us as the city of Toronto is homes for the aged. We have a very good and developed homes for the aged network of 10 homes covering the city of Toronto. And of course we have a very good community network base for that as well, with community consultation committees that make sure that the level of service is high and that there's a lot of community and civic engagement for them. We are frankly proud of the homes for the aged offering as good a quality of service as anywhere. The fear here is that with Toronto being broken up into five distinct areas, there will be a different quality and perhaps quantity of service for the people in the homes for the aged in Scarborough versus homes for the aged in Etobicoke or north Toronto. I don't think that's a healthy thing. Poor Sandra here, who is the director of our homes for the aged, if she's trying to get some kind of equity of service and to know how we, as municipal service providers—because we kick in tens of millions of dollars to the homes for the aged. To make sure there's an equity of service, she'll have to be bouncing around to five different boards to make sure their budget concerns are addressed, filling a gap here, filling a gap there, filling a different kind of gap depending on the area. That's why, if you can't go with the one LHIN, make sure that at least there is something built in so there's one table that the city of Toronto folks would have to go to to make sure that we have a coherent, good, well-planned, appropriately funded system across the city.

The Chair: Thank you. Ms. Wynne?

Ms. Kathleen O. Wynne (Don Valley West): Thank you. Welcome, Joe. It's nice to see you. I take your point about the homes for the aged and the need for inter-LHIN communication. There is nothing in the legislation, as you said, that would prevent that kind of communication. The whole thrust of this bill is about better planning and fostering collaboration.

In terms of the city of Toronto being discrete, I know that in my riding, and I think in your ward, the reality is that people from outside of Toronto refer to and need the services in Toronto all the time. What the LHIN boundaries recognize is those referral patterns and the reality that Toronto has to relate to the rest of the province. I think that's an important piece that we can't lose.

The question I have for you is that in section 16 of the bill, there's the issue of community engagement. What do you think we should put in the bill to be more explicit about how to engage the community? That's something the city of Toronto has done very well and it's something the minister is interested in having more specifics about, so could you give us a bit of direction about what you think we should have in terms of specifics around community engagement?

Mr. Mihevc: I'm not that familiar with the details of that particular section.

Ms. Wynne: Well, the section is very broad and basically says that each LHIN will have a mandate to engage the community in its planning process. You could get back to us later, but what are some of the things that you think we might do? You said you didn't think the community engagement section was specific enough, so what could we do to make it more specific? That would be a helpful amendment.

Mr. Mihevc: I'll refer that to staff. I think they're better placed.

Ms. Julie Mathien: We have recommendation 3 in our document, which is that each LHIN be required by legislation—because you don't have that now—to have a community advisory committee of its board and that details regarding the community engagement be specified in the legislation; and furthermore, that part III of the legislation be revised to mandate full community consultation before you add services to the LHINs. If, for example, you wanted to add EMS or something like that in five years, that would not be a stroke of the pen, as is currently provided for in the legislation, and there would actually be a full consultation process for that.

Ms. Wynne: That's helpful. Thank you.

The Chair: Thanks very much for your presentation.

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CATHOLIC HEALTH ASSOCIATION OF ONTARIO

The Chair: The next presentation is from the Catholic Health Association of Ontario. There are four individuals: Ron Marr, Jeff Lozon, Major Dennis Brown and Peter Lauwers. Good morning to all. You can start any time you're ready.

Mr. Ron Marr: Good morning. My name is Ron Marr and I'm the president of the Catholic Health Association of Ontario. I thank the committee very much for providing us with this opportunity to speak with you this morning. Joining me is Jeff Lozon, who is the past chair of the Catholic Health Association of Ontario as well as the president of St. Michael's Hospital here in Toronto; Peter Lauwers from the firm of Miller Thomson; and Major Dennis Brown, the CEO and president of the Salvation Army Toronto Grace Hospital.

The Catholic Health Association of Ontario, as many of you know, is the umbrella group that represents the Catholic health ministry in this province. Our members are Catholic hospitals, long-term-care and mental health facilities and community health services in the province. There are 29 such organizations operating on 39 sites. Our members operate large teaching hospitals, long-term-care centres and psychiatric hospitals in our major health science centres, as well as small facilities in mid-size and rural communities across the province. Also included in our membership are the seven religious communities of sisters and lay groups that sponsor these facilities, and the Ontario Conference of Catholic Bishops.

Catholic health services strive to provide the highest quality care with respect and compassion to all of those in need regardless of religion, socio-economic status or culture. We collaborate in open partnerships with other members of Ontario's health care system, and we are dedicated to voluntary governance to ensure accountability to the government and to those we serve.

Our members have more than 160 years' history of providing exemplary care. We have an outstanding record of good stewardship and have taken leadership roles in many areas of need. Catholic facilities reflect a proven, community-based, voluntary approach to governance. Our boards of directors are representative of the cultural, linguistic, socio-economic and religious composition of the communities in which we are located.

We have clearly stated the intent of the partners in Catholic health care to remain active participants in all sectors of Ontario's health care system into the future and to work collaboratively for positive change and progress. As active participants, we recognize and applaud the government's desire to preserve medicare for the future well-being of all Ontario residents, and also the government's commitment to a system where public accountability and the shared responsibility of consumers, health service providers and governments are important and fundamental components.

Over the last number of years, the leaders of all three political parties in Ontario have shown their support for this faith-based approach to health care. Indeed, in an August 2003 letter to us, Premier McGuinty said:

"The Ontario Liberals recognize the invaluable contribution that the Catholic Health Association ... and the caregivers you represent have made as partners in the delivery of quality health care in our province.

"As I have stated in the past, the Ontario Liberals are committed to preserving the Catholic health ministry in our province. We appreciate that governance issues are of the utmost importance if Catholic hospitals, long-term-care facilities and home care providers are to preserve their ministry."

I'm going to call on Major Brown to say a few words, and then we'll get to the specifics of the bill.

Mr. Dennis Brown: Thank you, Ron. As president and CEO of the Salvation Army Toronto Grace Hospital, I want to appear here this morning in support of what the CHAO is doing. The Salvation Army of course is one of these faith-based providers, and we operate not only hospitals but long-term-care facilities, mental health programs, addiction and a wide variety of other social services. The Salvation Army and the Grace are committed to improved health and health care and really recognize the benefits that integrated systems provide, so we really want to work with you to make sure this legislation reaches its potential.

We want to affirm as well that within the evolving world of health care, faith-based providers do have an ongoing role. On the one hand we have the history of excellence, and on the other hand our desire to find the gaps and to respond to the needs of people who are marginalized and the most vulnerable. That really has something to offer in the new LHIN environment. I think that ongoing partnership with government and with the LHINs is really symbolized by the recent announcement of the Salvation Army building a new specialized hospital in this province as an integral part of the LHIN.

So we're really grateful to the CHAO for their work and we support their brief. I'll mention in passing that you've got the OHA later today and you had the Ontario Association of Non-Profit Homes and Services for Seniors. We also support their briefs, but I'm not going to take up your time going over more here. I'll pass it back to Ron.

Mr. Marr: Thank you very much, Dennis.

I have a few comments on Bill 36 for myself, and then I'm going to ask Peter to comment specifically on a section that we have some very real interest in.

First of all, CHAO supports the public policy goals of Bill 36. We support equity in health services across Ontario, better co-ordination of health care services, and accessibility. We also support effective and efficient management of the system. Bill 36 continues to respect the unique missions of health service providers, the voluntary nature of governance and the importance of local

control by local communities. Bill 36 represents a made-in-Ontario solution that avoids the regrettable and paradoxical centralization that has accompanied regionalization elsewhere in Canada.

CHAO particularly supports the preamble to Bill 36, which acknowledges "that a community's health needs and priorities are best developed by the community, health care providers and the people they serve," and the evident commitment in the preamble of the government to "equity and respect for diversity in communities." The members of CHAO are deeply committed to voluntary governance, as I've said consistently, and we believe voluntary governance best reflects accountability to the local community and best accommodates diversity.

A few comments on part IV of Bill 36 in regard to funding and accountability, and the accountability agreements in particular: Our written brief provides you with a substantive background and details for our comments on accountability agreements. We talk there about the process that was used under Bill 8, specifically for hospitals. Because of time restrictions this morning, I will simply summarize our recommendations on the accountability agreement process that is envisioned in Bill 36.

There are several features of the hospital accountability agreements that I wish to point out to you and remind you about. First, the Ontario joint policy and planning committee, in its statement on accountability dated August 2005, states, among other things, that the following commitments are fundamental to the success of the hospital accountability process. Two items on that list that we support and refer you to are, first, "The negotiation, content, and implementation of accountability agreements will respect the governance of hospitals by voluntary boards of directors," and second, "The negotiation, content, and implementation of accountability agreements will respect the diversity of hospitals, including any geographic, teaching and research, size or denominational considerations relating to the delivery of hospital services."

In addition, the draft accountability agreement templates themselves provide, in specific reference to denominational hospitals: "For the purpose of interpreting this agreement, nothing in this agreement is intended to, and this agreement shall not be interpreted to, require a hospital with a denominational mission to provide a service or to perform a service in a manner that is not consistent with the denominational mission of the hospital."

Bill 36, as you know, will extend the requirement that accountability agreements be put in place between all health service providers and their local LHIN. We request and we recommend to the committee and to the Ministry of Health that the Ministry of Health ensure that parallel language to the language I've just quoted is contained in the accountability agreements provided for in Bill 36.

I'd now like to ask Peter Lauwers to address our comments on part V of Bill 36 related to the limitations on the powers of LHINs and the minister.

Mr. Peter Lauwers: You can see from the brief that we're particularly concerned about the language in clause 26(2)(f), which you'll see on page 9 of the brief, and subsection 28(2), which says, "An order made by the minister ... shall not unjustifiably require a health service provider ... to provide a service that is contrary to the religion related to the organization."

Some people have said that the word "unjustifiably" is too loose, making justification too easy. Our understanding of the word "unjustifiable" and the minister's intent in bringing it in is that it relates to the Canadian Charter of Rights and Freedoms and the sense under that bill that decisions under Bill 36 would respect charter rights. The argument around that is that section 1, as you'll see on the top of page 10, says, "The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it and is subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

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The test that the court has set for this is called the Oakes test. It's very clear: The limiting measures must be carefully designed or rationally connected to the objective, they must impair the right as little as possible, and their effects must not severely entrench on the right in question. That test is pretty clear. Courts understand it; administrators understand it as well. We say that it's appropriate to include the language that we suggest on page 10, that "(2)(f) shall not unjustifiably, within the meaning of section 1 of the Canadian Charter of Rights and Freedoms, require a health service provider" to do this. The ministry accepts that this test is what is applicable. We are asking that the language make direct reference to the charter and that it be added for clarity. We understand that the minister is personally supportive of the proposed language and we commend it to you.

The Chair: Thank you very much for your presentation. You've used the 15 minutes.

YEE HONG CENTRE FOR GERIATRIC CARE

The Chair: The next presentation is from the Yee Hong Centre For Geriatric Care—Dr. Wong and Madam Wong, please. You've got 15 minutes total. Happy New Year. You can start any time you're ready.

Dr. Joseph Wong: Thank you very much for giving us the opportunity to talk to you today. I'm Dr. Joseph Wong. I'm the founding chairman of Yee Hong. On my right is Florence Wong, who is not related. She is the CEO of the centre.

The Yee Hong Centre for Geriatric Care is the largest non-profit geriatric care centre providing services to Chinese Canadian seniors in Canada. It was founded by me and a lot of committed volunteers in 1994. The centre provides a continuum of services to Chinese Canadian and other seniors in the GTA through four long-term-care facilities, with a total of 805 nursing beds, close to 1,000 units of senior apartments and a wide range of community support services, including daycare centres. We

have medical services, as well as cancer and palliative care services.

While the first Yee Hong Centre was completed in 1994, I established a Yee Hong community wellness foundation in 1987 and started to rally support from the community and the provincial government to establish a comprehensive geriatric care centre offering language and culturally appropriate services to Canadians of Chinese descent.

I came back from the States after finishing my medical studies in 1976 and started to serve the downtown hospitals and nursing homes. At that time, I was often required to see patients in nursing homes, and that is where I met a lot of Canadians of Chinese descent. They suffered so much physical and emotional stress that many of them asked me to end their lives, because they didn't want to endure years of isolation, hopelessness and frustration. It was at that time that the idea of establishing a centre appropriate to the culture and language of Chinese Canadian seniors germinated.

Historically, health delivery in Ontario has been blind to the needs of culture and language. It took me more than three years, from 1987 to 1990, to convince the Ministry of Health and Long-Term Care that the needs of seniors of different cultural diversity in Ontario really do require special treatment. In 1990, the provincial government awarded 660 beds to different communities, of which the Chinese community got 80. We started the first centre in 1994. Subsequently, because the standard of service and excellence of service delivery to seniors of Chinese descent was so good, the ministry awarded Yee Hong Centre a total of 715 beds in 1999-2000. That is the single-largest allocation of nursing home beds in the history of the province.

The waiting list now for the four Yee Hong centres totals more than 1,000 people. Although we have less than 1% of the total beds in the province, our waiting list consists of more than 30% of the total waiting list of the whole province. That is why the service at Yee Hong attracts not only people of Chinese descent but other seniors who really require culturally appropriate services.

The Yee Hong Centre has been commended by the Canadian Council on Health Services Accreditation as a provider of best practices in multicultural services. The centre has achieved this recognition by devoting tremendous energy to developing and providing culturally and linguistically appropriate and compassionate care, not only to Chinese Canadian seniors but also to South Asian, Japanese, Filipino and Portuguese Canadian seniors. Throughout the years, the centre has worked with many cultural communities to plan, develop and provide senior services. With its opportunities and experience, the centre is able to understand the needs of various communities and the inadequacy of the current health and social services system in Ontario to respond to these special needs. It is therefore an obligation and a responsibility of the centre to review the proposed Bill 36 through the critical lens of a provider of culturally appropriate senior services, with the goal of improving access to services for all cultural and language minority seniors in Ontario.

The Canadian Constitution recognizes the essence and nature of nation-building in this country. Multiculturalism and diversity is not only a policy; it is the character of the Canadian people and the most important and vital part of the Canadian fabric, which makes us unique in the world. This characteristic and trend is more obvious in this province than the rest of the country.

Bill 36 aims at enhancing access, accountability and integration of health services across the province. Given the diverse cultural and linguistic demographic makeup of Ontario, it is critical for the legislation to provide access to culturally and linguistically appropriate services as needed by our diverse community across the province, particularly in the GTA. To this end, we wish to address the following four issues raised by Bill 36 in this submission. I will be talking about the number one issue, regionalization and service utilization of cultural minority seniors, and my CEO, Florence Wong, will be talking about governance/accountability, funding and integration.

Because of the lack of culturally appropriate services in their communities, cultural minority seniors such as Chinese Canadians often have to seek such services outside of their areas of residence. Out of the 1,221 individuals on the waiting list for the four Yee Hong facilities, 645 reside outside of their areas. That means more than half of the waiting list of seniors for Yee Hong reside outside of the areas where our facilities are located. Some residents are as far away as Vancouver, Ottawa and Edmonton.

The need for culturally and linguistically appropriate services is not only evident in the long waiting list for Yee Hong services, it is also reflected in national survey research conducted by a professor at the University of Toronto in 2002. The survey aimed at examining the relationship between culture and health among older Chinese Canadians in this country. From the 2,272 respondents interviewed, over 45% identified health professionals who did not speak their language as the most common barrier in accessing health care services. The other common barriers related to professionals not understanding their culture, and programs not specialized for Chinese users.

Until such time as service providers in their regions are able to meet their needs, cultural minority communities will continue to access services outside of their regional catchment areas. Regionalization of health care services based on the utilization pattern and flow of users of acute care may not reflect the user flow of seniors for long-term-care facilities. Planning on a regional basis tends to focus on the needs of the population of the specific geographic boundary. The region may not take into consideration the needs of a specific cultural minority seniors' group that lives outside of the boundary. So there is a need for planning at the provincial level to ensure continuing access to services.

We have two recommendations in this area. The number one recommendation is that the legislation should be amended to specifically ensure that individuals are able

to access services that are culturally and linguistically appropriate. Second, the legislation should be amended to ensure that there is planning at the provincial level to ensure continued access to services that are culturally and linguistically appropriate.

Florence?

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Ms. Florence Wong: Recognizing the time constraints, how much more time do I have?

The Chair: About four minutes.

Ms. Wong: Okay. I'll address the balance of the three issues. I will first of all address governance/accountability. As community accountability is one of the legislative objectives of Bill 36, it is important to ensure that the governing bodies of LHINs—that is, the boards—reflect the diversity of the population they serve in terms of culture, language, gender and other demographic characteristics. Diversity of the boards could provide better linkages with a broader range of communities and enrich the experience of the board members to ensure that their decisions are relevant and effective. We therefore recommend that the legislation should be amended to specify the requirement for LHINs' boards of directors to reflect the diversity of the population they serve based on language, culture, gender and other grounds.

The next issue I want to address is about funding. While LHINs are empowered to provide funding to providers for services, there are no further details in the proposed legislation with respect to how funding will be allocated. Without any consistent funding formula, there is a risk that regional discrepancy in funding allocation for long-term-care services may lead to differences in standards of care and access to services. Without specific requirements for LHINs to take into consideration the needs of service users outside their catchment areas to access culturally appropriate services, these services may be at risk. We therefore have two recommendations in this area. The first one is that to ensure equity in services and minimum standards of care, the legislation should ensure that the provincial funding formula currently in place for all long-term-care facilities continues. Second, the legislation should also be amended to include criteria for funding allocation so that special-needs populations, such as those for cultural- and linguistic-specific services, are reflected.

Finally, on the subject of integration, currently there are no criteria specified in the legislation for integration decisions or orders by LHINs or by the minister other than that they are not to contradict the integrated health services plan and accountability agreement with the ministry. In the absence of clear criteria, there is a risk that integration decisions may negatively impact on access to culturally and linguistically appropriate services. Culturally appropriate services are developed through time commitment and resources by the provider. Consumers choose these services after the provider has proven its credibility and accountability. We therefore recommend that the legislation should be amended to provide for criteria regarding issuing integration decisions or orders taking into account consumer choice for culturally and linguistically appropriate services as well as quality of and access to the services.

We thank you for the time given to us. We have a written submission, which has been distributed.

The Chair: Thank you. We have a minute. Madame Martel, do you want to use one minute, please?

Ms. Martel: Thank you very much for your presentation this morning. You have a broad range of services, as you've indicated. I would assume that they cut across the LHIN boundaries and that your concern would be not only with respect to ensuring that the level and the quality of service is maintained but that that service be culturally and linguistically appropriate. Right now, there isn't a guarantee of how all of that will happen, of course, because you'll be dealing with different LHINs. How do you see that each LHIN should be dealing with those matters to ensure that the high quality of service that you provide, which is linguistically and culturally appropriate, is able to continue to be provided?

Ms. Wong: We don't think that each LHIN could do it on their own, because minority groups tend to go to the place where they can find culturally appropriate service, so they do cross LHINs. I think it is necessary for LHINs to work together on a regional or provincial level to plan for services for cultural minorities.

Dr. Wong: Yee Hong serves a lot of people outside of the catchment area. As we said, we have a lot of Chinese Canadian seniors coming from northern Ontario to our four centres in the GTA. So it is very important for the legislation to require LHINs to co-operate on this area. We really would like to see the legislation not leave the discretion to the LHINs but that it be required for the LHINs to work on this area. We understand that each individual LHIN would not be able to establish culturally appropriate services in that particular area, because it should be a concentration of services so that culturally and linguistically appropriate services could be provided at a very reasonable cost to the constituents.

The Chair: Thank you. Ms. Witmer, please.

Mrs. Witmer: Thank you very much for an excellent presentation. We do appreciate your recommendations. When you talk about legislation, you talk about the need for it, obviously, to take into consideration culturally and linguistically appropriate services. Do you have a concern that some of these services could disappear under the LHINs?

Dr. Wong: We are very concerned that present health care access does not reflect the importance of culturally and linguistically appropriate services. A lot of minorities in Ontario still do not have access to culturally appropriate services. Yee Hong has been trying to provide services not only to Chinese Canadians but, as I said, to Filipino Canadians, of which there is a big concentration in Mississauga. That is why, in the Mississauga Yee Hong Centres, we have a wing specifically to serve those cultural and language needs of Filipino seniors. In Markham, we have a whole floor dedicated to serving Canadians of south Asian descent. Also, in our newer centre

at Scarborough-Finch, we have a wing for Japanese Canadian seniors. We also serve a small number of Portuguese Canadians in our Mississauga area because of the big concentration of Portuguese Canadian seniors in Peel region. So we are looking for ways to improve health care access from different health care communities. We have been successful to a certain degree, but I really hope that the legislation should provide a very clear guideline to all LHINs so that this particular very important aspect of senior long-term-care services should be respected.

The Chair: So everybody can ask a question, we'll just go over the time a little bit. Ms. Wynne.

Ms. Wynne: Just very quickly. The level of specificity that you're talking about, I understand, is not in the legislation, but the planning process is to include community engagement and is to deal with the issues of each of the communities involved in the LHINs. To my mind, that's where these concerns get taken up. I take your point about the boards representing the demographics of the area. I think that's a very interesting suggestion. Could you just talk briefly about the community engagement process and what you think needs to be explicit that would ensure that your concerns were taken care of?

Dr. Wong: Very often, many of these cultural communities are newer Canadian communities, and a lot of the people inside the community, including so-called leaders of the communities, have not been able to use effectively the language and other aspects to provide access for the seniors within their community. So I believe that LHINs should be required to actively seek out these needs rather than waiting passively for people to come to them. A good example is the Portuguese community. A good example is other communities that we are serving: south Asians and others. The Filipino communities particularly have not been in this country for too long, and they often lack the connections to access health care authorities giving them the funding or other requirements so that they could provide access to their own seniors. Yee Hong is a good example, but I hope it would be enshrined in the legislation so that LHINs should be able to seek out services that are appropriate for various cultural communities, since they really make up a big part of southern Ontario.

Ms. Wynne: Would you put that in section 16, in that community engagement section? Just a quick yes or no.

Dr. Wong: Yes, I would.

The Chair: Thank you very much, Dr. Wong and Ms. Wong.

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 2.ON

The Chair: We'll move to the next presentation, from the Service Employees International Union, Local 2.on, Toronto, Shalom Schachter. Good morning.

Rabbi Shalom Schachter: Good morning. Sorry that Nathan Kelly was not able to join us this morning.

I represent Service Employees International Union Local 2. We have 7,000 members in Ontario, including security officers at local hospitals in Toronto. For our oral presentation, I'm going to highlight sections of our written submission. Some of the recommendations are interspersed throughout the written submission, and the remainder of the recommendations are at the end of our brief.

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On page 2, we indicate that Bill 36, as it is presently drafted, is not local, not comprehensive of health nor sufficiently comprehensive of systems integration. The first point we deal with at the bottom of page 3 is in terms of the absence of local accountability.

You've heard many of the criticisms from others about the absence of "local" in the legislation. What we bring to this committee today is the statement by the minister when he introduced his estimates at the standing committee on September 27. The minister stated that LHINs are going to be "community-based government, by and for the community." Unfortunately, these sentiments are not reflected in the bill. This failure of the legislation to live up to the minister's undertakings that were given at the commencement of his presentation to the committee and therefore form one of the presumed conditions upon which his estimates were approved, is particularly troublesome. We conclude our submission on this part on page 5, indicating that the absence of locally elected LHIN boards leaves the decision-making in the hands of provincially appointed bureaucrats, giving credence to the criticism south of the border that our health care system is Stalinist-light.

In terms of the interest in community engagement, a necessary condition for that is that the LHIN board members be elected by the adult population served and by the adoption of recommendation A at the back of our submission concerning CCAC governance.

The second deficiency is the absence of crucial elements of health from the bill. Again, you've heard from a number of presenters. At the bottom of page 6, we indicate that we urge that these gaps be reviewed; that after the bill receives royal assent, there should be a wholesale review of the legislation 18 months later to see how we can best incorporate those gaps; and that paragraphs 10 and 11 of subsection 2(2) should be immediately amended so that those health care providers are covered whether they provide services on a for-profit basis or a not-for-profit basis. Right now, only the not-for-profit health service providers are covered by the legislation.

In terms of the third deficiency, systems integration not being sufficiently comprehensive, that starts at page 7 of our submission. I'll direct you to page 8. There is a widespread belief that one of the unstated objectives of the government is to increase the role of the private sector in the delivery of health care. This objective was held by the Harris government and is manifest in the allocation of the additional long-term-care beds that were issued under the RFP process. On a net-change basis, all of the new beds were allocated to for-profit nursing homes. In 2000, prior to the expansion, there were a total of 55,784 long-term-care beds, of which 30,899, or

55.4%, were in nursing homes. Six years later, there are now 69,580 long-term-care beds, of which 46,105, or 66.3%, are in nursing homes, an absolute increase in this number of almost 50%, with a shrinkage both absolutely and proportionately in terms of other types of long-term-care beds.

On page 9, we indicate that the McGuinty government has already increased the role of the private sector through its alternative financing program for hospitals. You've heard from OANHSS and today from the city of Toronto that there is no valid reason for the exemption of for-profit health service providers from the scope of authority of subsection 28(1) of the bill, and we ask that that section be broadened to include for-profit providers.

Another area of missing systems integration is in the area of labour adjustment—at this point, I'll direct your attention to page 10 of our submission—in terms of the inadequate scope of the Public Sector Labour Relations Transition Act, otherwise known as PSLRTA. There is a typographical error on page 10 and again in the references on page 11. Where you see subsection 31(3), it should refer to subsection 32(3). Please make that correction. I apologize for that error. That section excludes successor employers who are not health care providers and where the health sector is not the primary recipient of their services.

Our union represents security officers at many hospitals in Toronto. The environment where these services are provided has special requirements. Not only are all persons in the province invited to come onto the premises of hospitals, but hospitals, unlike other providers of services such as retail malls, do not have the right to deny access to persons deemed socially undesirable.

Special care must be taken by security officers in the hospital environment. The SARS outbreak of a few years ago brought home the importance of effective entry protocols to such facilities. The current concern over the outbreak of a pandemic demonstrates the need to maintain and improve such protocols.

These security officers regularly interact with psychiatric patients, as well as others who may become aggressive or even violent. The role of the security officer in this environment is not only to protect the safety of the public and the property of the hospital, but also the safety and health of the person who is the subject of the security officer's attention and to support that person's therapeutic rehabilitation. In short, the skills and abilities of security officers in the hospital environment are not interchangeable with those working outside of health care.

Section 32(3) would mean that, if the security service is contracted out to a provider who is larger and who's not primarily operating in the health care environment, existing security officers will be prejudiced in the following way: Their employment may not have to be continued; even if their employment is continued, their wages and benefits can be reduced; and even if their wages and benefits aren't reduced, the new employer doesn't have to recognize the right of these employees to be unionized and represented by the union of their choice.

In cases where section 32(3) is not applicable, the actions listed above cannot occur before a vote is taken.

Going on to page 12, aside from the prejudice to the health care system that would result from a loss of experienced security personnel is the infringement on democracy and the absence of a secret ballot on the making of these important decisions. Later this morning, a change is going to take place in our national government which was accomplished peacefully through the means of a secret ballot. It is unthinkable that in this province, given the importance of health care to Ontarians and the crucial role of human resources in the delivery of that care, any workers involved in health care would have their union representation rights removed without a secret ballot. We urge this committee to arrange for the deletion of section 32(3).

Our presentation then continues, indicating at the bottom of page 14 that there are other recommendations on democracy and integration at the back of our submissions. Finally, other deficiencies in the bill are set out on page 15. There are deficiencies in the accountability of the LHINs, deficiencies in the accountability of the minister and in the absence of adequate transparency in decision-making.

There should be an amendment requiring that all decisions of the LHINs, the minister and the Lieutenant Governor in Council made under this act be consistent with the purposes set out in the preamble and section 5 of the act. Every decision taken must set out the key facts demonstrating that it meets such purposes.

Much of the public concern surrounding the introduction of the LHINs is the uncertainty over the values and approaches that will guide the integration decisions. The minister has attempted to discount many of these concerns, stating that there's nothing in the legislation that gives a basis for that. In fact, there is, and that is section 14, dealing with the adoption of a provincial strategic plan. The committee should recommend that no strategic plan shall take effect unless it is ratified by a motion in the Legislature.

Going on to page 17, in terms of the shifting of public resources to for-profit providers, the bill should be amended to require that any decision transferring delivery of a service from a not-for-profit to a for-profit provider require the publication of the data that demonstrate that the for-profit provider will have a better health care outcome for no more than the same cost, or at least as good an outcome as the not-for-profit deliverer and a lower cost. Similarly, the extension of the request for proposal or any other competitive bidding system should not occur without documentation that it results in a better quality at no increase in cost, or a lower cost with no decrease in quality. Finally, any future RFPs should require that the winner employ the employees of the loser and that any issue of representation rights be resolved under PSLRTA.

At this point, if there's time, I'm going to answer any questions.

The Chair: There is only one minute. I'll go to Ms. Wynne.

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Ms. Wynne: Sure. Thank you very much for your presentation. I guess the overarching question I'd like to ask you is whether you believe that there's a need in this province for an increase in coordination of care, because that's really what this legislation is about. We've heard a number of times from SEIU across the province. This is our fifth day of hearings, and we've heard every day from one local or another of SEIU. I just need to hear whether you believe that it's a good thing that we would be trying to coordinate and plan. I'm curious specifically about your concern about the provincial plan. Is there not a need for a provincial plan into which the LHIN planning would fit?

Rabbi Schachter: Yes, we do believe in the need for integration. This submission contains some recommendations to improve and enhance integration. In terms of the other hat that I wear, while I'm a member of SEIU, I'm an employee of the Ontario Nurses' Association. You've heard from ONA that for the past 10 years we've been supporting integration. The problem is that this model doesn't do it right, and the provincial strategic plan is going to contain very crucial elements. It may contain issues in terms of how local services are going to be delivered and whether there has to be travel. It may contain issues in terms of whether there's going to be a bias in favour of for-profit providers. These things, that are maybe in the provincial strategic plan, should be the subject of debate in the Legislature, and there should have to be a motion supporting that provincial strategic plan before it's implemented, and then before the LHINs accountability agreements and integration decisions that are based on the provincial strategic plan get adopted.

The Chair: Thank you very much for your presentation, sir.

ONTARIO HOSPITAL ASSOCIATION

The Chair: The next presentation is from the Ontario Hospital Association. If you could start when you're ready. We have 15 minutes in total, please.

Ms. Hilary Short: Good morning, I'm Hilary Short and I'm president and CEO of the Ontario Hospital Association. Joining me is Mark Rochon, chair of the advocacy committee of the OHA's board of directors, and president and CEO of the Toronto Rehabilitation Institute.

We are pleased to have this opportunity to comment on Bill 36, the Local Health System Integration Act, 2006. Let me begin by saying that the OHA supports the aims and the principles of Bill 36. We believe that local health integration networks have the potential to improve the integration of health care services while meeting the unique needs and priorities of communities across Ontario.

OHA has consistently endorsed the made-in-Ontario model of integration that the government has adopted. This model recognizes the value of voluntary governance and the importance of local decision-making among interdependent organizations such as community-based health providers and hospitals. Since November 2004, the OHA's board of directors, advocacy committee and staff have worked hard to provide constructive advice and support to the government as its integration plan moves from the theoretical to the practical. In concert with other stakeholders, the OHA developed a set of principles meant to guide and facilitate the development and implementation of LHINs. Many of these principles were subsequently adopted by the Ministry of Health and Long-Term Care.

In February 2005, we published a policy paper that provided concrete recommendations about how LHINs could be constructed and could be run most effectively. We hosted a conference on LHINs that attracted hospital leaders, doctors, nurses, decision-makers and stakeholders from across the broader health care sector. We plan to continue offering legislators and the government whatever assistance we can because we want LHINs to be successful.

Today we're pleased to offer this committee our comments on Bill 36. We strongly believe that our proposed amendments to Bill 36 are needed to improve and strengthen the bill to the benefit of those who use and work in Ontario's health care system. While our recommendations are set out in detail in our written submission, I'm going to ask Mark to speak to some of the more important aspects of the submission.

Mr. Mark Rochon: Thank you, Hilary, Mr. Chair and committee members. Our review of Bill 36 was guided by a number of considerations: First, we wanted to ensure that LHINs had sufficient authority to do their job. Second, we felt it was important to examine what, if any, process LHINs would be required to follow when consulting with the community and health stakeholders, developing plans and making decisions. Finally, we looked at whether the provisions of Bill 36 require LHINs to operate in the open, accountable and transparent manner that Ontarians would expect.

We have identified a number of ways in which the bill could be significantly improved, and with input from our members have developed some recommendations in that regard. I'll now review some of these recommendations.

First, I would like to speak to Bill 36's treatment of hospital foundations. Our members are concerned with proposed amendments to the Public Hospitals Act that would give LHINs the ability to receive the financial reports of foundations. Given that foundations are independent corporations that do not fall within the scope of LHINs, these amendments seem out of place in the context of the broader bill. This has sparked concerns among hospitals, foundations and donors about why Bill 36 would give LHINs an interest in hospital foundation matters. We are concerned that any perception of donated funds possibly being directed by the LHIN for unintended purposes could severely damage foundations' fundraising efforts. As you know, these fundraising

efforts make hospital capital renewal projects possible. Any reduction in donations would make it more difficult, if not impossible, for hospitals and the province to move ahead with these needed capital projects. Given this, we strongly recommend that this provision be deleted.

One of the most important aspects of the LHINs' mandate is the development of an integrated health services plan for its local area. This plan will form the basis of most LHIN decisions, including those respecting service integration. Although Bill 36 requires LHINs to consult with the community when developing their plan, it does not define "community," nor indicate what the nature and extent of the community engagement must be. In the absence of a specific definition of "community," it is possible that hospitals and other health care providers, those most responsible for providing most local health services, would not be consulted prior to or during the development of this plan. As this consultative process will be critical in determining what programs and services will be offered within a community, we believe that Bill 36 should be amended to provide an explicit consultation process that includes local health care providers.

The OHA also looked at the basis upon which integration decisions and orders will be made. In the interests of ensuring evidence-based decision-making, we recommend setting out objective criteria that must be considered prior to issuing an integration decision or order. We believe that, at a minimum, decisions must be evidence-based and take into account factors affecting patient care, such as choice, quality and access. Bill 36 obligates LHINs and the minister to consider the public interest when issuing integration decisions or orders. However, the bill leaves the term "public interest" undefined. We believe that the bill should be amended to include a definition of "public interest" similar to that found in either the Public Hospitals Act or the Commitment to the Future of Medicare Act. This would ensure that patient care and community needs are given due consideration.

One of the most important issues for the OHA and its members with respect to Bill 36 is the need for due process. We believe that Bill 36 should provide for due process prior to the issuing of integration decisions or orders. As currently drafted, Bill 36 permits LHINs and the minister to issue integration decisions or orders without having first provided affected providers with an opportunity to be heard on the merits of the specific proposed decision. Although providers have 30 days to request reconsideration of an integration decision or order, there's no requirement for LHINs to consider the submission of the affected party, nor does the bill provide for any third-party appeal process. Given the potential impact that integration decisions and orders may have on communities, facilities and stakeholders, we believe that those most affected should have an opportunity to be apprised of and provide input on a proposed integration decision or order, particularly if there is no avenue for appeal.

We therefore request that Bill 36 be amended to provide for some minimum procedural standards prior to the issuance of an integration decision or order. This might include notice of an intended decision to the affected provider, the opportunity for the provider to provide comments, and a requirement that the LHIN or minister take into account the submissions made.

These are a few of the suggestions that we believe will improve and strengthen Bill 36. Further details and additional recommendations are set out in our written submission.

I'll now turn to Hilary for some concluding remarks.

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Ms. Short: Let me close the way I began. The Ontario Hospital Association supports the aims and principles of Bill 36. We stand squarely behind the government's plan for health system transformation and the establishment of LHINs, and we believe that our proposed amendments to Bill 36 will help make LHINs a success. Providing constructive input over the last year, today and in the weeks and months ahead with respect to LHINs is part of that effort.

Once again, thank you for the opportunity to appear before you today, and we'd be pleased to take any questions.

The Chair: We have at least a minute each. Ms. Witmer, please.

Mrs. Witmer: Thank you very much for your presentation. The question I have for you is, how does the power of the Minister of Health differ in this legislation? It appears at first blush that there's more power here for the minister than there was under the Health Services Restructuring Commission. What additional powers does the minister have in accordance with this legislation?

Mr. Rochon: We see the powers as somewhat similar. In our view, the powers that exist under the Public Hospitals Act that the minister now has would be similar to those that would exist once the legislation is considered and its final form proclaimed.

Mrs. Witmer: We've heard from some people that they think the power of the minister is more far-reaching in this legislation.

Mr. Rochon: We don't see it that way.

Mrs. Witmer: Are your hospitals at all concerned about section 30, the foundations, where if a service or program is shifted to another hospital, the money in the foundation would follow that movement?

Mr. Rochon: That's why we're recommending the changes that we're suggesting here in terms of reporting of foundation issues.

Mrs. Witmer: Right, but you haven't made any reference to section 30, I don't believe.

Mr. Rochon: Correct.

Mrs. Witmer: Do you have any recommendations for amendments there?

Mr. Rochon: I don't believe we do.

Ms. Short: We don't at this point. I guess we would consider that somewhat more like an implementation issue. Under the restructuring commission, the foundations did find ways to merge and create different organizations when the commission ordered mergers. So

I think the foundations have found ways to merge successfully.

The Chair: Thank you very much. Ms. Martel, please.

Ms. Martel: Thank you for being here this morning. I wanted to go to your proposed amendments for sections 26 and 28, because you made a point to say that there really isn't due process either with respect to an integration decision or an order by the minister.

If I read the amendment right, you didn't go so far as to make reference to a third-party dispute mechanism, because for some people it seems a bit unrealistic to go back to the same body that already made a negative decision and hope for a successful reconsideration. You talked about a third-party process. It's not in the amendment. What's your view then on some kind of third-party appeal mechanism?

Mr. Rochon: We're not recommending a third-party appeal mechanism, in part because we believe that the body that is accountable for the execution of the decision and for making the decision ought to hold that decision close to their own processes. In our view, ensuring that there is an opportunity for hospitals to recommend on an intended decision on the part of the LHIN would make more sense than continuing to deal with appeal mechanisms.

Ms. Short: We should add that this was the subject of quite intense discussion and debate, obviously, on the question of whether there would be a third-party appeal mechanism.

Yes, there was another concern too that the hospitals really—because we support this bill, there is sort of a risk. As Mark says, there's also the further risk that it doesn't have sufficient authority to carry out its decision and it would get tied up, and any decision could be held up for a long period of time. That was the other thing, but it was something we thought about very carefully. We decided that we felt having clear criteria to make these decisions, having decisions evidence-based and making sure that there was a notice would be better than a third-party appeal process.

Ms. Martel: What about the notice to the public? Right now, all of this goes between the service provider and the government, and there's no role for the public when they want to express concerns about the loss of a service.

Ms. Short: I think we are suggesting that that notice be public.

Mr. Rochon: That's a reasonable perspective. This should not just be between providers and LHINs.

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: Thank you very much for being here. I wanted to just follow up on your concern about the local health care providers and community engagement. If this bill passes, there will be a process whereby the specifics around community engagement will be articulated in regulation, and people will have the ability to have input into those regulations.

Are you suggesting that subsection 16(1), which says, "A local health integration network shall engage the community of persons and entities involved with the local health system about that system on an ongoing basis" etc., is not specific enough? Because it seems to me that provides for consultation with the local health care providers on an ongoing basis.

Ms. Short: We're suggesting that it be made more specific in the legislation and not left to regulation. We see the community engagement process, particularly, let's say, in Metropolitan Toronto, in the GTA, as pretty complex. We think more should be made explicit in the legislation, since it's something new and something that we would prefer to see more of and not just all left to the regulations.

Ms. Wynne: I haven't looked at your specific recommendations but if there's language—because, as I say, that section seems to have provision for the health care community to be involved, so I thought it was adequate. But if you've got language, maybe you could let us see that in the written—

Mr. Rochon: Yes, we have—

Ms. Short: The language is in the written submission. We have precise language suggested in the submission.

Ms. Wynne: Okay. Thank you.

The Chair: Thank you for your presentation.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair: The next presentation is from the Registered Nurses' Association of Ontario. You can have a seat. There are 15 minutes for the total presentation and potential questions and answers from the members. Whenever you are ready, you can start.

Dr. Mary Ferguson-Paré: Thank you for the opportunity to address the committee on this very important piece of legislation. My name is Mary Ferguson-Paré. I'm the president-elect of the Registered Nurses' Association of Ontario.

From the outset, I want to reiterate our association's support for the government's health care transformation agenda and our support for the role that LHINs can play in that agenda. Medicare will be strengthened by reforms that improve population health and improve access to care by the right provider, at the right time and in the right place. However, we have some profound concerns about this proposed legislation. In my remarks, I will provide you with an overview of how we believe these concerns can be addressed. For more details, please refer to our submission, which I believe you have in front of you.

We understand that the government's objective for system transformation is to serve Ontarians better. This bill will not achieve that objective without an explicit commitment to a single-tier health care system and to expanded not-for-profit delivery. Instead, this legislation will result in an erosion of medicare and lower quality health care services for Ontarians.

We remain puzzled and gravely concerned by the McGuinty government's choice not to make the Canada

Health Act a centrepiece of the LHINs legislation. We recommend that both the Commitment to the Future of Medicare Act and the Canada Health Act serve as central themes to both the preamble and the objects of the bill.

We are similarly concerned that there are no provisions in the bill which encourage, let alone require, LHINs, the minister or cabinet to preserve or expand public not-for-profit delivery of health care services. The evidence is clear: A single-payer system of not-for-profit health care delivery results in higher quality care at lower cost.

We believe that three amendments to Bill 36 would provide LHINs with the tools they need to support and expand not-for-profit delivery. The first is to give not-for-profit providers the first right of refusal. Only if not-for-profit providers are unwilling or unable to accept the transfer of health services should transfer to for-profit providers occur.

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The second is to ensure that integration between a for-profit provider and a not-for-profit provider would only be allowed if the resulting health service provider operates on a not-for-profit basis.

The third is to provide the minister with identical powers with respect to both for-profit and not-for-profit providers.

Concerns have been expressed by health care workers and a range of Ontarians, including seniors, that this bill will facilitate an expansion of competitive bidding in health care. Such an expansion would be expensive, inefficient and lead to deteriorating health outcomes.

We have been assured by senior government officials that there is no intention to expand competitive bidding beyond the home care sector. As any legislation passed will continue beyond the current government and minister, it is essential that this policy decision be enshrined in the proposed legislation.

We recommend an amendment to the bill that prohibits competitive bidding as a way for LHINs to allocate funds among health service providers. This would address these concerns.

Bill 36 provides for contracting out of both clinical and non-clinical support services. As nurses who are at the bedside 24 hours a day, we understand the importance of every member of the health care team in ensuring patient safety and contributing to healthy work environments. Housekeeping and nutrition services are two such services that have a profound impact on patient outcomes, including infection control and nutrition support.

Contracting out of these services results in workers who are disengaged from the important work they do and demoralized by low wages and lack of job security. High employee turnover disrupts care, as does transitory employment where workers do not understand the culture and values of the organization they are working in.

When these services that include direct patient contact are contracted out, there are two choices: Either patient care and patient environment suffer or nurses are taken away from their central clinical work to provide these services. If nurses pick up the slack, the additional workloads for overburdened nursing staff will increase burnout and injury rates, hence creating shortages. This will worsen patient outcomes.

The following two amendments to the legislation would address these concerns: Prohibit LHINs from facilitating or ordering contracting out of any hospital or residential care facility service that provides direct clinical or non-clinical patient services. Secondly, prohibit cabinet from ordering contracting out of any hospital services that provide non-clinical patient services.

I now want to turn to the issue of health human resources. We cannot forget that transforming the health care system means transforming the way people work and where they work. Given that physicians are outside the sphere of LHINs, this legislation will, to a large extent, mean transforming where and how nurses work.

We cannot forget the characteristics of the nursing workforce. The first is that the average age of registered nurses working in Ontario is 45 years. More than 50% of them will be eligible to retire over the next 10 years. More than 60% of registered nurses work in hospitals. We have to compete internationally and interprovincially for this generation of nurses. We also have to compete with a myriad of other professions and occupations for the next generation of nurses.

This legislation must address the retention and recruitment issues that it will provoke. It should be guided by the following principles: The need to maintain the acute care nursing workforce as an essential part of the system; the need to equalize remuneration and working conditions across sectors; the need for quality work environments across sectors; and the need for professional development and training to move across sectors.

I thank the committee for your attention. We look forward to working with you to ensure that this legislation meets the government's objectives of health care transformation.

The Chair: Thank you. Madam Martel, one minute each, please.

Ms. Martel: Thank you for your presentation today. Congratulations, president-elect. I'm sure you'll enjoy your time.

I want to thank you very much for making a point that if the government is serious when it says that competitive bidding is not going to be used as the model for LHINs to acquire services, that should absolutely be in the legislation. Also, I thought it was important that RNAO has pointed out that your position on outsourcing is very clear.

You've specifically said that the bill should prohibit cabinet from ordering contracting out of any hospital services that provide non-clinical patient services. You've talked about cleaning and infection control. The problem is that "non-clinical" is not defined in the legislation. So while we all think we're talking about the same thing, it's not clear to me that when this process starts

down the road, "non-clinical services" is not going to have a broader definition. Do you have some other suggestions about how we get at "non-clinical," or do we just say we should be deleting that whole section altogether given the lack of clarity?

Ms. Sheila Block: I think we have a concern. If you look at recommendation 4, we talk about both the ability for LHINs to issue decisions and the ability of cabinet. We share that concern about the definition of non-clinical services. What we are looking for is a definition of both clinical and non-clinical services that have direct patient contact, so that moves from unit clerks to housekeeping to dietary to actual delivery of meals. Those are the kinds of patient contact we're concerned about contracting out and it doesn't include back office kinds of operations, to be clear.

The Chair: Thank you. Mr. Ramal.

Mr. Khalil Ramal (London–Fanshawe): Thank you for your presentation. You touched on so many different elements, but I want to go back first to when you talked about two-tier health care. Do you not think the minister, when he opened the session of this committee, was clear in terms of keeping health care in the public domain? He's against any hospital closure and against two-tier health care. It was a very comfortable zone for you and for many health care providers in Ontario.

The second question would be, I don't understand what you meant by the same power for both for-profit and not-for-profit.

The third part of my question is about the policy. You said you spoke to the ministry and the minister's staff and you got an assurance about no expansion of competitive bidding. You mentioned later on, "Well, if the government changes and if the minister changes, what's going to happen to us?"

I want to tell you that we cannot control this issue beyond our government. As you know, any minister or any government, when they come to power, has a right in law to change whatever rules and laws have been implemented before, and can change it to the way it suits the direction of their government.

Those are my questions, if you wish to answer those.

Dr. Ferguson-Paré: Perhaps to begin with, we are looking within the legislation for a commitment to the Canada Health Act and the Commitment to the Future of Medicare Act, that it would actually reference that in the legislation to ensure that that commitment is enshrined there.

Similarly, we are aware that of course different governments have different perspectives, strategies, plans. We believe since this government is presenting this bill and is not interested in expanding contracting out, we would like that to be enshrined within this bill, so that the legislation would be clear on that and it would carry forward to future governments.

Lastly, with regard to the same powers for for-profit and not-for-profit, those powers would include transfer, amalgamation. Presently, the minister has the power to determine those things in not-for-profit, and we would be asking for the same powers in terms of for-profit services. Perhaps Sheila could expand on that.

1030

Ms. Block: Yes. We're looking at section 28 of the bill, and that is the minister's powers. As Ms. Ferguson-Paré said, we are looking for parallel powers, both for-profit and not-for-profit providers, because we feel otherwise it will bias against not-for-profit providers and facilitate an expansion of the for-profit sector.

Mrs. Witmer: In looking at your recommendation, I see that you've expressed some concern about the local control and autonomy of the LHIN boards and the fact that people can be, I guess, recalled at the pleasure of the minister and cabinet. What is your opinion as to them being selected by cabinet and approved by cabinet for this position? We've had somebody come in this morning and indicate that if this is indeed the case, they really do not represent their community, and perhaps there needs to be another selection method for the LHINs board.

Ms. Block: I think we both have some concerns about an order-in-council appointment method and some sympathy and understanding for it, so we believe that that should really be counterbalanced by our recommendations, in terms of fixed terms and other issues, to maintain the independence of those boards.

Mrs. Witmer: Okay. So you don't have a concern about cultural or linguistic representation on these boards.

Ms. Block: Our hope is that the order-in-council appointment process will provide that these boards are representative, and we think there will be the usual kinds of political pressures to ensure that they are representative. So far, in terms of the appointment process that we're aware of, that seems to be taken into account.

The Chair: Thank you very much for your presentation.

ST. JOSEPH'S HEALTHCARE HAMILTON
HAMILTON HEALTH SCIENCES

The Chair: The next presentation is from St. Joseph's Healthcare Hamilton and Hamilton Health Sciences, Dr. Kevin Smith and Murray Martin. Good morning. Gentlemen, you have 15 minutes in total for your presentation and potential questions. Thank you.

Dr. Kevin Smith: Thank you very much for the opportunity. My name is Kevin Smith. I'm here with my colleague from Hamilton Health Sciences, Murray Martin. I'm very pleased to have an opportunity to talk to your group this morning and the opportunity for consultation around this important legislation.

Perhaps a bit of where we've come from: The Hamilton area hospital, St. Joseph's Healthcare and Hamilton Health Sciences, supports an area of over 1.5 million Ontarians from LHIN 4, now known as the Hamilton-Niagara-Haldimand-Brant and beyond LHIN, with a combined budget of almost $1.2 billion, which is obviously a very large fiscal investment. We also have the good fortune of being part of an academic health science centre affiliated with McMaster University and

Mohawk College. The whole role and relationship of health science centres within LHINs will be an important part of our discussion. I'll just refer you to the document as it stands around our campuses. Collectively, our corporations operate 10 sites throughout our region.

First, let me start with a commentary on the widespread support for local health integration that our region enjoys, that our boards represent, and some observations we'd like to share with you. In our opinion, it's extremely important to explicitly recognize and respect the mission and values of denominational hospitals in legislation, and I know that there has been some discussion at these tables previously. We certainly support that. Beyond principle perhaps, in operations the issue of forced mergers have rarely been successes in hospitals, and I think there are many examples of that. The opportunity of appropriate merger or dissolution of a corporation is a different approach that we certainly would endorse.

Legislation should clearly identify that LHINs do not have an academic health science centre. It should be explicit around those that do have health science centres what our relationship must be between the other. I believe there are now five academic health science centres, so the remaining nine LHINs in our province.

Similarly, a theme you've heard a lot about—and we would certainly also support that—is the importance of a dispute resolution and appeal mechanism, an important part of modifying this legislation and an essential component to due process and natural justice.

Perhaps a word about some of the positives that the emergence of LHINs have shown for our region so far, and hopefully a strong commentary on the success of collaboration in our region: As I mentioned, we very much support the aims and principles of health system integration, and as a result of that, a number of things have happened in our LHIN in our region, which include integrated vice-president roles across our hospitals with emergency services, mental health, support services, children's services, cardiac services, cancer services and beyond. So in our $1.2-billion collective entities, we actually have one leader within those entities to represent each of those important programs. As an academic health science centre, within those programs we reach well beyond Hamilton but into our broader LHIN, and in fact outside the LHIN as well.

Another important initiative that's been very beneficial so far, and that I think will show even greater promise in the future, is a LHIN-wide chief information officer. We have done so in a model with all 12 hospitals, and come forward now with our LHIN office, with a single individual speaking on all our behalves in terms of building an integrated information system for Ontarians.

Certainly the advent of the LHIN or the evolution of LHINs has allowed extensive collaboration on systems planning and recruitment and retention, which Ms. Ferguson-Paré mentioned previously. We do, however, have a number of suggestions for improvement.

At this point I'd like to turn it over to my colleague, Murray Martin, who will speak to you.

Mr. Murray Martin: In terms of the comments from the previous group, we support the notion, and I'm sure everyone else does, that the board members be selected from the community's pool of skilled persons. We would never want to see the notion of moving to elected boards, as that has not proven to be very effective in other jurisdictions. But certainly the real key of the LHINs is going to be what that selection process is.

There are obviously many issues that actually need to be contained within the regulations, and it's likely the issues that will come into regulations that perhaps are of greatest concern. In terms of how hospitals negotiate accountability agreements with the LHINs is going to be terribly important to us, so there is a sense that there should be some reflection of what that process may look like in the legislation.

Next, providing an explicit consultation process on the integrated health service plans; in other words, spelling out at least some parameters as to how the creation of that plan is actually to take place, because that is the document that's going to be the road map for future health service delivery in the community. How we actually arrive at that and how we actually participate in that process is very important to us.

Some other issues that need further clarification—and again, recognizing that a lot of these will likely come out in regulations—are things like the extent, manner and timing of funding responsibilities. We know that we are going to move to a totally different funding model which, as you can appreciate, does scare people as to what that will mean for their individual institutions.

The issue of hospital accountability agreements: We're actually now into our first year of these new agreements. How will the sign-backs actually work with the LHIN? Will the Ministry of Health totally be out of the process? Is there an ability to have an appeal process to the ministry? Again, maybe getting into more of the details.

Another issue is really the silence related to the relationship with our physicians. That is something that I think needs to be looked at within the context of LHINs. What will this mean as it relates even to our legal relationship with our physician groups?

Kevin mentioned that we are academic health science centres. We actually do believe that within the context of LHINs there needs to be some specific reference to an association of every LHIN with an academic health science centre, as the reality is that there are 14 LHINs and there are academic health sciences centres in only about half of them. So those that don't have an academic centre should have a formal affiliation.

Reference was made in the previous presentation as to how it applies to the private sector. Obviously, we want to keep a fair and common system in place—certainly an implication for facilities with provincial programs for major teaching hospitals. People want to know how we will be assured that these provincial programs carry on.

1040

There is need for a specific reference to an appeal mechanism for a variety of aspects of the legislation, and

I'm sure you've heard that from many others. We certainly feel that is very important, the criteria for decisions and orders in terms of how this will actually work. Kevin mentioned the denominational safeguards required. There are question marks around the labour relations implications and, obviously, questions about a lot of the issues that are not within the LHINs, such as academic and especially hospital roles, physicians and provincial programs.

Finally, we all know that working effectively and efficiently together is an attitude, and it's about relationships. One of the things that we've noticed in our LHIN area, frankly, for people who have been in our community a lot longer than I, is that in the last six months, whether it's the fear of LHINs or not, we've actually accomplished more working together in six months than happened in the previous 60 years. So we do see it in a positive way.

Thank you very much.

The Chair: Thank you. There are about three minutes, one each. I'll start with Mr. Ramal, please.

Mr. Ramal: Thank you very much for your presentation. I was listening carefully to what you said, and I agree with most of the elements you mentioned, but I want to speak to your concerns. First, I have a question, and also some comments.

First, the question: What's the reason behind wanting every LHIN affiliated with an academic health science centre? Second is my comment, which turns into a question: Why are you concerned about the accountability agreement being different, now and in the future when the LHIN has been established, since we don't talk about it in the bill? Is there going to be a difference? You don't think it will be very important, since the LHIN people will be selected from the community, will be in touch directly with the needs and issues of the hospitals and health care providers, and will give you a better perspective, a better idea and a good relationship between the LHIN and the accountability agreement?

Dr. Smith: Let me maybe take a stab, and I know Murray will correct me where he disagrees. I think the academic health science centre component is very much related to tertiary programs. That's where tertiary programs resign—reside, rather. Some days, it feels like "resign." Beyond that is the nature of education and research, renewal of the professions. Frankly, the academic health science centres are the port of last call, when you're transferred to the tertiary facilities of the province. Beyond that, there is nowhere else to transfer you, number one.

Number two is the outreach component of both technology and treatment. It's very important, in my opinion, for all of us to be working on a playing field with common information. If academic health science centres can have a relationship between multiple LHINs, and LHINs can all have a relationship with an academic health science centre, we can in fact build the basis of research and education into all LHINs, as opposed to those that have traditionally been with teaching hospitals.

Mr. Martin: I think the bottom line is that we feel that those that do not have a relationship will be disadvantaged, because of the unique resources that are part of an academic health science centre.

Your second question?

Mr. Ramal: Your concern about accountability.

Mr. Martin: The concern is obviously any change process in terms of what drives what. You could actually end up with very different dynamics within each LHIN. You could have one LHIN that wants to see things very decentralized; you could have another that is very centralized. Who actually is going to decide on what the drivers of the overall direction of a LHIN are going to be and how that reflects into an accountability agreement?

The Chair: Thank you. Mrs. Witmer, please.

Mrs. Witmer: Thank you very much for an excellent presentation. I appreciate the co-operative manner in which you presented it, and I would certainly support the inclusion of an academic health science centre for each LHIN to have the lead.

You're proposing that there would be some criteria for the decision-making process and the orders that would be issued. I wonder what type of criteria you think should be included there, because I think this is going to be, obviously, a very contentious area once decisions are made.

Mr. Martin: An example would be the one I just referred to, whether services are to remain as they're currently distributed, or is there a desire to move to a more decentralized model or a more centralized model, or is it simply going to be economics that drives decision-making in program allocations, and those types of decisions.

Dr. Smith: Clarity of outcome and purpose, I think, is really the basis. So if we need to make decisions based on population, demography or growth versus perhaps ability to pay or economic realities, that needs to become transparent, number one. Number two, as people go back—and they will, as we try to push things together—it will be important for providers and consumers to be able to see the data that led to a decision. I think we're appealing to the view that if people have access to information and understand why a decision has been made and can replicate some of that by way of information sharing and critique, then we have a much better chance of acceptance.

The Chair: Ms. Martel.

Ms. Martel: Thank you for being here this morning. On page 4, you list your areas of potential concern. On your point number 4, I may paraphrase, but I think you said there are question marks around labour relations implications. Can I ask you what that's a reference to?

Mr. Martin: The reference is really just uncertainty. Is there intended to be an overall direction? There was discussion previously about the issues of contracting out or non-contracting out. Frankly, we would certainly hope that whatever is done is done in a way very thoughtful of the impact on organizations. There is an element of contracting out that currently exists. To go to a total ban on contracting out has a significant financial implication to it. We would hope that decisions like that would be made understanding those realities—those kinds of issues.

The Chair: Thank you very much for your presentation, gentlemen.

ONTARIO COALITION OF SENIOR CITIZENS' ORGANIZATIONS

The Chair: The next presentation is from the Ontario Coalition of Senior Citizens' Organizations, Lisa Hems, please, and Ethel Meade. Good morning.

Ms. Lisa Hems: I'm Lisa Hems and I'm with OCSCO, the Ontario Coalition of Senior Citizens' Organizations. Here to speak today is Ethel Meade, our co-chair.

The Chair: Okay. Please start your presentation any time.

Ms. Ethel Meade: Good morning. The Ontario Coalition of Senior Citizens' Organizations—we generally say "OCSCO" for short—for whom I speak today, is a coalition of 150 Ontario seniors citizens' organizations in Ontario with a combined membership of half a million seniors. Our mandate has been, from our beginning 20 years ago, to enhance the quality of life of Ontario's seniors. This includes their two top concerns, which are about appropriate and affordable housing and health care. We appreciate the opportunity to participate in these hearings, because this bill is of particular concern to seniors who, as we all know, are the major users of health care.

OCSCO stands strongly opposed to any move that increases the creeping privatization in our health care system. We support a completely public system which allows no room for the profit motive to drive any decisions concerning our health care.

Integrated health care has always sounded attractive. While the Canada Health Act, which Canadians value so highly, never contemplated anything beyond the cost of hospitals and doctors, current experience has shown that health care today has many more sectors, including pharmaceuticals; rehabilitative care delivered in the community, in the home or at dedicated hospitals and ambulatory care centres; in-home care for post-acute patients; supportive community-based care for the chronically ill, the disabled and for older persons with age-related functional deficits; and long-term-care homes.

1050

Every Canadian will, at some time, need care from one, two, three or more of these sectors, often simultaneously. Integrating all sectors of our system could produce what many of us have dreamed about and talked about for years: a seamless continuum of care within which patients could move as their health needs require, among various levels of care, and move without delays or hassles.

With our currently fragmented health care system, integration means a lot of changes, and change is never easy. "Transformation," the current buzzword, means very complicated and, by definition, very difficult changes. The work of everyone involved in health care will be affected, and the experience of ordinary citizens may be affected even more.

We are looking at how the provisions of Bill 36 would affect us as seniors and what opportunities it would provide for input from all of us, including ordinary citizens and organizations that serve them or advocate on their behalf.

Our first concern is about not-for-profit delivery of health care. Many of our members are wondering if the whole LHIN project is a backdoor way to bring in two-tier medicine. We trust this is not the government's intention, but there is not much in the legislation to reassure them. Is the purchaser-provider split merely a more palatable phrase for managed competition? We have not forgotten how public-private partnerships were given the more palatable name of "alternate financing initiatives."

What is missing is a clear prohibition against allowing profit-seeking businesses to invest in any sector of our health care system. Experience in various parts of the world have made it abundantly clear that when the profit motive drives decision-making in a public program, the cost goes higher and the service to the public goes lower in both quantity and quality.

OCSCO believes that the managed competition model in home care is a case in point. It has resulted in for-profit agencies squeezing out more and more non-profit providers. The quality of care has suffered, and communities have suffered from losing community service agencies that have for many years played a substantial role in promoting caring and coherent communities.

Moreover, the contracting out of so-called non-clinical services to for-profit providers has been a disaster in many jurisdictions. It leads to an unstable workforce, a lack of continuity in the services provided, as well as a very dangerous worsening of sanitation in our health care institutions.

We believe that Bill 36 should include an explicit commitment to the Canada Health Act and a proactive stance on strengthening and increasing the proportion of health care services allotted to not-for-profit entities.

Our next concern is about public consultation. We have noted the provision, repeated several times in different sections, that LHIN boards and organizations of health providers must make no decisions that are not in accord with the strategic plan being prepared by the Minister of Health. That plan has not, however, been made public, so we are, in effect, being asked to comment on the means to an unknown end. Another way of saying this is that with Bill 36, we're being asked to buy a pig in a poke. We have heard no indication that public consultation about the strategic plan is being contemplated. Does the government consider the Minister of Health to be infallible?

We have not forgotten that the crucial matter of defining LHIN boundaries, as well as eliminating district health councils and their traditional boundaries, was carried out through a method chosen by the ministry. Public input was invited only on minor adjustments to the boundaries that had already been selected, yet this may

have been the most critical decision in the whole transformation process.

While we welcome the inclusion in Bill 36 of a section called "Community engagement," we are not at all sure when and by what means such engagement will be allowed. Open board meetings is an excellent first step, but it is qualified in the legislation by the provision that the cabinet will determine by regulation which subjects should be discussed behind closed doors. And instead of a specified number of days of public notice being required, the legislation requires boards to give the public "reasonable" notice of board and committee meetings. Explicit parameters for public engagement should be included in Bill 36.

We welcome also the end of cabinet appointment of board chairs and executive directors of community care access centres and their return to community control. But again, the way this will be effected is murky and obviously will take a long time. The legislation makes clear that we are not to expect any provision under the "Community engagement" section to be actualized until at least a year after the legislation has been enacted.

The provision for health professionals advisory committees seems reasonable, but it is disappointing that no provision has been made for seniors advisory committees, which the many community and health provider organizations affiliated with the Elder Health Coalition have been urging for well over a year.

The integration of care for the elderly should be an immediate and crucial undertaking for LHIN boards, because we all know that seniors are, proportionately, the major users of health care. Priority-setting workshops across the province recognized that senior health care and care for the mentally ill should be the top priorities for service integration. The voices of seniors need to be continuously available to every LHIN board. Bill 36 should explicitly mandate seniors advisory committees for every LHIN and, at the ministerial level, for the development of the contemplated strategic plan.

Our next concern is with the foundation of all policy-making, which is funding.

No policy can be put into effect unless adequate funding is made available. There has so far been no indication of the basis on which funds will be allocated to the local health integration networks. Will it depend on population viewed through an age/gender lens? Will it be considered with a more finely differentiated lens? Will it depend on the persuasiveness of the board chairs? Will it be adequate to meet the actual health care needs of each region's population?

We know from experience over the years that government policy may be unarticulated but made fully effective by government funding decisions. Home care is a flagrant example. The previous government gave responsibility to the community care access centres to provide both post-hospital care and ongoing supportive care for the disabled, the chronically ill and persons with age-related disabilities. The funding provided was never adequate for the access centres to carry out both functions, and with patients being discharged from hospitals quicker and sicker, the available resources were absorbed more and more by the needs of discharged patients who were indeed sick enough to need in-home care urgently. Supportive in-home care has thus virtually disappeared, without anyone in government ever acknowledging that their policies effectively eliminated it.

The government must ensure that LHINs' funding is adequate to meet the actual health care needs of Ontario's population.

In conclusion, we hope that the government will give serious and respectful attention to the problems raised in these hearings and to the recommendations proposed to deal with those problems. Transforming our public health care system is a huge undertaking, affecting every Ontarian, and it will succeed only to the degree that the public, as well as health care providers, buy into it.

We have therefore concentrated our attention in this submission on three crucial questions:

—Will there be adequate opportunities for public input before changes are made?

—Will there be adequate guarantees that our health care will be delivered by non-profit public health entities?

—Will there be adequate funding to meet the actual health care needs of the people of Ontario?

OCSCO appreciates the opportunity to place our views before this committee, and we'll be glad to answer any questions from committee members.

The Chair: You've finished right on the 15 minutes, so thank you very much for your presentation. There's no time for questions.

1100

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 2280

The Chair: The next presentation will be from the Canadian Union of Public Employees from Peterborough. You already know that there will be 15 minutes in total for your presentation and potential questions. We welcome you here in Toronto. You can start any time you're ready.

Ms. Candace Rennick: Any time I'm ready?

The Chair: Yes. We are ready.

Ms. Rennick: Did the clerk pass out copies—

The Chair: Yes, she did. Two pages, I believe.

Ms. Rennick: Yes, that's right.

My name is Candace Rennick. I'm the president of CUPE, Local 2280, which represents 200 long-term-care workers at a not-for-profit charitable organization in Peterborough, Ontario, called St. Joseph's at Fleming. I also have the great pleasure of representing over 200,000 CUPE members in Ontario as a CUPE national regional vice-president and as a vice-president to the Ontario Federation of Labour.

Our members provide services at the facility in housekeeping, laundry, dietary, maintenance, recreation and nursing services, and our members provide the best care

that they can in a seriously underfunded system which has no minimum hours of care for residents. They take the work they do very seriously, and they're more than a little concerned that the government of Ontario has done little or nothing to consult with a huge workforce about LHINs, about introducing competitive bidding, about privatizing support services or about what kind of change is really needed for the Ontario health care system.

Bill 36 specifically targets not-for-profit long-term-care facilities like St. Joseph's at Fleming in Peterborough. I appreciate the opportunity to be here with you today to share with you, on behalf of the members I represent, the concerns we have around Bill 36 and the unprecedented powers it hands over to the Ministry of Health and Long-Term Care. I thought that my own MPP, Jeff Leal, would be here today, but unfortunately he's not.

The Chair: I was with him on Friday. He's the PA for energy, and we are debating that bill, so he can't leave. But we will certainly let him know.

Ms. Rennick: Fair enough. I was actually just going to acknowledge and remind Jeff that on July 28 in his constituency, I met with him to discuss the concerns I have around the legislation—and many of those I'll provide today in my presentation—but unfortunately, to this day I have not had a response to those questions. I did, however, get a response from a Ms. Gail Paech thanking Jeff for his support of the appointment of the LHIN CEO in our area. Unfortunately, noticeably absent from that response were any answers to the questions we posed to Jeff that day. I certainly don't mean to single out Mr. Leal. Dozens of our members have met with Liberal MPPs and are still awaiting answers to the questions they have on the LHINs.

On the subject of consultation, I want to note the irony of having to travel over 150 kilometres to make a presentation to you here today, especially on something as important as health care. It seems like this may be a reflection of what business will be like under a LHIN: travelling hundreds of kilometres just to be seen and heard. I might take the opportunity to note that there was a massive snow squall on the 115. Several cars were in the ditch between two cut-offs. If circumstances were a little more dramatic out there on the roads, it's quite possible that I might not have been here to give this presentation today. It also speaks to the fact that people having to travel to access services may not be able to make those services, just based on the fact that traffic is bad, the roads are bad, and stormy weather hinders travel. And did I mention that I'm a part-time worker in a one-vehicle family with little or no resources to travel or miss work? I'm concerned that the so-called integration this legislation will introduce will require patients and family members to travel further for care. So having to travel 150 kilometres to meet with the standing committee reviewing the legislation does not bode well for the future, in my opinion.

I have split my presentation up into four categories, and I will attempt to cover all my points under the following four headings: accountability and community control, access to services, privatization and protection for workers. I have made recommendations for each of the headings, and they've been provided to you.

Bill 36 grants little power to local communities and providers to make decisions. Instead, it transfers control over local, community-based providers to the minister, cabinet and their agents, the LHINs, thereby centralizing, not localizing. This province does not need another level of bureaucracy. We need government accountability and transparency in all the decisions that affect the way we deliver and access health care.

The proposed geographical boundaries are not boundaries that reflect our local community. The central east, which is where I will work, live and access services, spreads from Victoria Park to Algonquin Park. Seriously, what does the community of Haliburton have in common with Scarborough or even Oshawa? How likely is the community of Lindsay going to be able to compete with communities like Ajax or Whitby? How can all of these communities possibly have a voice at a single table responsible for the entire area? More importantly, how will the LHIN make sure that it is accountable to each and every community for each and every decision?

It concerns me a great deal to think that the CEOs heading the LHINs are hand-picked and will be working under pressure of potential termination if they don't meet the directions of the government, yet I would suspect that the government will be using the LHINs as a shield for political purposes.

We elected the government of Ontario, and we have a right to expect that our valuable public services and access to health care will be protected by that government. Historically, as a rule, health care and social service organizations are not appointed by the provincial government, and I would recommend that this provincial government respect that long-standing practice.

Community-controlled boards have the ability and the desire to ensure that services are available in their community, and when those services are threatened, they have the political will to change that. I'm concerned about a board that is so non-representative. Is the Central East board really going to understand the needs of the residents of Peterborough or Campbellford?

How will funding within a LHIN be prioritized? In Alberta, they have nine health boundaries, and with that, they have nine different funding models in long-term care. Can one expect that the LHIN will be funding nursing homes differently and, more importantly, can we expect the same level of care and quality of service in each LHIN?

Community control must be strengthened. I have provided a list of seven recommendations on how that can be achieved. If there is time at the end of my report, I would like to review those recommendations with you.

As services are integrated, this will most likely have the largest impact on smaller, more rural communities. In our area, Lindsay, Campbellford and Haliburton are only a few. As services are dedicated to only a few hospitals or clinics, what does this mean for our ability to access

services in our community? It suggests that you will have to travel to other communities possibly hundreds of kilometres away and, in addition, you will have to compete with all the other patients in your LHIN waiting for the same service that may only be provided at one or two facilities. What does this mean for the elderly couple trying to access services to keep their health well enough to stay in their home? What about the outpatient who isn't allowed to drive after day surgery? Are we going to keep them overnight or perhaps cover the cost of their 100-kilometre taxi fare? Or are we going to download more pressure onto the person?

In December 2005, the maternity ward at the Rouge Valley Hospital was threatened. The proposal was to temporarily close the unit and transfer it to Scarborough. Community residents feared that if it left, it would never come back, so they organized and rallied and they saved the maternity ward. That was real life, right down the road in my own LHIN: saved by the community looking out for the best interests of the public. If that was a threat for communities like Ajax and Whitby, then who is to say that couldn't happen in our own community? Imagine not being able to give birth in a community like Peterborough.

Access to local services must be protected. Integration will remove jobs and services from local communities. Picking up and moving or finding a new job is not an option and, frankly, should not be expected. People have built their lives in these communities. They work there, their children go to school there and they should have the right to expect that they will be able to access health services there. A reduction in community control and provincial accountability will make it easier for the government to force this type of reform. If the provincial government is not fearful of giving up their unprecedented powers under this bill, then they will consider and introduce the six recommendations that have been provided to you in your package under the heading "Protect Local Services and Access to Care."

Disturbingly, there are no provisions in the bill which ensure, require or even encourage LHINs, the minister or cabinet to preserve the public, not-for-profit character of our health care system. Instead, these bodies will now be armed with the legal authority to privatize large parts of our publicly delivered health care system. As a worker coming from a not-for-profit long-term-care facility, I have great concerns about the negative impact Bill 36 will have on not-for-profit delivery in long-term care.

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The legislation not only jeopardizes the future of not-for-profit long-term care delivery, but clearly discriminates against not-for-profit providers and could result in the expansion of for-profit delivery in this sector. The legislation creates an unfair advantage to for-profit providers. Section 28 gives the minister sweeping powers over not-for-profit organizations, including the authority to integrate, merge and even close. As an employee in a not-for-profit home, these powers concern me, especially when the bill gives no such powers to the ministry over the for-profit sector.

The government of Ontario has said that the proposed legislation does not provide for more privatization. On the contrary, the simple fact that section 28 excludes for-profit providers suggests that Bill 36 very clearly opens the door to increased private delivery in long-term care. What do these powers mean for St. Joseph's at Fleming, a charitable, not-for-profit institution in our community? It means that when a facility is forced to close in the community, the not-for-profits will be forced to close first, each and every time. Such a risk would deter people from wanting to operate in a not-for-profit capacity. I would ask if anybody has a rationale or an explanation for that, and why that power would be necessary and so discriminatory. I'd certainly like to hear it.

The LHINs will also create a split between the purchasers and providers of health care. Such a split has already been established in the home care sector, where CCACs purchase home care services through a disastrous system of competitive bidding. I won't get into the stats, as I'm sure you've heard them, but the increase in for-profit delivery since competitive bidding was introduced has skyrocketed. The government of Ontario should be moving toward a model that eliminates expansion of for-profit delivery of health care, not setting up measures that support the opposite.

A recent study conducted by the Ontario Health Coalition identifies that 1,000 home care workers were laid off in a period of eight months as a result of their employer's losing contracts to competitive bidding. This model does not belong in the health care sector. The facts prove that it creates a life of uncertainty and vulnerability for workers in the sector, the majority of whom are women, most likely women of colour working with inferior benefits and often no pensions, who are among the lowest-paid. They should not have to work and live in fear of their employer not being able to compete.

In Britain, over the last 20 years they have introduced the purchaser-provider split in health care, leading to massive privatization expansion. With this split, every new contract has the potential to divert resources to the for-profit sector. So with every new contract an opening has been created for privatization. While the government of Ontario has sold LHINs as a way to integrate services, the purchaser-provider split has led to fragmentation in Britain. Funding comes by winning contracts. Private diagnostic and surgical clinics have taken over work previously done in hospitals, despite costing more, and hospitals that cannot provide a service for a set price have to subsidize it or give up providing it altogether.

All this change has led to serious problems for the British health care system. Despite more than doubling the funding since 1997, the service is running into a funding crisis with massive debts, bed closures, operating closures and thousands of layoffs. If that model is duplicated through the LHINs here in Ontario, it will create a known recipe for disaster. Does that description represent the Ontario we want: massive debts, bed closures, operating closures and thousands of layoffs? I don't believe that it does.

Privatization and decreased co-operation between providers are major threats of this reform. The institution of the purchaser-provider split and the expansion of privatization in health care and social services should not be part of this health care reform. We ask you to rethink this reform. I have attached recommendations under the title "Stop Privatization—Build Co-operation." Please ensure that these recommendations are seriously considered so that the disastrous model of competitive bidding and the expansion of for-profit delivery are prohibited under this legislation.

Do I have time left?

The Chair: You have only a minute. You can use it, or we can ask questions.

Ms. Rennick: I'm just not done. Last but definitely not least is protection for workers. Many unknowns are causing worry among workers in the health and social services sectors. Any restructuring must fully protect the rights of workers. Some changes are necessary. Please see attached the three recommendations. Workers' rights must be protected.

In closing, I must say that I don't believe the Ontario government has a mandate to plow through this type of radical reform. An approach of consultation with local communities, health care workers and the public about how health care should be reformed is much more democratic and transparent. Canadians, including Ontarians, have built a public health care system that is envied by the world. We need to continue to maintain the standard of quality, accessible, not-for-profit delivery of services that so many don't have the privilege of enjoying. We have a responsibility to maintain that standard, not just for the rest of the world but for future generations right here in our own province. While I don't claim to be an expert on this bill in any sense of the meaning, I'd like to know, as the government has constantly given us reassurances that this bill is not harmful, where in the bill does it say that it won't lead to more privatization, that it won't close hospitals, that it won't create a life of uncertainty for workers and patients and that it won't lead to an inferior level of care in our province?

I thank you very much for the opportunity to be here today. I hope that due consideration will be given to each and every recommendation.

The Chair: I know there are people who want to ask you questions, but there's no time. Forgive me for that. Maybe the whip should let her MPP know that she has questions and maybe he, or any of you, can ask those questions later on. Thank you for your presentation.

Ms. Rennick: Thank you very much.

ASSOCIATION CANADIENNE-FRANÇAISE DE L'ONTARIO DU GRAND SUDBURY

The Chair: The next presentation is going to be a teleconference en français. Richard Théoret, are you on the line?

Mr. Richard Théoret: Yes.

The Chair: Would you please proceed with your presentation. There will be 15 minutes in total. We also have someone who can assist us if there's a question in French. So please proceed with your presentation, and good morning.

M. Théoret: Good morning. Mon nom est Richard Théoret. Je suis président de l'ACFO du grand Sudbury.

L'ACFO du grand Sudbury a pour but de promouvoir le développement et l'épanouissement de plus de 50 000 Franco-Ontariens sur son territoire, qui s'étend des limites de la municipalité de Markstay-Warren à l'est, la Rivière des Français au sud, Espanola à l'ouest, et la ville du grand Sudbury au nord. Elle agit en concertation avec les organismes qui travaillent à la promotion des intérêts et à l'amélioration des services aux francophones dans tous les domaines tels la santé.

L'ACFO du grand Sudbury s'intéresse au dossier santé depuis déjà quelques années, et il nous apparaît essentiel de vous faire part de nos inquiétudes relativement à la réforme de santé en Ontario et, plus précisément, de la Loi 36 et de certaines de ses faiblesses.

Selon nous, des services de santé de qualité ne se résument pas uniquement à un acte technique consistant à soigner les gens. Une prestation de qualité est aussi étroitement associée à la capacité des intervenants de soigner, aider, conseiller, orienter et éduquer les utilisateurs de service. L'accessibilité à des services de santé dans sa langue constitue par le fait même bien plus qu'un respect pour la culture de l'utilisateur de service. Il s'agit d'un élément parfois essentiel à l'amélioration des conditions de santé et à l'approbation de la santé par cette population.

L'Organisation mondiale de la Santé a développé une définition de la santé qui est maintenant largement acceptée. Selon l'Organisation mondiale de la Santé, la santé est un état de complet bien-être, un état de bien-être qui est autant physique que mental ou social. La notion de services de santé prend alors un contour bien différent que si l'on définit la santé comme étant l'absence de maladie, notamment physique. Ainsi, en envisageant la santé sous un angle plus large, on se doit également de reconnaître que les services de santé couvrent un éventail d'activités qui dépassent les aspects curatifs et embrassent par le fait même des actions de prévention, de promotion et d'éducation à la santé. L'approche des déterminants de la santé développée au cours des dernières années insiste également sur plusieurs facteurs qui relèvent des comportements individuels, des styles de vie, des conditions socio-économiques.

En Ontario, le deuxième rapport sur la santé des francophones confirme que la population francophone possède des caractéristiques qui lui sont propres et qui ont un impact sur la santé. Par exemple, elle est plus âgée en moyenne que le reste de la population; son niveau de scolarisation est moins élevé que le reste de la population; elle a une moins bonne perception de leur santé; elle a une proportion de fumeurs quotidiens plus élevée; et finalement, elle a un plus faible sentiment d'appartenance.

En vertu de la Loi sur les services en français de l'Ontario, chacun a droit à l'emploi du français pour communiquer avec une organisation gouvernementale se situant dans une des 23 régions désignées. Malgré l'entrée en vigueur de cette loi en 1989, il reste difficile pour une bonne part de la population francophone d'avoir accès à des services de santé en français.

D'ailleurs, l'étude Pour un meilleur accès à des services de santé en français, publiée en 2001 et coordonnée par la Fédération des communautés francophones et acadienne du Canada, révélait que moins de 41 % des francophones en Ontario ont accès à des services de santé en français.

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Pourquoi est-ce si difficile d'obtenir des services de santé en français? Pourquoi est-ce que les personnes âgées en perte d'autonomie avancée, francophones et unilingues se retrouvent placées dans des établissements où il n'y a pas de services en français?

Nous le savons. Le système de la santé en Ontario doit faire face à des défis de taille : augmentation des besoins de services de santé et vieillissement de la population, réduction des revenus de la province, augmentation des coûts des médicaments, pénurie de professionnels etc. Dans ce contexte, il est vrai que des changements sont nécessaires pour permettre de mieux faire face aux défis présents et à venir.

La décision de régionaliser la prise de décision en regard de la planification et du financement des services de santé est sans doute une bonne nouvelle. En effet, les réseaux locaux d'intégration des services de santé—RLISS—devraient permettre aux différents milieux d'avoir plus de place dans la prise de décisions. Nous pouvons souhaiter des solutions répondant mieux aux besoins locaux. Cet impact est également à souhaiter pour les services en français.

Malheureusement, la Loi 36 présente des faiblesses importantes qui risquent encore une fois de nuire au développement des services de santé en français et à leur maintien. Ainsi, malgré la Loi sur les services en français, la Loi 8, et malgré la volonté de régionaliser la prise de décisions, les francophones resteront pris avec les mêmes problèmes d'accessibilité à des services de santé en français.

Rien n'indique que les réseaux locaux d'intégration des services de santé se préoccupent des besoins spécifiques aux francophones. En effet, respecter les exigences de la Loi sur les services en français n'est pas suffisant. Nous en avons les preuves aujourd'hui. Ainsi, il est recommandé que le paragraphe b) de l'article 5 à la partie II de la Loi 36 soit modifié comme suit :

« Déterminer les besoins du système de santé local en matière de service de santé »--et nous voudrions ajouter—« dont les services de santé en français »—et nous pouvons continuer—« et prendre des dispositions à leur égard conformément aux plans et priorités provinciaux et faire des recommandations au ministre au sujet du système, y compris ses besoins de financement et d'immobilisations; »

De même, le fait de respecter les exigences de la Loi 8 n'implique pas nécessairement la consultation et l'implication des francophones dans la planification des services. Ainsi, il est recommandé que le paragraphe c) de l'article 5 à la partie II de la Loi 36 soit modifié comme suit afin de garantir que la population francophone soit également consultée relativement à ses besoins :

« Engager la collectivité de personnes et d'entités qui oeuvrent au sein du système de santé local dans la planification du système et l'établissement des priorités de celui-ci, y compris l'établissement de mécanismes formels pour la consultation et la participation de la collectivité »—et nous voudrions ajouter—« dont la communauté francophone; ».

Il est écrit dans le paragraphe b) de l'article 5 à la partie II de la Loi 36 que chaque réseau local d'intégration des services de santé doit déterminer les besoins du système de santé local en matière de services de santé et prendre des dispositions à leur égard conformément aux plans et aux priorités provinciaux. Comment alors s'assurer que les réseaux locaux d'intégration des services de santé détermineront les besoins de la population francophone si le plan provincial ne le fait pas? Ainsi, il est recommandé de modifier comme suit l'article 14 de la partie II de la Loi 36 :

« Le ministre élabore pour le système de santé un plan stratégique provincial qui comprend une vision, un ensemble de priorités et une orientation stratégique »—et nous voudrions ajouter—« adressant entre autres les services en français »—et nous pouvons continuer—« et il en met des copies à la disposition du public aux bureaux du ministère. »

Finalement, rien dans la Loi 36 ne protège les francophones contre les décisions d'intégration ayant un impact négatif sur l'accès aux services de santé. Ainsi, il est recommandé qu'il soit ajouté une interdiction supplémentaire à l'article 25(3) de la partie V de la Loi 36 :

« Aucune décision d'intégration ne doit pour effet d'affecter négativement le développement, la qualité et le maintien des services de santé offerts en français. Toute décision d'intégration ayant un impact négatif sur les services en français est contraire à l'intérêt public ».

Pour terminer, je voudrais vous remercier de votre attention. Tout comme il est plus facile de prévenir que de guérir, nous vous recommandons donc d'imposer des conditions claires et précises maintenant pour la prestation des services plutôt que de tenter de réparer les pots cassés dans quelques années. « An ounce of prevention is worth a pound of cure, » comme diraient les anglais.

Nous espérons que la Loi 36 permettra de mettre un système de santé intégré permettant d'améliorer la santé des Ontariens et Ontariennes grâce à un meilleur accès aux services de santé, incluant les services de santé en français.

Merci beaucoup. Est-ce que vous avez des questions?

The Chair: Merci, monsieur. Nous avons trois minutes. Mr. Arnott, one minute each, please.

M. Ted Arnott (Waterloo–Wellington): Monsieur Théoret, merci beaucoup pour la présentation.

M. Théoret: Ça fait plaisir.

Mr. Arnott: We have heard from a number of representatives of the Franco-Ontarian community during the course of these hearings over the last few days about the issues you have raised, and I want to thank you as well for your particular expertise in this area. Do you have confidence that the government is listening to your concerns, and have you had any reassurance of amendments forthcoming?

Mr. Théoret: No, but we are proposing a number of amendments because we feel that, while Bill 8 is an adequate piece of legislation, this is a specific piece of legislation that we feel could be reinforced if certain guarantees are put in the act.

The Chair: Madame Martel, s'il vous plaît.

M^me^ Martel: Merci, Richard, pour votre présentation ce matin.

M. Théoret: Bonjour, madame Martel.

M^me^ Martel: Je voudrais vous remercier pour votre identification des faiblesses du projet de loi, mais aussi, plus important, pour les détails des recommandations pour les amendements du projet de loi. Je voudrais savoir, est-ce que l'ACFO du grand Sudbury ou même l'ACFO provincial a eu des discussions avec le ministère de la Santé ou le ministre à propos du plan provincial stratégique pour la santé? Est-ce que vous êtes impliqué dans des discussions en ce moment à propos du plan provincial?

M. Théoret: La réponse est non, parce que l'ACFO de Sudbury ne travaille pas au niveau provincial. Mais je sais qu'au niveau de l'ACFO provincial, étant donné qu'on a une restructuration présentement, je ne peux pas savoir si celui-ci travaille avec le ministère. Par contre, je sais qu'une alliance des réseaux de santé travaille étroitement avec le ministère.

M^me^ Martel: Vous attendez ce rapport en ce moment, parce que le rapport a été rendu au ministre, mais les recommandations ne sont pas publiques en ce moment.

M. Théoret: Vous parlez du rapport de M. Savoie?

M^me^ Martel: Oui, c'est ça.

M. Théoret: Oui, on n'a pas évidemment vu le rapport. Donc, on n'est pas prêt du tout à commenter sur le contenu du rapport.

M^me^ Martel: C'est un peu difficile de savoir si on va avoir des améliorations ou non en ce moment. Tout le monde l'anticipe peut-être, mais c'est difficile parce les recommandations sont encore privées.

M. Théoret: Exactement.

Le Président: Merci. Madame Wynne, s'il vous plaît.

Ms. Wynne: Mr. Théoret, I apologize for speaking in English.

I just want to follow up on the issue of the conversation between the ministry and the francophone community, and to let you know that the issue that's being discussed is that the francophone voices need to be heard and there need to be protections in the legislation. I have also not seen amendments at this point, but I know that the report is being reviewed. I look forward to seeing those amendments that I hope will go some way to addressing your concerns.

Mr. Théoret: We're certainly hopeful also.

Ms. Wynne: Okay. Thank you very much.

The Chair: Merci, monsieur. Thank you for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1487

The Chair: We will be moving to the next presentation, Janet McIvor and Zoran Pivalica. Would you please have a seat. Good morning again. You have 15 minutes in total for your presentation. You can start any time you're ready.

Ms. Janet McIvor: Good morning. My name is Janet McIvor. I'm a registered practical nurse. I work at the Scarborough Hospital, general campus, and I am also a local activist in my CUPE Local 1487.

Mr. Zoran Pivalica: My name is Zoran Pivalica. I'm a maintenance mechanical millwright, plant operator. I'm employed by Scarborough Hospital, Grace division, and I'm a member of Local 1487.

Ms. McIvor: We are here today because we are very concerned about Bill 36 and the impact it will have on all Ontario citizens, and especially our health care system.

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First, I was a patient. I was born at the Scarborough General Hospital in 1965. Second, I'm a community member. I've spent my life in Scarborough. Third, I was a patient again when I was five years old and was seriously ill. At that point in my life I decided I wanted to be a nurse and I wanted to work at the Scarborough General Hospital. The tower was always the landmark that, when I drove by as a kid, I said I was going to work there. I did my nursing training at Scarborough General and I became an employee there in 1985. I had my child at Scarborough General and I met my life partner at Scarborough General, who also was born at the hospital and had his children there. Also, his mother worked there, his brother works there and his sister-in-law works there. I tell you all this to let you know that I'm not here just as a CUPE representative but I'm here because I'm a patient, I'm a community member, I'm an RPN and a patient advocate, and I'm an advocate of our public health care system.

In truth, there are thousands of Ontario health care workers just like me, people who care about people, who work in our health care system because of our calling to help people. We are unique. We are here and dedicated through all the difficult conditions that we face in the health care field: death, terminal illness that lingers, infectious diseases, patients and family members under tremendous distress and uncertainty, body fluids, confused patients who become violent and injure health care workers, 24-hour shift rotations, working holidays through staff shortages, high workplace injuries and always-increasing workloads. We are here because we

care. We are professionals. We need to be valued, encouraged and supported by our government, not demoralized, devalued and left with total uncertainty with regard to our futures yet again.

As an RPN and patient-employee advocate for 20 years, I've had the privilege of being on many hospital committees: nursing councils, operation plan, fiscal advisory, and healthy workplace, to name a few. I've experienced first-hand the restructuring and transformations that different governments have initiated, and in every one of these reforms, the governments have assured constituents that these were to improve our public health care system. This has not been the reality from the perspective of a patient, community member and health care worker.

The elimination of chronic care beds, long-term-care beds, in our community hospitals: We have lived through year after year of hospital budget cuts in the 1990s and the continuous closing of existing hospital beds. As an example, in 1985 the Scarborough General had 770 beds. In 1985, the Scarborough Grace had 220 beds. Now, in 2006, after our merger in 1999, we have 560 beds between the two sites. That's a loss of 430 beds in just over 20 years for the Scarborough community, which has grown substantially in that time.

No wonder there are waiting lines in emergency rooms. An easy solution is to open some of those lost beds in the hospitals you already have. We see the constant reduction in front-line staff—people who provide meals to patients, transport patients, clean their rooms and prevent infections—and a huge increase in administrative staff, whose wages are usually double that of our CUPE members. In 1996, the Health Services Restructuring Act closed many hospitals, merged hospitals and reduced beds. These forced involuntary mergers are still causing major difficulties in the fabric of these new hospitals that cannot seem to integrate different cultures and move forward as one consistent organization. One manager rep told me that it usually takes up to 30 years—a generation of employees—for the fallout from mergers to lose their negative impact on the organization culture and workplace morale. Now, with the LHINs, I can only imagine the fallout to our health care system from them and Bill 36.

Millions, probably billions, of taxpayer dollars have been spent on restructuring, consolidating, consultants and commissions in my 20 years of service. Last year alone, my hospital spent $2,700,000 in restructuring costs. There needs to be stability, accountability and true consultation with community members and health care workers to improve the health care system. Instead, health care workers feel under attack from the government—the government we elect to represent us, the government we serve as public service employees. We are called glorified hotel workers. We face continuing threats of contracting out to private, for-profit companies. We're faced with decreased staff levels and increased workloads. We're faced with high stress and workplace injuries. Some of health care workers' illnesses are directly related to the government's attitude and approach to health care workers. As front-line health care workers, we are dedicated to Ontario citizens providing the best patient care we can, yet with all the cuts, which we have no control over, we seem to be blamed for the wait-lines in emerg.

I have to focus on section 33 of your bill. As employees of the Scarborough hospital, we were at ground zero during the SARS crisis. As you know, our Grace site faced Ontario's first case of SARS. Our CUPE members and all Scarborough hospital staff rallied together to the aid of our hospital and community, working endless hours to do whatever we could to help. Several of our CUPE members ended up with SARS. Some of those health care workers are still disabled as a result of SARS. But we are dedicated to our calling as health care workers. We were there to meet the needs of our community and patients. That was not the case for the for-profit, private companies that service our hospital. Cancore, the security company, could not get guards to come to work. Agency nursing companies demanded triple pay. Merrik, the contract company that our hospital had just retained to provide cafeteria services, refused to start operations until the crisis was over. I can only imagine what would happen in a crisis situation, say bird flu, if all the support service workers at the hospital were contract companies. We would be up the creek.

Let's not pretend about how for-profit companies make their profits. They make their profits by paying hard-working people minimal wages with huge workloads, which of course leads to decreased quality and employee constituent poverty. I have an example of just what I'm speaking about in our hospital. In 2003, our hospital decided to contract out the cafeteria services to Merrik Hospitality Inc.

The Chair: Excuse me. Could you just move away a little from the mike? We are recording it and it's a little—

Ms. McIvor: Sorry. Where was I? I was talking about Merrik Hospitality. Our CUPE members who worked in the cafeteria made $17 an hour. Merrik employees start at $8.75 an hour, and their highest wage is under $10 an hour. Imagine working full-time for $8.75 an hour and trying to afford rent, food and clothing. In our city, I really don't think anyone could. Also, at that wage, do you really think anyone would stay in the job for long or show up at work in the hospital if there was an infectious disease rampant in it? If you are honest, you will see my point.

I've already touched on the reduction of beds at our hospital from 999 in 1985 to 560 today, and yet the LHINs are set with a clear mandate to continually restructure health care within each region. This means permanent instability for patients and workers. Your integration actually means mergers, transfers, wrap-up of services and contracting out of health services, as per sections 33 and 28. We already have projects under way at our hospital—HBS, Hospital Business Services, supported and funded by you—that are waiting in the wings

to take our CUPE members out of the hospital and have them working for this other company with much uncertainty and, for sure, layoffs, reduction in wages, possible loss of their pensions and who knows what else.

Threats of closed emergency rooms and consolidations of maternity and pediatric services leave us concerned about when we are patients. Increased pressure to reduce patient length of stay due to bed shortages pushes doctors and nurses to discharge patients who would be better off staying in the hospital for a day or two more. Patients who are post-discharge or visiting our emergency rooms end up back in hospital with infections or more serious complications, which would have been avoided if they had been allowed to stay in hospital a day or two more. One patient was told by his surgeon, after having vascular surgery, "You really should be staying in hospital for a week to avoid infection, but with the new directives and bed cuts, this is now a day surgery procedure and you go home straight after it." That patient ended up with an infection, costing our health care system more than if he had been able to stay there for a couple of days.

The increased pressure and decreased ability to provide the excellent patient care we desire to give are causing severe burnout and stress illness in health care workers. Many nurses, when asked if they would go into nursing today if they were just starting out, say no. With the negative, uncertain future of our health care system, it will be difficult to recruit nurses, added to the already difficult shortages of nurses. Many of our hospitals have slogans such as, "Your health care family," or "Caring together, caring for your community." We are the community and deserve healthy workplaces to live in, not stress levels over the top, pressure to reduce that jeopardizes patient care and infection control, workloads that foster mistakes and injuries, and increased sick time due to pressure and stress which trigger many illnesses and aggravate pre-existing health conditions. Mission and values statements of our hospitals talk about prevention, trust, honesty, compassion, integrity, accountability, valuing staff and commitment to continuous quality improvement. How can that be real when all the government seems to care about is reducing budgets and putting pressure on hospital boards and administrators to cut, even when they know it is not in the best interests of patient care or their staff? It seems you are taking the "care" out of "health care," and if this restructuring continues much longer, many of your dedicated doctors, nurses and clinical and support service workers will lose their "care."

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In SARS, we were heroes. Now, we are expendable. We are called an essential service, and that is why we are bound by HILDA, unable to strike after negotiations don't work and having to use the arbitration system to settle contract disputes. Yet it seems, by this government's plans, that we are not essential, and if we end up working for contract, for-profit companies, I guess we cannot be bound by HILDA. What does that mean to our health care system?

What our health care system needs is for all Ontarians to work together. You need input from all perspectives—community members, support staff, nurses, doctors, managers, administrators and, most of all, patients—when talking about health care reform. With all perspectives on the table and debated, we could collectively come up with real solutions to the issues. As well, all Ontario citizens have a right to know the implications of this legislation and the facts around LHINs.

Please keep our health care system public. Consider our seniors who have multiple health conditions and their inability to get from hospital to hospital to care for various health issues which all hospitals will not provide in the near future. Think of those who cannot afford to pay for transportation to get the care they need. Please think about us, your health care workers, whose wages could be cut in half if the for-profit companies are allowed into our public health care system. Please think about all Ontario citizens equally when deciding to deregulate services that many cannot afford. Please continue to advocate for higher standards of living for all Ontarians instead of increased profits for private companies. Amend Bill 36: Help us put the "care" back into "health care."

The Chair: You still have a couple more minutes.

Mr. Pivalica: In our submission, there is a part I want to cover, but because of the time, we will leave the rest for questions.

The Chair: Okay. We'll start with Ms. Martel.

Ms. Martel: Thank you for your presentation. I want to focus on your point about what happened during the SARS crisis, how employees of the hospital stayed on the job, providing health care services, and employees of the private companies decided not to. In the submission you didn't have a chance to read, sir, I noted that you say you saw workers of the contracting companies walking off the job and asking the companies for reassignment from the Grace. You also referenced the problem that, even though the hospital was offering triple pay to nursing agencies, they couldn't get nurses. Do you want to expand on that?

Mr. Pivalica: Yes. Our security is contracted to Cancore, and security guards walked off the job and requested to be reassigned to other organizations; they didn't want to perform the job during the SARS crisis. Also, because the ICU and the emergency department were hit very hard by SARS and we had a lot of nursing staff—a total of 64 staff members—affected by SARS, we needed nursing agencies to bring nurses into the hospital, and the agency was requesting triple pay. The hospital offered that, but still there were problems getting nurses in during the crisis.

The Chair: Ms. Wynne.

Ms. Wynne: In the five days of hearings, we've heard three or four times from CUPE each day, and I do appreciate your taking the time to come as an individual to present. But I guess one of my questions—you asked a rhetorical question about what the health system will look like after LHINs. Our approach is that the health system will look more coordinated, that there will be a

plan in place. You talked about what happened with restructuring under the previous government. There wasn't a plan. There wasn't a provincial plan, and there certainly weren't local plans. What we're trying to do with this legislation is push some of that planning function into the local community so there can be coordination, because that has been sorely lacking.

The answer from us to your question is a more coordinated system. Do you want to comment on that?

Ms. McIvor: Yes. First of all, I don't see the LHINs' geographical regions as local at all. As Scarborough hospital employees, we are grouped with Peterborough and Haliburton, and we don't see how that is local. In fact, we know that even though we're in the GTA, there are five different LHINs in the GTA.

When I was talking, I was really focusing on the aspect of how all these different restructurings, year after year, impact the staff who provide care. The fact is, it's causing major stress, major illness. We need health care workers to focus on caring for patients. It's not just nurses; it's the people who are making sure that rooms are clean and that infection isn't spread, it's the people who are transporting patients and being there to support them when they're going through the worst experiences of their lives.

The Chair: Ms. Witmer.

Mrs. Witmer: Thank you very much. I would respectfully disagree with Ms. Wynne's comments. When we underwent the restructuring of the health care system, there was a plan, and that was to provide a continuum of services. In fact, you would not be in the position you are today with family health teams if we had not initiated the primary care model and put in place the first teams, and if we had not gone through an evaluation of all the hospitals and looked at where we could provide services better and closer to home in a more efficient manner.

I understand the concern of these presenters. You're saying the bill gives the government and the minister unlimited power and takes away democratic rights from the public and communities, and we're certainly hearing it. This bill is not about local autonomy. One of the LHINs has 1.5 million people in it. Obviously, you don't know the chair and you don't know the members. Could you just expand on what power you see that is quite concerning to you?

Ms. McIvor: From my understanding, the Minister of Health can basically direct LHINs to do whatever he wants to our public health care. My understanding is that the minister can order that they wrap up services in the hospitals and let private, for-profit companies come in and provide those services. To me, that spells disaster. It also very much concerns public servants, who are here trying to do our best to provide good care to patients.

The Chair: Thanks very much for your presentation.

CANADIAN HEARING SOCIETY

The Chair: The last presentation before we break for lunch is from the Canadian Hearing Society, Toronto: Gary Malkowski, Kelly Duffin, Fred Enzel and Penny Parnes. Good morning and welcome. You can start your presentation any time you are ready.

Ms. Kelly Duffin: Good morning, Mr. Chair and committee. I'd like to thank you very much for allowing the Canadian Hearing Society to present before this distinguished group. We will try to contain our comments to 15 minutes. However, we do have two accommodations: We have sign language interpreting and we have captioning, and that does create some lag. We'd appreciate your understanding of that.

My name is Kelly Duffin. I'm the president and CEO of the Canadian Hearing Society. I'm here with my colleagues, Penny Parnes, vice-president of hearing health care; Gary Malkowski, our special adviser on public affairs; and Fred Enzel, our CFO.

The Canadian Hearing Society is a 66-year-old non-profit organization that provides services to deaf, deafened and hard of hearing people in 28 offices across Ontario. Those services include health care services, such as audiology, hearing aid dispensing, speech-language pathology, hearing health care and mental health counselling.

We come before you today, then, in two capacities: (1) as a community health care provider in the voluntary sector, and (2) as an agency serving people with disabilities.

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Before we begin, I also wanted to introduce two other community health care and disability service providers with us today: Linda Kenny, from the Canadian Paraplegic Association Ontario, and Christopher McLean, from the Ontario arm of the Canadian National Institute for the Blind. Their organizations and ours have prepared individual and independent submissions to this commission, but we endorse each other's submissions and we're pleased to provide a shared statement of principles which will be attached to our written submission for this committee's consideration.

First let me say that in principle we support the concepts attached to the creation of the LHINs: coordinated services that are customer- or patient-focused; services that match community needs; an efficient and effective health care network; and promotion of wellness, independence and aging in place. Those are in keeping with the philosophy and approach of CHS as well as CPA Ontario and CNIB.

That said, we want to make strongly four recommendations regarding the legislation as proposed:

(1) Community health care and non-profit providers, their specialized knowledge and skills, must be valued, funded and be represented at all levels of decision making.

(2) Recognition for people with disabilities and their distinct needs and rights to choose and access services must be articulated in the legislation.

(3) The drive for local planning and accountability must be balanced by the need to account for province-wide priorities and consistency of service and must not

increase the administrative burden on provincial health providers.

(4) Due process—including consultation, observance of current statutes, transition plans that minimize service disruptions, and an equitable appeals mechanism—must be better defined in the legislation.

Ms. Penny Parnes: I'd like to speak first about community health care and non-profit providers, their specialized knowledge and skills. These must be valued, funded and represented at all levels of decision-making.

What the LHINs have recognized conceptually is that community health care providers are key players in the system. Generally speaking, we can provide non-acute services quickly, effectively and efficiently. We also have a key role to play in health maintenance and prevention that assists the whole system in managing costs, reducing demands on service and promoting wellness. However, community health care providers can be the forgotten or less understood players in this continuum of health care. We're not as high-profile and sexy as the large acute-care service providers and we often have critical mass only at the provincial level, not at the local level.

In order to make appropriate decisions in the sector as a whole, it will be critical for LHINs to have appropriately balanced legislated representation on LHIN boards and committees as well as at the provincial advisory table. This will be especially important in consideration of people with disabilities.

Although it is outside the scope of the legislation per se, it must be said that in addition to having appropriate representation, community health care partners must be adequately funded. Many recent studies substantiate the claim of the Ontario Community Support Association that for every $1 of funding, the voluntary sector delivers $1.50 worth of service. In part, this is due to the unpaid contributions of volunteers; in part it is due to the fact that most voluntary sector organizations are not fully funded by governments. While there have been some welcome increases in the last two years, the decade before that we saw the erosion of 15% in agency operating expenses throughout the sector. This is according to a study done by Howarth in 2003 entitled Shaken Foundations: the Weakening of Community Building Infrastructure in Toronto.

In the cases when a simple approach to seeking service providers is based only on a lowest-cost-provider basis, damage to long-standing service providers and tremendous disruption in patient service have occurred. In a sector where salaries already lag behind other sectors, and indeed even behind hospitals, these factors have combined to make staff recruitment and retention increasingly challenging.

For these and other reasons, it is critical that the LHINs planning process not enable further erosion to this major, underfunded and cost-effective sector. Clearly, you have identified that a strong potential value of the LHINs will be in enabling hospitals to focus on those activities which only they can do, such as surgeries and emergency procedures. These tend to be high-cost. Community health care providers could, and should, assume increasing responsibility for other services with the potential to reduce both cost and wait times. This must be premised, though, on appropriate funding for the community health care sector, not further erosion of that funding. Improvements in the health care system as a system cannot come on the backs of agencies that are already overstretched and on the backs of staff who are chronically underpaid.

Our recommendations regarding the legislation is that representation of the community health care partners must be enshrined in the legislation. Thank you.

Mr. Gary Malkowski (Interpretation): I'm going to discuss people with disabilities and their rights to access.

The duty to accommodate and access health care is a right affirmed in the Charter of Rights and Freedoms and confirmed by the Supreme Court of Canada's 1997 Eldridge decision and within the Ontario Human Rights Code. Indeed, being able to communicate your symptoms or medical history and being able to understand what is being said by doctors and nurses is the absolute cornerstone of health care. Without communication there can be no care.

It must also be said that the LHIN legislation is the first major piece of legislation that will impact the lives of people with disabilities since the passage of the Accessibility for Ontarians with Disabilities Act, the AODA, in June 2005. It is imperative that the LHIN legislation get it right and reflect the letter and the spirit of this new law.

Within the LHIN legislation there should be guaranteed equal access to consistent special services no matter where people live, and this access should not be subject to discretionary funding by LHINs. In addition, in the spirit of the people-centred approach to the LHINs, the ability to choose a service must be the patient's choice.

The LHINs must make sure that all aspects of the system are accessible irrespective of the type of disability, and that the specialized services required by people who are deaf, deafened or hard of hearing are retained and expanded to meet the growing population of seniors and others requiring these accommodations.

We recommend that within the preamble of Bill 36 there should be an amendment that includes affirmation that persons with disabilities, consistent with the Ontario Human Rights Code and other legislation in the spirit of the AODA, will be guaranteed equal access to special services regardless of where they live in Ontario. The legislation should affirm that the LHINs do not have the discretionary power to opt out of funding specialized services for persons with disabilities, which has been in place as a result of the community care access centre legislation.

Mr. Fred Enzel: Continuing, the drive for local planning and accountability must be balanced by the need to account for province-wide priorities and consistency of service, and not increase for us the admin-

istrative burden on provincial health providers. As it currently stands, the legislation is silent on the issue of provincial programs, agencies and their interface with the Ministry of Health and the LHINs.

In many cases, these agencies provide the best of both worlds: responsiveness to local needs; and provincial planning, standards, controls and a cost-effective centralized infrastructure. These agencies cross LHIN boundaries and have many funders for several interconnected programs.

The Canadian Hearing Society, as well as CNIB and CPA Ontario, would like to see this type of approach accounted for in this legislation. We believe that types and quality of services should be consistent from community to community. We are also concerned that inefficiencies and added cost may be created if 14 different agreements have to be negotiated and contracted by one provincial agency. For these reasons, the possibility of centralized provincial multi-year contracts need to be explicit in the legislation.

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In addition, we also strongly suggest that applications, agreements, funding formulae, forms and processes be as consistent as possible across LHINs so that those service providers who will have to deal with more than one location will not have to detract from service delivery to manage differing types of paperwork.

We've made two recommendations in this area: to allow for some central, provincial contracts to assure equitable service and controls; and to the extent possible, assure consistency in LHINs paperwork so that the administrative burden on service providers operating in more than one location doesn't divert resources from service delivery.

Ms. Duffin: Our last point relates to due process, including consultation, observance of current statutes, and transition plans that minimize service disruptions. An equitable appeals mechanism must be better defined in the legislation.

This legislation as written would override much current legislation, including the Statutory Powers Procedure Act. The extent of that authority is disconcerting. While we believe the stated intentions to be true and fair, without appropriate due process in the legislation, there could, down the line, be dire unintended consequences.

For instance, the proposed legislation would give powers of integration to MOH, even when they are not the sole or even primary funder. Furthermore, many not-for-profits operate a series of interrelated programs to meet the needs of their consumers. The cessation, transition or integration of other services could have serious implications on the viability of other related programs. By extending the power of the minister and the LHINs to assets not funded by the government, these foundations could be completely decimated.

Also, Bill 36 leaves many details to regulations and grants the minister discretionary powers to dispense with public consultation before introducing a regulation, so much of what comes into force could be enacted unilaterally.

The finality of integration decisions is also troubling. A health service provider can make a submission to have the order reconsidered only once, and within 30 days of the order. Once the order has been reconsidered, it is final and there is no right to appeal. A health service provider can only apply for judicial review, and the test for review is whether the decision is patently unreasonable, which is a very high standard. There is no compensation for loss or damage and no right of action.

Transition plans and timelines are also not mentioned. Staffing considerations, for those of us who work with unions and have lay-offs clauses, leases, legal and other wind-down or expansion considerations, need to be incorporated. Whether a provider is being closed, contracted, expanded or partnered, a too quick or ill-considered transition can cause major disruptions in client service. It can also create undue hardship on the affected service provider, who may have to consider labour and union issues, leases and other legally binding arrangements that can be complicated, costly and sometimes actually impossible to amend.

Many agencies such as CHS enjoy the support of the public through donations and fundraising. We must also remain true to the obligations which accompany such public trust.

Finally, the LHINs and the minister must consider the public interest when issuing integration decisions and orders, but Bill 36 does not set out a definition for this term as do the Public Hospitals Act and the Commitment to the Future of Medicare Act. If this is a guiding principle, it should be better defined.

This issue of public interest is particularly true for people with disabilities. If, as is the stated intention of LHINs, the desire is to view health care from the perspective of the clients, the question must be asked of the clients which services they need integrated. CHS, for instance, provides a very integrated spectrum of services for people who are deaf, deafened and hard of hearing, which enables them to have a series of appointments at one location. The trend in some areas of government, though, is to dis-integrate this type of service under the banner of integrating all disability services. For the client, however, this then means attending at multiple locations, several that present barriers to them, rather than at one. At a minimum, the legislation should assure that there would be no reduction in services or in access to services for people with disabilities.

As it is currently written, LHINs' statutory objects focus more on system management than on patient care and experience. While a stated goal is transparency, there is no safeguard against unilateral decisions and actions. If the true focus is a consumer or patient focus, there must be more attention given to their perspective and more consultation in the process.

Our recommendations in this area are:

—Provide for due process before issuing an integration decision or order.

—Include criteria for making integration decisions and orders. These criteria should take into account patient care, including access, choice and quality.

—Public interest should be defined; and

—There should be an allowance for transition periods of six to 12 months to implement integration orders.

In summary, we want to be clear that we are not wedded to the status quo, afraid of change or driven by the desire to provoke fear; nor do we question the sincerity of the stated intentions or assurances given during this transformation of health care in the province. But legislation cannot account for intention or assurances that are not documented in it. Legislation must be written to govern not only those currently in power and executing a current vision but for all those who may come, including those with different views. For those reasons we are bringing, as invited, our sincere recommendations about how to best capture the goals we share in this important new initiative. Thank you for your time and attention.

The Chair: Thank you to all of you for making the presentation. There's no time for questioning.

We will break until 1 o'clock.

The committee recessed from 1208 to 1302.

BURLINGTON HEALTH COALITION

The Chair: Our first presentation is from the Burlington Health Coalition, Mr. David Goodings. You can start any time you're ready. There's 15 minutes in total.

Mr. David Goodings: Thank you. I'm very pleased to be here representing the Burlington Health Coalition, which is a group of about 200 citizens in Burlington who are concerned about health care issues. We have been studying Bill 36, and in a broad way we are in support of the bill. We think the integration of the delivery of health care services is something that has many benefits, and that it should be given at a local level, where the LHINs would be in touch with the needs of the people within their geographic area; that is highly desirable. So we broadly support the LHINs legislation.

We also are pleased that the meetings of the LHIN boards and their committees will be open to the public. We are a little bit concerned about what it says about notices: that notice of meetings will be given "in a manner that is reasonable in the circumstances." We would like to see that spelled out in a little more detail, as would be done, say, for school boards or municipalities. However, we do generally support the reservations.

What I'm going to say now are just one or two concerns we have about the legislation. The first is that the ministry will produce a strategic plan. This strategic plan, of course, is unavailable at the moment, so we don't know what's going to be in it. We assume that certain goals will be stated and also that there will be budget targets. We would really like to see more about the strategic plan tabled before the bill is enacted.

With regard to the process by which LHIN board members are chosen, we would like to see that process be as transparent as possible. In the interest of the public knowing what's going on, we would like to see that spelled out a little bit more.

It's clear from reading the act that a great deal of authority is going to be given to LIHN administrators and boards and also to the ministry. As we see it, that really means a shift of authority and decision-making from the hospital boards and CEOs, and also from the boards and CEOs of other health care providers, to the LHIN administrators and their boards. I understand that is probably needed in order to bring about the integration of services, which didn't seem to happen very well under the district health councils. We understand that more authority is going to be needed; however, there are concerns that so much power is being shifted to the LHINs and to the ministry that this government or a future government, perhaps of a different political stripe, could use this legislation to impose rather deep cuts on hospitals and other health service providers. We view that with some anxiety.

The area that is of greatest concern to people in the Burlington Health Coalition is the steady growth of for-profit corporations delivering health care over the last few years. I realize that the LHINs legislation is an administrative structure and doesn't deal directly with either for-profit or not-for-profit, but we have looked at the legislation to see whether it encourages for-profit or not-for-profit delivery of health care, and have come to the conclusion that it is really quite neutral with regard to those two types of delivery, except for what I think are minor considerations, such as that Bill 36 can bring about the amalgamation of not-for-profit corporations and agencies but not for-profit ones. However, our reading of the bill is that it does nothing to impede the growth of for-profit delivery in Ontario. We know that the government is planning numerous new hospital projects along the P3 model—or the new term, the AFP model—and it seems clear that a private partner in one of these P3 projects will demand that many of the services in a new hospital be privatized, that they be sent out to different corporations. So it seems that it does open, or at least make possible, for-profit delivery of services on a larger scale than we have at the present time. Although the bill is neutral, it does seem to allow that to happen.

A final concern is that the bill seems to make possible a price-based competitive bidding model of the kind we have seen in home care. That was introduced in home care through the CCACs about six years ago. We believe it had a very bad effect: lowering the quality of service in home care. We are very concerned that this price-based competitive bidding model might be used in areas like long-term-care facilities, the delivery of mental health—mental health associations—also Meals on Wheels and, possibly, public health. There are many areas where that model could be used, and we view that with considerable anxiety.

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Just to sum up, we broadly support the LHINs initiative of bringing the administration of health care closer to the communities in which they are doing it. We have some concerns about how the board members will

be chosen. Our major concern is that it does nothing to impede the for-profit delivery of health care in the province. Finally, we are worried about the competitive bidding model being used in more areas of the health care sector.

The Chair: Thank you. There are about three minutes, one minute each. Mr. Ramal, you may wish to ask some of the questions, please.

Mr. Ramal: Thank you for your presentation. I know you mentioned so many different concerns that we listened to across Ontario, and also some kind of built on speculation and assumption. For instance, you mentioned that P3 was going to lead to privatization and more private services. I think our minister and our government were clear on this issue: It's 100% publicly run and operated and controlled by the public, not by private institutions.

The second concern is about shifting the power. We listened this morning to many health professionals and people who have been dealing with the government for a long time. They won't see in the LHINs a shift of more power from the past to the present. So they believe the power will be the same, that there will be no difference. As a matter of fact, it will be enhanced, because the ministry has a huge administration in Toronto. It would be difficult to deal with a huge budget, $33 billion, altogether from Toronto. That's why the LHINs have been created: to assist the minister locally and to give advice in order to enhance and consolidate health services in the province of Ontario, all because we believe in publicly funded health care accessible for all.

Mr. Goodings: Do they not see it as taking power and decision-making away from hospital boards and CEOs?

Mr. Ramal: No. We listened this morning to the Ontario Hospital Association. They mentioned that clearly. They've been professionals in this matter for a long time. They've dealt with the government. They don't see any difference.

Mr. Goodings: On the question of the P3s, I'm really talking about non-clinical services. If there's a private partner, the private partner will expect and perhaps demand in the contract that all the non-clinical services be under the control of the private partner. That's where we see them being more expensive and very likely of lower quality.

The Chair: Thanks very much. Mrs. Witmer.

Mrs. Witmer: Thank you very much for appearing before the committee and representing those in Burlington who are obviously extremely concerned and follow health issues closely. You've indicated that you have some concern around the appointment process, and we have heard this morning from different groups that they're not sure that the boards, as presently constituted or to be constituted in the future, are necessarily going to represent the people in that particular LHIN. I guess I would ask you, how do you think we can ensure that those boards actually represent the people in the LHIN?

Having said that, these are not going to be your neighbours, because in the central LHIN, you've got 1.5 million people. So it's not as though we're shifting power to local communities, because we're not. In fact, all power remains in the hands of the minister. What could we do?

Mr. Goodings: I think the process should be more transparent. What I'm thinking of is that the members of a committee that would appoint the administrators would be known. In my previous life, I was an academic at a university, and I know how committees were set up there to find and appoint, say, a dean of a faculty. You would know who was on the committees, and people would then be able to talk to them and make their concerns known. I was thinking of that kind of process.

Mrs. Witmer: That's right. As I say, we keep hearing that they should be representative of the community and transparent.

The Chair: Thank you. Madam Martel, please.

Ms. Martel: Thank you for coming in from Burlington today to make the presentation. You're going to correct me if I'm wrong—I'm going to paraphrase—I thought I heard you say that there's nothing in the bill to impede the move to for-profit delivery of health care. I would agree with you and go further and say that in fact there's a lot in the bill that just influences that even further. If you look at the fact that the government has not put in a specific clause that says that LHINs will not acquire services or pay their providers through the competitive bidding model—we know in home care there's been a shift from about 18% to now over 50% of those in the sector that are for-profit that are providing care.

Secondly, in section 28 the minister is allowed to integrate not-for-profit providers, but the bill says nothing about the for-profit providers, so there certainly is a great concern that this will be done at the expense of the not-for-profits.

Thirdly, section 33, of course, allows the minister to essentially outsource any prescribed non-clinical service. There's no timeline given for that, there's no identification of what the non-clinical service is or who's going to get it, but it's certainly clear that other people have pointed it out as the area where privatization is going to occur.

Over and above that, significant job losses could occur under any of those three scenarios. My concern is that money that goes into health care should be going into patient care, not into the profits of some of these providers. I wonder if you would want to comment on that aspect of this bill and certainly the areas where privatization can occur.

Mr. Goodings: I agree very much with what you have said and I don't think I have any more comments to make.

The Chair: Thanks very much for your view. You did answer the question.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 345

The Chair: We will go to the next presentation, from the Ontario Public Service Employees Union, Local 345

from Peterborough. It's CarolAnn Bolton. Welcome, ladies. Good afternoon, and you can start whenever you're ready. You've got 15 minutes' total time for your presentation. Thank you.

Ms. CarolAnn Bolton: Good afternoon. My name is CarolAnn Bolton. I have worked at Peterborough Regional Health Centre for 25 years, currently as a ward clerk in the birthing suite. I am the president of OPSEU Local 345, which represents 250 clerical staff, half of whom are part-time and almost all of whom are women. Our members have been providing clerical and support services, some for more than 30 years. Members of Local 345 live in and around the Peterborough area, which includes many townships, as do many of their families. This places us in the unique position of being both employees and patients for the health care services provided in our hospital.

The LHIN is called the Central East Health Integration Network. It is the second-largest LHIN in Ontario, with a population of 1.5 million people. Travel time in our region, from Haliburton in the north to Scarborough in the south, is 203 kilometres or 2.5 hours, depending on the weather.

Peterborough Regional Health Centre currently serves four counties, with a population of approximately 350,000 people. We have a very large geriatric population, many of whom have no access to a family physician. Many residents are living in poverty. How can our most vulnerable handle the extra traveling time to access the health care that they require? Would this not reflect a two-tier system? Those that can afford to travel will get timely health care and those that cannot will get delayed or substandard care.

This regional hospital is the largest employer in this region, employing 2,000 staff plus 600 volunteers. In 2004-05, we had 85,018 emergency visits. We have the busiest emergency department in Ontario.

As health care workers, we know that the system is not broken but is severely underfunded and has been for over a decade. Last week, Dr. Gary Hill, an emergency room physician, wrote a letter to MPP Jeff Leal detailing the conditions and appalling state of the emergency room at Peterborough Regional Health Centre. Dr. Hill has been working there for 14 years and he states that the situation has never been worse.

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The editor of the Peterborough Examiner identified our health services as "A Decade of Shame.…

"Patients who lie for days on narrow gurneys in the busy, brightly lit hallways of the Peterborough Regional Health Centre—that's the shameful stain on local health care that just won't go away."

The problem is that Peterborough Regional Health Centre doesn't have enough beds, and it doesn't get enough funding for the ones it has. A detailed Ministry of Health review found that Peterborough needed 480 beds in 2005, but it gives funding for about 330 beds. With that formula, having patients in the hallway is a given. The hospital actually has 50 more beds that are partially funded, but every time one is used, the hospital goes a little further into debt. The Ministry of Health recognized how badly underserved this community is when it approved construction of a new Peterborough Regional Health Centre, scheduled to open in 2008 with 489 beds. Our current bed status is 335 beds.

Can anyone here explain, then, why the new, two-year budget imposed by the ministry is supposed to slash another $2.3 million out of annual hospital spending? There is no logic, but one would have to question if this is a deliberate creation of crisis for our health care system to justify the drastic changes that will be imposed under LHINs Bill 36.

From a health care worker's perspective, I must state that Bill 36 scares the hell out of me. We have survived the restructuring commission, layoffs, Bill 136 and SARS. The proposed LHINs structure will create chaos across the health care system by moving services around within the region and opening the door to privatization and competitive bidding.

In our hospital, new initiatives are being introduced that will downsize our workforce. They are voice transcription, automated staff scheduling and payroll system and back office transformation. During the past year, the hospital has issued layoff notices and services have been lost, all in the name of being accountable as the hospital had a deficit. The services lost are the day hospital and the prenatal clinic. We no longer offer childbirth classes. The public health unit now provides this service, but at twice the cost to the patient.

The rehabilitation day hospital was a multi-disciplinary, comprehensive service offered to patients in the four counties served by Peterborough Regional Health Centre. Its primary mandate was to assist persons with complex neurological and physical rehabilitation needs to remain independent in their own homes rather than become hospitalized or take up a bed in a long-term-care facility. Patients presented with a variety of diagnoses, including stroke, 54%; other neurological diagnoses, including brain cancer and the effects of chemotherapy and radiation, seizures etc., 19%); multiple sclerosis, 14%; acquired brain injury, 10%.

I can speak from experience for the excellent care provided by the day hospital. In December 2002, my husband suffered a stroke at the age of 46 and, following his hospital stay, utilized this outpatient service with much success. Had my husband suffered his stroke today, the degree of his recovery would be questionable, as he would not have the rehabilitation and care provided by the day hospital. Although he had been on a waiting list for CCAC, it was over six months before he was contacted by them.

As of September 2005, this service was eliminated from the hospital before it could be established in the community. We were reassured by hospital administration that in a short period of time the CCAC would provide this program. Last week, five months later, the director of the CCAC, Stephen Kay, advised that funding from the government has not yet been established, but he

was hopeful it would be in place in another three months. This is unacceptable.

The community raised these concerns at a public forum in the spring of last year. Hospital and CCAC administrators and our local MPP were all present. All acknowledged the need to keep this service intact but have failed to do so. How long must those most vulnerable wait to receive the care and support they so desperately need? Another shame.

Last year, the Women's Health Care Centre, currently a department of the Peterborough Regional Health Centre, was identified as a service to be eliminated in the balanced budget proposal. This threat is still there. Last year alone, the Women's Health Care Centre had 21,940 contacts. Women without family doctors were able to see a nurse practitioner for a routine physical, cervical health and birth control. Abortion services, counselling for sexual abuse, sexual assault and eating disorders are also provided.

The lack of family physicians is a critical issue for women in Peterborough. The development of family health teams has been a slow and inadequate process to date. Due to an overwhelming outcry from the women and men in this community, the Women's Health Care Centre was left out of the balanced budget scheme.

Seamless and transparent transfer of service from the hospital to the community has not been a reality in Peterborough. How could the ministry and the hospital even think that closing the Women's Health Care Centre and the day hospital before the establishment of replacement services in the community would be acceptable?

What I do know about the LHINs, as detailed in the present legislation, is that they will be controlling our future. They will determine the funding and delivery within our region. This means permanent instability for patients and workers as services and programs are continually restructured, transferred and contracted out. Where is the strategic plan? Why haven't the public or health care workers been allowed to give any input? Why aren't the LHINs accountable to the public? What will happen to the current board of directors at our hospital? What will their local role be? The Minister of Health has an enormous amount of control over the LHINs, and the LHINs are a highly centralized control centre for the minister.

What will be the economic impact on our community when the largest employer in the region eliminates staff or contracts out the jobs, resulting in lower wages and no benefits? Money from good paying jobs that once flowed into the community will be no more.

Can you tell me who will look after our hardworking, dedicated and professional workers when they are told they no longer have a job or, due to competitive bidding, they have to reapply for their job at a lower wage rate? What will happen to their pension plans? What does the human resource plan look like?

Currently, health care workers are doing more with less. Our hospital is dirtier, staff morale is extremely low, staff are ill due to injuries and burnout, workload has increased and expectations of the staff are higher.

Nursing shortages became so critical that extra money from the government for incentives for nurses became available, but nothing for the support staff. Yet the support staff, especially clerical staff who use computers, are faced with constantly changing programs and need educational upgrading. But due to the fast-paced changes, they are never given an opportunity to enhance their skills.

With the construction of our new hospital, members from our community have made generous donations. The question is being asked whether these dollars will actually go towards services and equipment in our own hospital or whether they will be transferred to another community. With the possible transfer of services going to other hospitals, I know of several community members who have called the foundation to pull their donations.

As the legislation stands now, there are many important questions that must be answered. Providing answers for these questions is a responsibility that you must fulfill.

In summary, the LHINs Bill 36 is flawed and must be rejected in its present form. The impact of this legislation on health care workers will be devastating. Health care is the provision of care by people. There must be a human resources plan, and it must include layoff as a last resort; measures to avoid layoff; voluntary exit opportunities; early retirement options; pension bridging and protection of pension funds; and retraining options.

A transitional fund should be established. Similar to the private sector, the Health Sector Training and Adjustment Panel should be resurrected.

Stop this legislation now. Involve the public. Do a proper provincial strategic plan. Put protections in place for health care workers. If you don't take care of your workers, you have no health care system. Thank you.

The Chair: Thank you. There's only one minute left. Mr. Rinaldi, if you can have a short question, please.

Mr. Lou Rinaldi (Northumberland): I'll make this very brief, Mr. Chair.

Thank you very much for your presentation. I know you ask a lot of questions in your presentation. We only have a minute, and I'd love to address them all.

You talked about the size of the Central East LHIN. Ninety per cent of the riding I represent is in that LHIN. I represent the riding of Northumberland, Cobourg east. The question needs to be asked: Yes, it's a large LHIN, but how does that compare to the one LHIN we have now in Ontario? So when you talk about being closer to the people—we've divided the province into 14 sections. I think that's smaller than what we have now, with the centre being down here. That's just to give you some perspective when you say it's a huge LHIN.

1330

I did visit your hospital, because a lot of the folks in my riding, at least in the west end of the riding, go to Peterborough. Yes, it needs repair. It's not in the best shape. I visited it about a year ago. That's why I believe a

shovel has been put in the ground. A new hospital is being built that has been long-awaited. You folks were working out of trailers, and that's not a decision we made. We're trying to fix that. So when you say that conditions are bad, we understand they're bad. I think the need is recognized for the new hospital, which I believe is being built.

The other question I'd like to try to address is, what happens to hospital boards? We made it very clear: Hospital boards are going to be there. Whatever they did yesterday, they're going to be doing after the LHINs. I addressed my local hospital board in Cobourg last week, and I'm going there to speak to the staff tomorrow.

I think we're throwing a lot of fears in the air. That's my opinion, but I respect your opinion as well. I think we need to work with concrete ideas; that's just maybe a comment.

The Chair: Unless there are any questions from anybody, we'll move to the next presentation.

Ms. Marion Burton: Can I just comment?

The Chair: Surely. You're over time, but that's fine.

Ms. Burton: As health care workers, we're asking you, where is the strategic plan to deal with the issues of the workers? The LHIN identifies the possibility, the opportunity to severely change conditions of work for the workers. You have not described that at all. These LHINs do not address that issue, and that's what we're saying to you. You need to focus on how you're going to support health care workers. If you don't, I hope you don't wind up in the hospital.

The Chair: I think you have made that point. I thank you both for your presentation.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 581
ONTARIO NURSES' ASSOCIATION, LOCAL 111
CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1487

The Chair: The next presentation is a joint union presentation from the Scarborough Hospital: Janet McIvor, Patricia Ignagni, Pat Collyer and Susan Brickell. Is that close?

Ms. Susan Brickell: You almost got all our names.

The Chair: I mentioned four people.

Ms. Brickell: I think you did well.

The Chair: One is missing? Okay. You can start your presentation. There's a maximum of 15 minutes.

Ms. Brickell: Thank you for giving us this opportunity to speak to you today. We're here from the Scarborough Hospital. Pat Collyer from OPSEU technical is not here today. My sister unions would like to introduce themselves.

Ms. Patricia Ignagni: Patricia Ignagni, OPSEU Local 581, Scarborough Hospital.

Ms. Janet McIvor: Janet McIvor, CUPE Local 1487. I'm deferring to my sister, as I took too long this morning.

Ms. Brickell: I'm Susan Brickell. I'm an RN and president of ONA Local 111 at Scarborough Hospital.

We're here today with 86 years of experience at the Scarborough Hospital among the four of us—Pat has the most; she has 30 years. Unfortunately, she's not here. She has to be at the hospital today.

Personally, I was born at the Scarborough Hospital, I've been a patient there many times, my son was born there and I've had family members die there. I live and work in the community. I've worked for 20 years at Scarborough Hospital. I'm an RN. I love my job, but I'm very frustrated at my inability to provide the care to my patients that they deserve. I can't provide even minimal care anymore.

Over the last decade, the Scarborough Hospital has lived through many, many crises. In 1996, we dealt with health service restructuring. When a lot of hospitals were closed, we had to amalgamate. We took on dialysis, our burn unit went to Sunnybrook—it was a major, major upheaval. In 1999, we had Bill 136, the amalgamation of Scarborough General with the Scarborough Grace Hospital—again, huge chaos, huge confusion. In 2003, we had SARS.

Even though it's seven years later, we are still not one facility after the amalgamation. We still have two sites; it's two hospitals. There's animosity. There's a lot of disparity between the Grace and the General. Staff are torn between where they started and where the employer thinks they are today. This doesn't serve our community well.

The cost of the amalgamation was to be offset by the savings; however, we feel we are spending more dollars now. We have more management, administrators and vice-presidents than we had before, and we have far fewer front-line workers. As well, we've lost many beds.

Our fear is that the LHINs will simply be a larger version of this experience. You're proposing 14 regions, each with a nine-member board, plus all the office and human resource staff you'll need. Where is this money coming from? When the patients arrive in the emerg, shall we inform them that we have no bed or staff because that money is paying for more administrative staff? Our members will experience more fear: fear of change, fear of job loss, fear of an inability to do their jobs. This will lead to increased stress, increased illness and increased sick time and a generally unhappy, dissatisfied staff.

Let's stop and think about that. When you or someone in your family ia ill and in emerg, hopefully not dying, do you want to be cared for by an unhappy, stressed, ill worker or someone who is secure in their work and able to focus all their knowledge and attention on you or your family member?

On to 2003: The Grace site was SARS Central, Canada. Welcome to TSH-Grace. This should have been a huge wake-up call for everyone. We were not, nor are we today, prepared for a pandemic, and it will come; it's a given. I have grave concerns. I do not believe we will cope with it. I'm sure you've heard from every hospital worker that the hospitals are filthy: absolutely, disgust-

ingly filthy. I'm on the health and safety committee. The inspections I do—it's absolutely disgusting. Imagine not cleaning your house for two months. That's the filth that's in the hospitals.

We found that hospitals employed at multiple facilities during SARS. Why do I bring this up? Infection, cross-contamination. People have to work at multiple facilities, so they carried the SARS germ throughout the city. I believe we are lucky we did not see more deaths from SARS. It was pure luck. It wasn't knowledge; it wasn't skill. It was luck.

In my bargaining unit at Scarborough Hospital, I still have a number of RNs off as a result of SARS. I feel they never will return to nursing. I have a couple who have returned, but they'll never be able to do front-line nursing again. We had RNs die. We had health care workers and their families die as a result of SARS. During SARS, we saw outsourced workers refuse to work and walk off the job, and yet the dedicated Scarborough Hospital staff came in daily, without regard for their own lives. I personally was quarantined three times. My entire family was quarantined the third time, as I was investigated for SARS. It was frightening. Three years later, I'm still there.

I urge you to listen to those who have taken the time to speak to you. I urge you to keep our health care system public, strong and accessible to all.

I'll defer to my sisters, if they have anything to add.

Ms. McIvor: I get a chance. I just wanted to say that we are here jointly. This obviously is a very serious matter to us. In my 20 years of involvement in the hospital and in union activity, this is the first campaign where ONA, OPSEU, SEIU and CUPE have joined together to stand strong for health care. We, as local representatives, are going to our members jointly and having sessions like this, and I believe that is happening across the province. I can't say enough about our concern for the future of our health care system. You have to understand that we are your community too. You have to think of us when you're making these changes, because if you don't, you won't have a health care system when you're done.

The Chair: Any other comments? If not, there is a minute each. I'll start with Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation. I can certainly hear the passion and concern.

The minister has said over and over again that there was extensive consultation with stakeholders in the province prior to the introduction of Bill 36. Your comments seem to indicate that maybe you weren't involved in that consultation.

Ms. Brickell: We're front-line workers. We're never involved in any consultation.

Mrs. Witmer: Would your union provincially—

Ms. Brickell: I don't believe so; otherwise, our provincial union leaders wouldn't be together as well arguing against this.

Mrs. Witmer: So what is your main recommendation to the government, seeing that we have a bill here that obviously does not reflect your input? What should the government—

Ms. Brickell: It should take a step backwards. We need to take a step back and actually have some consultative process with front-line workers, those who actually do the job and those in the community. I've spoken to multiple people in my community, from patients to neighbours to family. Nobody has an idea what I'm talking about.

Mrs. Witmer: I know. Nobody understands LHINs. They don't know about them.

Ms. Brickell: When I say "LHINs," they go, "What?" They have absolutely no idea. My ex-husband works as a paramedic. Neither he nor any of his co-workers know.

Mrs. Witmer: So what should the government do? Should they go back and rewrite the bill?

Ms. Brickell: Before rewriting, you need to actually have some consultation with the worker bees, as I refer to us.

1340

The Chair: Madam Martel.

Ms. Martel: Thank you for your presentation. I want to focus on the cleaning, because this wasn't clear to me. In an earlier presentation, we heard about the contracting out of food services. Is the problem with cleaning that it has been contracted out already or that there has been a cut in staff as a result of the restructuring?

Ms. Brickell: A huge cut in staff. We need to save money. We're in a huge deficit. There's not enough staff to do the work. It's continual reorganization and restructuring. In the last 10 years, hospital workers have been restructured multiple times. We're dealing with it almost on a yearly basis at the Scarborough Hospital.

Ms. McIvor: I can speak to that: Last year, part of the $2.7 million that was spent was to take apart a program we had called PSA. They were multi-skilled workers who did cleaning, portered patients and also delivered meal trays. It was a good system. At first we fought it, as a union, but when it came in, it worked well for the patients. The wait times for tests were shorter, and it did work well. The problem was that each PSA was to a floor, instead of a centralized system. Instead of making it centralized and having managers and coordinators over that, they eliminated it, which caused major packages, early exits. They created a new role—housekeeping aide—going back to the centralized service. And afterwards they realized, "Oops, we made a mistake. We have piles of gaps that no one can do," and they created a TA position, which is basically what the PSA was. With the cleaning issues right now, sick calls aren't being replaced. You have people with huge workloads getting ill, getting stressed, and then when someone calls in sick, the other staff have to cover two units. They're not getting replaced. That's just adding to the workload and to workplace injuries. You can check it out: We have major workplace injuries in the hospitals. It's like a coalmine, compared to other places.

The Chair: Ms. Wynne.

Ms. Wynne: I want to thank all of you very much for coming and talking to us. It's extremely helpful to us as we consider the legislation.

A couple of things: The minister has committed himself to no net new bureaucrats, so the closure of the district health councils, the closure of the regional offices and the closure of some of the CCAC admin offices should offset. You were worried about the costs and the administrative costs. There should be an offset there.

The other point I wanted to make was on the consultation strategy. In this legislation, there is provision for ongoing consultation. There is also provision for a provincial strategy to be developed; there's a consultation plan being developed on that. So consultation is integral to what is going to roll out here.

I understand that people don't know what LHINs are yet, and that is part of what's causing the fear. But the minister is committed to coordinating the system. That's why he's doing this. When he came into office, he discovered that there really wasn't a health system. There were silos, and there weren't the connections that needed to be there. I personally think that SARS made the argument for doing this. We must have better communications; we must have plans in place across the province if we're going to be prepared for future catastrophes.

I don't know if you want to comment on any of that, but that really is the root of this bill.

Ms. Brickell: I did want to say one thing. I think what you're creating is more silos. I think you're disjointing the system even further. Now it's going to be battles within each LHIN for the dollars and who gets those dollars, and health care consumers are the ones who are going to end up holding the bag.

Ms. Wynne: I hope you're wrong. I believe you're wrong.

Ms. Brickell: I don't think I am. Unfortunately, I'm a little tainted when it comes to the argument that one price should offset the other cost. I don't think that will happen. I've seen bureaucracy. I'm not young. I've been nursing 20 years, and I've seen many layers of bureaucracy in hospitals.

Ms. Wynne: But when you wipe three out and replace it with one—

The Chair: Thank you very much for your presentation.

ASSOCIATION OF ONTARIO HEALTH CENTRES

The Chair: Next is the Association of Ontario Health Centres, Adrianna Tetley and Scott Wolfe. You can start your presentation. Good afternoon.

Ms. Adrianna Tetley: Good afternoon. I'm Adrianna Tetley, executive director of AOHC. With me is Scott Wolfe, our policy adviser.

The brief is being handed out, and I am going to mostly focus on the recommendations that are on pages 7 to 14. Before I start that, I do want to give a little bit of background of who we are. The association is the policy and advocacy association for non-profit, community-governed, interdisciplinary primary health care in Ontario. We currently represent 54 community health centres, 10 satellites and seven aboriginal health centres across the province. In particular, we provide accessible, community-governed, interdisciplinary, not-for-profit primary health care services; health promotion focusing on social determinants of health; prevention and treatment of illness, including chronic disease; and building capacity for people and communities.

When we first heard about the LHIN legislation in terms of integration and partnerships, we realized that community health centres have basically 30 years of experience, and when we understood what a LHIN was—I often refer to the CHCs as actually mini-LHINs. Part of my comments are going to be from that perspective, especially in terms of the size of the LHINs that are being proposed.

Recently, over the last number of months, the minister has announced a number of expansions to the community health centres, so we are going to grow significantly over the next couple of years as we move into LHINs, increasing the number of people who receive care at community health centres to 550,000. We have also recently, because of our integration and partnerships, been recognized as a vehicle for diabetes education across the province, and we've had recent success in terms of getting Early Years funding established as base funding instead of program funding. So we recognize that the government recognizes community health centres as one of the vehicles through which we can deliver care.

The perspective we bring today that is unique is that we have a strong focus on barriers-to-access populations, none of which many of the other providers before you do, and the other really important one to which I draw your attention is that we're the only primary health care model that is going to be under LHINs. This is a bit of a dichotomy. The rest of primary health care is outside of LHINs. We're not sure, in terms of some of our comments, about how that planning is going to happen when we're the only primary health care model inside of LHINs and the rest of the family health teams and all the physicians are outside of LHINs.

If you turn to page 7, I'm going to focus specifically on the recommendations, which are tied to a number of principles. The first principle is that Ontario requires a culture of health service coordination and integration, not merely a system navigation mechanism. We believe very strongly that people have to be supported at where they enter the system, wherever that may be, and that every door must be the right door to services. We believe that an effectively coordinated system, not the role of an individual sector, organization or individual, is the answer. Also, a culture of system integration and coordination is needed, not any single system navigator.

We're actually recommending that there be an additional clause added to the legislation that prohibits any single care sector or organization being supported or funded, via the act or through regulation, to perform an exclusive system navigation role for clients.

The second principle is really focusing on the whole issue of community engagement. While we support in

your bill part III, section 16, around community engagement and the requirement to do community engagement, we have a major concern because the word "community" is not defined. It is left wide open. Does "community" mean that they only need to consult the health system providers? I would reiterate that part of the community is the employees who work in the system, and our recommendation 2 is that you actually add a definition of "community" to the legislation, a definition that includes all clients who receive service, the residents of the geographic area, the full complement of health service providers that are funded, and the health care institutions and providers, so that you really have a full consultation of the community. As it is left now, it could indicate that "community" is left to just the service providers as a whole.

The next point, recommendation 3, is really related to community governance and the definition of community governance. We have a very strong concern that community governance could mean that the government will move towards having one governance structure over the entire LHIN. We've seen the example in Quebec, where they have moved towards a community governance structure where the whole city and all the health providers are under one community governance section. In other parts of the country there have been examples where community governance is one structure over a large region.

1350

We do not believe that this is a definition of community governance. We have 54 very unique community health centres, and the reason is that they are community governance. They meet the needs of their local neighbourhoods, not the entire region's. Yes, we understand that each region is different, but we also say that a CHC governs a smaller area and they are unique. Even in the city of Toronto, even in Ottawa, they are unique because of the needs they are serving in their community. We would really like you to strengthen the definition of community governance and not allow actually in the legislation for that wholesale community governance. There's a really strong feeling that maybe community governance is protected now, but down the road future governments—even if this government's committed to community governance, there's no protection in here that in the future community governance will disappear, especially if it's broadly defined as a volunteer board over a very large area. For us, that's not community governance.

As well, on recommendation 4 around integration, there is no advance notice if there's an integration order. At this moment, a community health centre, for example, could get a letter today saying, "You are no longer going to provide this service," or, "You are going to inherit this service," and there is no requirement in the bill for any advance notification for potential integration orders.

Even when the appeal process is there, the appeal process says that you only have 30 days. Our recommendation is that there be at least 30 days' notice of the potential of an integration order, so that people can start having solutions.

Principle 3 is really talking about safeguarding the programs in the community when we have a large, decentralized, locally managed system. I echo the concerns of the previous speaker, but the concerns are equally felt in the community side. When you move services from one organization to the other, what is the plan? What is the plan to move workers from one system to the other? What is the plan to move funding from one system to the other?

The huge concern is that—and we've seen this. We've seen this in community health centres, for example, even as recently as last year where programs for breast cancer or chiropody ceased to exist in hospitals; they closed their doors. The next day, they're sent down the street to the local community health centre, if there is one. The community health centre got no advance notice, didn't know that it was coming, and the dollars did not follow. You're trying to solve the problem of orphaned patients in terms of doctors, but you're creating potentially all kinds of orphaned patients if the money, the resources don't follow the services to where they're going.

We have a very strong recommendation 5 for a one-way valve where we're basically saying that if you needed to get it into community care, the dollars, the resources, the people have to flow with that to the community. We believe that the answer is in the community, but adequate resources have to follow with them. We also clearly want to be protected from any deficit that might follow in a large institution.

A very strong point is that there's one large hospital in one of the LHINs and we have six community health centres in that LHIN. The deficit of that hospital equals the full budget of all six CHCs. There's a very strong concern that if the hospital, even if it goes with a balanced budget, one year later has a deficit budget—they're not allowed to borrow money—are they going to do that on the backs of community governance?

Across the country, there are examples of regulation and legislation in two different cases where there is protection for community groups, that they are not going to have to absorb large deficits from large institutions that incur the deficits historically from year after year.

We also have recommendation number 6 that elaborates on that, where it basically says that the legislation should be amended to not allow a health service provider to retain resources specifically dedicated for service that has been ordered to cease or it has decided to cease as a result of an integration order and that they meet with whoever the recipient group is to ensure that the appropriate resources are continued so that there's a continuation in services that are received by the client.

Our recommendation number 4 is about the continuum of care, especially those facing barriers to access. This recommendation is largely around the whole question of people are going to look forward to the issue around—that there are services. "With a small community, they both have mental health. This must be a duplication of service. Let's just get rid of one." The idea is, especially when you're dealing with barriers to access—and in a lot

of these community-based organizations, even though they're serving mental health, because you're dealing with culturally appropriate services or a specific focus on mental health, it may not at all be a duplication. You will probably be filling different needs, and different client-based groups are being needed. The stronger recommendation is that through integration and partnerships, groups work together. So the solution is not just elimination of services.

Recommendation 7 is also focused on the issue, and we have a very specific example. In your recommendation, you talk about the service providers in and for the geographic area of the network. We do have community health centres whose physical building is on one side of the boundary but whose entire catchment area is on the opposite side of the boundary. A lot of our satellites are in two different LHINs attached to that community health centre. Even now, as they are having the early consultations, they want to talk to somebody in the other LHIN about their satellites. They're saying, "Well, you belong in LHIN 1. You don't belong to LHIN 2. Go talk to LHIN 1." But all of their services are in the second LHIN. So how is this going to happen? We're actually recommending an additional clause that says, around health service providers: "including health service providers mandated to provide services to clients or population groups that span across LHIN boundaries." Our catchment areas are not restricted by the highway, where people are going, and it's a very strong concern.

As well, right now there is a very strong problem in that there is really no major appeal process. The appeal process for any integration order is only 30 days. That is very insufficient. It needs to go to at least 90 days. You have to appeal back to the same body who made the first decision, and there is no appeal further than the LHIN. So once they've reconsidered it, that's the end. So a 30-day window is very much too short for dealing with that.

Principle 5 is about provincial health system standards and assurances that all health sectors will be involved in provincial and LHIN-level planning. In our brief that we submitted back in May, we were very clear that if you're going to move to LHINs, all the primary health care should be in LHINs. That is not the decision that was made. The decision that was made is that community health centres are in LHINs, but the new family health teams, all the doctors, are outside of LHINs.

We're very concerned about where the provincial health care standard is going to be developed for primary health care; what is the role of LHINs with family health teams? In particular, you have a clause in your legislation that is contradictory as far as we can see it. This is referring to part I, section 2 of the act, where in one part of the act you actually define who is a health service provider. Then, in the next subsection, you've got exclusions, and who's excluded are the college of doctors, the College of Chiropodists of Ontario, the college of physicians, the college of dentists—a number of colleges. Yet physicians, chiropodists etc. are employees of community health centres and hospitals. I'm assuming the OHA would raise this issue with you as well. So what is the status of a doctor who works at a CHC, a chiropodist who works at a CHC, and yet they're being excluded in the legislation under subsection (3)?

Our recommendation is that a clause needs to be added that basically says: "A notable exception to clause 1, above, is any member of one of the professional colleges listed in clause 1 who provides professional services through a health service provider, as defined in part I, section 2. In such cases, the professional is deemed to be a member or a component of the health service provider." They can't be in one or the other. They need to be as part of the health service provider. There shouldn't be an exclusion.

1400

Recommendation 10 is about the health professionals' advisory committee—very open-ended as to who should be on it. It has been left totally open for the LHIN to decide who is on your professional advisory committee. Our concern, especially when we're the only primary health care organization in the LHINs, is (1) that this committee needs to ensure that all regulated health professionals are represented on that committee so it's not just a committee of doctors; and (2) that you ensure all models of care are provided. So a doctor who works at a hospital doesn't necessarily bring forward the views of primary health care.

We could clearly be excluded from those advisory committees, and we're the only model that the LHIN is responsible for. We are recommending that more specific language be introduced in there, defining the kinds of folks that need to be on that body.

Our final recommendation is around provincial strategic planning, and the requirement—it describes that the minister's duty is to develop the provincial strategic plan. It's clear in there that the LHINs have to consult with the community on developing their LHIN plans based on a provincial plan. We have frequently been asking who's establishing the provincial plan; what are the consultations for the provincial plan; how are we going to ensure that community health centres across the province are going to be funded fairly equitably, whether you're living in Ottawa versus Timmins; and where are these standards being decided? There is nothing in this legislation that says that the minister will do this. It doesn't say at all how those provincial standards are going to be decided. For us, that is really critical. We understand that the LHINs are going to implement the provincial plan, but the question is, what's the provincial plan and who's determining it? What are the standards at a provincial level?

Since this has come out, we have frequently asked for a table to be set for primary health care where provincial standards for primary health care be set, which would then guide the work of the LHINs. So far, there has been no response to that. Part of our concerns is that all of these 14 different LHINs are going to be one provincial plan, and yes, there might be standardization—there may not be; we're not sure yet—but the question is, who's

doing it in the first place? Where is the consultation for that? We would like to see a very clear plan established around consultations for the provincial plan, as well as that the minister has to deal with whatever report the Ontario Health Quality Council comes out with—it's supposed to be an independent body—that somehow there's legislation in here that the findings, the recommendations, from the Ontario Health Quality Council also need to be incorporated in any decisions and considered in terms of any future guiding of the minister's policies and plans.

Overall I would say that, with trepidation, we are looking at trying to figure out how the LHINs will work. We're working in support of the legislation. However, the concerns around properly engaging communities are key: ensuring that communities are properly resourced when this transition happens—we all know international research that shows you have to invest in primary care, in prevention, if we're going to save the system in the long run. We also want to ensure, though, strong equity for health care professionals across the system no matter where they work. And we want to ensure that basically, the comment at the end, as I just got the signal—we know that an ounce of prevention is worth a pound of cure—that CHCs are well-resourced and positioned to help the new health system as it moves forward. We're looking forward to trying to figure out the solutions for this plan.

The Chair: Thank you for your presentation. There's no time for questioning.

ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES

The Chair: The next presentation is the Association of Local Public Health Agencies, and it's Linda Stewart and Larry O'Connor. Good afternoon. You can start your presentation any time you're ready.

Mr. Larry O'Connor: Thank you, Mr. Chair. Hello. I'm Larry O'Connor. I'm past president of ALPHA, and I've been joined by the executive director of the association, Linda Stewart. The Association of Local Public Health Agencies represents the public health units across Ontario. We work closely with medical officers of health, boards of health and the affiliated organizations that represent the senior managers in public health units. We are pleased to have this opportunity to comment on the proposed legislation, local health integration networks, Bill 36.

First of all we want to recognize the progress the government has made with their ambitious transformation plan and their sustainable health care system. The achievements to date are commendable, and ALPHA is monitoring them with very close interest.

An observation, if I might, about the draft legislation: It doesn't clearly reflect the values of the health care system enshrined in the Canada Health Act, the five fundamental principles: universality, accessibility, comprehensiveness, affordability and public administration. I would like to suggest that these fundamental principles could be reflected in the preamble of the final legislation. I think it would go a long way to putting out the point to the public just where the government feels this health care system belongs. A strong signal is needed.

While public health units do not fall under the jurisdiction of LHINs, they certainly have an interest in the mandates and the planning functions of LHINs. One would perhaps ask why we're here, then. Clearly there are many issues that people have raised, and you've heard other presentations. I guess the point that we want to make is the value and the role that health units provide locally around integration and partnerships. It's always been a foundation, that public health units operate at a local level. Health units back home certainly work closely with a wide range of organizations, including family physicians, long-term-care facilities, social services, school boards, just to name a few. Certainly it's the population health that we work with those providers in.

Due to the relationships with public health and many of the health services providers that now fall under the LHINs, ALPHA wants to ensure that public health units continue to be consulted and that as the LHIN implementation process moves forward there's a role for us to have some interaction at a local level.

In addition, it's important that local, community-level public health units participate in the planning processes of LHINs to ensure that existing partnerships in each health unit remain intact. There are partnerships that have been involved in public health for a long period of time in the community. We want to make sure that they stay in place. You heard from the previous presentation about the interactions with primary care providers and some of the planning processes and the education and health promotion that we do as health units. Obviously, we want to make sure that remains intact.

We're pleased to see that the draft legislation makes provision for community engagement in the LHIN planning process, and ALPHA and the public health units across Ontario look forward to being involved in this process. Perhaps it may need to be strengthened, as we've heard from some of the previous presenters today.

I guess we're here to congratulate you for moving forward on this. We're not part of the process, but we still want to be involved at a community level with some of the communications.

The Chair: Any other comments? No. Thank you.

We have two, three minutes each, and I'll start with Ms. Martel.

Ms. Martel: Thank you for being here today. I appreciate the presentation. Why do you think that public health units were left out of the legislation?

Mr. O'Connor: Quite frankly, I think we're pleased as an association that they were left out of the legislation. I don't think it was appropriate that we would be included in the legislation. If we take a look at the move the government has made in recent times around Operation Health Protection and around the capacity review commission, the number of commissions and reports that

have been undertaken, we don't feel that it would have been appropriate for us to be included in that. We're certainly waiting to hear the outcome of the capacity review's final report. I guess there are some concerns perhaps that local health unit board members may have; they are actually concerns that they would have wearing another hat, perhaps as a municipal councillor, like I am.

Ms. Martel: Yet public health units receive provincial money, and municipal money as well. You're absolutely right: you need to be involved in this process because there are any number of alliances that have already been formed which support primary health care very particularly, but support other aspects of health care as well. Since you're not formally members of LHINs, what is your view of how you can participate on an ongoing basis in a way that's reflected in the legislation?

Mr. O'Connor: One part of the legislation, where it talks about community engagement—we think that's the role we could play. I think the language could certainly be strengthened, but that's perhaps a role that we do play, with that interaction we have with community organizations.

Ms. Linda Stewart: There are a number of committees that are proposed in the legislation, in that section, and public health would, I'm sure, be more than happy to be part of those committees.

Ms. Martel: We've got the health professionals advisory committee and a health service provider committee, but I'm not sure how you'd fit under either of those, actually.

Ms. Stewart: We certainly have groups of health service providers that work in health units that aren't strictly health care providers that are typically under the LHINs. You have public health nurses, public health inspectors. We have groups of different folks who interact with the communities and interact with the various organizations that are inside the LHINs, so there could be some benefit to them being together, working together.

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Mr. O'Connor: For purposes of discussion, perhaps an example is public health dentistry, where our public health dentists hold clinics within the community. Obviously, for planning purposes, we think we should work together. Sexual health clinics that are held in the communities: Obviously, there's a service component to that and an education component to that. We'd want to work together with the health care community to make sure we're offering the best service and at the same time involving them in the education process.

The Chair: Thank you. Mr. Levac.

Mr. Dave Levac (Brant): Thank you very much for the thoughtful presentation. Over the last little while I've heard some serious concerns being laid before us by various groups and individuals regarding the changes that are being proposed within this. Can you reflect for us on some of the changes that have taken place with the public health provisions over the years or the decades, from your experience, and once those questions were answered and once the process was put into place, the types of things that bettered the public health system in terms of trying to alleviate some of the concerns that are being expressed now? You sound like you're going to be partners with this, even though you're not attached, but could share some expertise on how those changes get implemented and show for the improvement of the system.

Mr. O'Connor: Certainly, we've been the subject of much consideration in recent times. One way that we as an organization interact with the government could be, for example, through our conferences, where we bring forward resolutions to talk about immunizations, where the government has actually acted upon our recommendations and has strengthened them. Certainly, it's a way that we've been able to work together with the government.

The review of mandatory programs is another one that's about to be undertaken. There's been much discussion in the past about actually reviewing these mandatory programs: Are they effecting the positive changes in the health of our population that we want to see and are we measuring them appropriately? Some of that has to be reviewed, and so we're continuing to be a part of that process. Some of it still remains yet to be seen; for example, the CRC, the report that is still outstanding. Linda, did you want to add?

Ms. Stewart: If I can add something there, the initial creation of the mandatory programs, which was back in the 1980s, was a reaction to something that may result or an issue that may certainly be perceived as possible with LHINs, that there may be inconsistency, that there may be no standards between LHINs. The mandatory programs were developed and in fact solved that issue. As Larry suggested, it's quite a few years later, 20 years later, and they're recognized as out of date and in need of review. But the implementation of that kind of standard that applies across the province can really help, recognizing that they need to be reviewed from time to time.

Ms. Wynne: Thanks very much for coming today. Earlier in our proceedings, the district health councils were referred to as toothless at one point. I'm just wondering how you see the LHINs—because you obviously see their coordination role as being important—what the key component of that is. What is it that you're going to be looking to the LHINs to do once they're up and running?

Mr. O'Connor: If I could speak to that community engagement portion of it, I think that's one that we won't know until that actually takes place. District health councils did have municipal representation on them in the past. The legislation doesn't allow for that to take place but the community advisory committees' intention that I'm hearing from local chairs is that they want to engage people in that sort of discussion. So perhaps the proof is still out there.

One thing that the district health councils did quite well was provide good planning advice at a local level for the Minister of Health. Quite often reaction to that good planning advice takes years and years before we ever see anything come out of it. Whether the LHIN gets

tied to that long-time frame around funding—certainly the last presentation actually spoke to some of the realities around funding.

Ms. Wynne: But you need that planning advice and you need it to be acted upon?

Mr. O'Connor: That's right. We obviously have the staff that can do some of that; for example, our epidemiologists provide that sort of expertise that can be used to complement some of the other work.

The Chair: Mr. Arnott.

Mr. Arnott: Larry, it's always good to see you back at Queen's Park. I want to thank you very much for your presentation. You have said that it's an important opportunity for your organization to be able to participate in the community engagement part of this. I was wondering if you would care to give this committee some advice as to what you think the guiding principles ought to be in terms of how the government would proceed with community engagement and exactly how your association would fit into that.

Mr. O'Connor: I think it could be strengthened. We've heard that from the other presenters today, that that role could be strengthened. I'll give you a local example, if I might. In Durham region we have a network of health care providers that come together, from the hospitals to the community providers. Our MOH for the region, Dr. Kyle, actually chairs that group. There is collaboration that takes place around local planning initiatives and they're all kept in touch with the realities of the budgets as they go through the process. It's not mandated anywhere that that type of collaboration needs to take place, but it does at a local level. I guess the fear is that when you put something out that's very prescriptive and doesn't allow that community development piece to take place, then you run the risk of overlooking some opportunities.

Mr. Arnott: In the communities that I'm privileged to represent, there are those kinds of efforts to collaborate that make a big difference in terms of the delivery of health care, and prevent small problems from becoming big ones and ensure that people continue to work together to maintain their foremost interest, of course, which is the improvement of care to the patient. I want to commend your area for pursuing that kind of approach.

Mr. O'Connor: In public health, our primary concern is population health, as opposed to that of the primary health care providers. There needs to be, obviously, that interaction at the local level at every stage through the process.

Ms. Stewart: If I can add some thoughts around principles, two really key ones that come to mind are inclusivity and being a bit careful about who decides who needs to be inclusive—what does that really mean?—as well as ensuring that an open atmosphere of what I would call dialogue exists so it's clear that everyone has a voice, everyone's voice is respected, and everybody is heard and so on.

The Chair: Thank you very much for your presentation.

ELDER HEALTH ELDER CARE COALITION

The Chair: The next presentation is from the Elder Health Elder Care Coalition. Just for the record, we have a letter that I received from Susan VanderBent. We will all have a copy. I'll read the first part:

"The board of directors of the Ontario Home Care Association is a member of the Elder Health Elder Care Coalition but is not a signatory to the Elder Health Elder Care Coalition submission to the standing committee on social policy. This is due to differences related to the content of some of the recommendations in the submission...." and so on. Do you have a copy? Okay. You can start your presentation whenever you're ready. Thank you again.

Ms. Gerda Kaegi: My name is Gerda Kaegi and I'm co-chair of the coalition. My colleague is Donna Rubin, a member of the steering committee of the Elder Health Elder Care Coalition.

What might be most useful to you—on the inside cover of our brief you will see a list of the coalition members who support this submission. I think that is in part a response to the letter that you cited at the beginning.

We are an umbrella organization that brings together seniors, social activists, health care professionals and providers interested in contributing to older persons' health and well-being. Our mandate is to advocate for healthy public policy for seniors. We have acted as an advisory group to Minister Smitherman and other ministry officials. We welcome this opportunity to convey our coalition's views and recommendations on Bill 36. As I said, the members who support this brief are listed.

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We believe that integrating all sectors of our system could produce a seamless, cost-effective continuum of care in which patients would be able to access various levels of care as their health needs require. In looking at Bill 36, we are looking at how its provisions would affect older persons in particular and what opportunities it would provide for input from all of us, including ordinary citizens and organizations that serve and advocate on their behalf.

The integration of care for the elderly should be an immediate and crucial undertaking for LHINs boards, because we all know that seniors are proportionately the greatest users of health care. The LHIN priority-setting workshops across the province recognize that senior health care and care for the mentally ill should be top priorities for service integration. We are going to argue, and we do argue, that the voices of seniors need to be heard and be available to every LHIN board and to the minister.

Therefore, we have our recommendation 1, which you see in the brief: There must be a seniors' advisory committee for each LHIN and for the minister.

We also, following presentations you've had from others, believe the legislation should be extended to the principles and spirit of the Canada Health Act. I don't

think I need to go through that argument, but we also say that it should eventually include pharmaceuticals, rehabilitative care delivered in the community, in-home or at dedicated hospitals, in-home care for post-acute patients, supportive community-based care for the chronically ill and the disabled and for older persons with age-related functional deficits and long-term-care homes.

Recommendation 2 asks for that extension with an explicit commitment to the Canada Health Act.

We are concerned, as a coalition, for the non-profit delivery of service, and we're afraid that it will be eroded. Bill 36 has no explicit provision for the LHINs, the minister or cabinet to preserve or expand public not-for-profit delivery of health care services. Seniors and the advocates are deeply concerned about the absence of that. Our brief cites some of the evidence to show that publicly funded and not-for-profit delivered health care services result in higher quality care at lower cost. Studies in many jurisdictions show that P3 initiatives have a higher cost and result in a deterioration of the quality of services.

So we've come up with recommendation 3:

—Amend the objects of the LHINs to include strengthening not-for-profit delivery.

—Amend Bill 36 to require that any transfer of services must be to not-for-profit providers and that only if these cannot accept the transfer of health services should transfer go to for-profit providers.

—The minister should have identical powers to make orders with respect to covering not-for-profit and for-profit providers—subsection 28(1).

We have an additional concern with the provision, repeated many times in different sections, that LHIN boards and organizations or health providers must make no decisions that are not in accord with the strategic plan being prepared by the Minister of Health. Others have just spoken to the same concern. That plan is not public. We are then in effect being asked to comment on the means to an unknown end. Another way of saying this is that, with Bill 36, we're being asked to buy—and I don't mean to be insulting—a pig in a poke.

So our recommendation 4 is to amend Bill 36 to include explicit parameters for public engagement in the development of the ministry's strategic plan, including the requirement to include seniors' groups.

We go on raising concerns that others have raised. We welcome the inclusion of a section called "Community engagement," but we're not at all sure when and by what means such engagement will be allowed. We note that holding open board meetings is an excellent first step, but it is qualified in the legislation. It talks about "reasonable" notice of board and committee meetings.

So our recommendation 5 says to amend Bill 36 to include explicit parameters for public engagement for each LHIN, including the requirements to include seniors' groups.

We welcome the return to community control of the community care access centres. Again, it is not clear how this will take place and it is over a long period of time. The legislation makes clear that we're not to expect any provision under the "Community engagement" section to be actualized until at least a year after the legislation has been enacted.

In recommendation 6, we are saying to amend Bill 36 to include an appeal process, accessible or available to the community, if the community is not satisfied with a decision made by each LHIN. The second part: Provide for a dispute resolution process when LHINs and the ministry cannot agree on an accountability agreement.

Then we turn to funding, which is the foundation of policy-making. Government policy is made effective by funding decisions. We use as an example one that has really affected seniors across the province: home care. The previous government gave responsibility to the community care access centres to provide both post-hospital care and supportive care for the disabled, the chronically ill and persons with age-related functional deficits. The funding provided was never adequate for the CCACs to carry out both functions, and with patients being discharged from hospital quicker and sicker, the available resources were absorbed more and more by the needs of discharged patients who were indeed sick enough to need in-home care urgently. Supportive home care has virtually disappeared, without anyone admitting in the government that their policy was to eliminate it.

Recommendation 7: The provincial government must ensure that LHIN funding is based on the actual needs of the population. The determination of those needs must include a number of variables, such as socio-economic and health status, age distribution, the number of recent immigrants and ethnocultural diversity, and must be made in consultation with the community.

Then we turn to the issue that has again particularly affected seniors, but others as well: the experiment with competitive bidding, or mandated competition in home care. It has been a disaster for seniors. Many have seen unnecessary changes in their caregivers. We're extremely concerned that Bill 36 may give way to an expansion of competitive bidding, leading to an inefficient and chaotic system. How care is structured has a direct impact on equity of access, continuity of care and quality of services.

Recommendation 8: Amend Bill 36 to prohibit expanding the use of competitive bidding as a method for allocating funding to health service providers and ensure that any allocation process is fair and transparent.

Finally, seniors and their advocates are most concerned that Bill 36 allows the LHINs to integrate or stop service provision or potentially contract out services and allows cabinet to order contracting out of non-clinical hospital services. This bill would provide LHINs with the legislative authority to act without having to follow clear criteria and to be publicly accountable for its decisions.

Seniors are concerned that mistakes from the past are not only being repeated but are being enshrined in legislation. Seniors and others will suffer the negative impact in the form of an unstable workforce and lack of continuity in the services received, as well as worsened conditions in institutional settings.

So we come up with our last recommendation: The regulations must prohibit a LHIN from issuing decisions that order integration or contracting out of any services without clear criteria for outcomes, quality and continuity of services, criteria that balance effectiveness and efficiency. We also say that all LHINs must have the same criteria.

This is a huge undertaking, and it will succeed only to the degree that the public as well as health care providers buy into it. We therefore concentrated on three crucial questions:

(1) Will there be adequate opportunities for public input, especially for seniors, before changes are made?

(2) Will there be adequate guarantees that the system will be structured to ensure continuity of care, quality of services and equity of access?

(3) Will there be adequate funding to meet the actual needs of the people of Ontario?

Thank you very much.

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

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OLDER WOMEN'S NETWORK, PETERBOROUGH

The Chair: The next presentation is from the Older Women's Network, Peterborough chapter: Kathryn Langley and Marie Bongard. Good afternoon.

Ms. Kathryn Langley: We are from Central East. Peterborough, is experiencing a blizzard, yesterday and today. My husband was killed in a snowstorm on November 20, 2000—triage system; a big mess—so I'm afraid to drive in inclement weather. I have a car. I wanted this to be local. It isn't local. Here we are. We came by Greyhound, and thank God for Greyhound, because in our LHIN area there are very few good roads.

I'm from the Peterborough chapter of the Older Women's Network. I'm going to turn over the microphone to one of our members, Marie Bongard, who you can see is a special person.

Ms. Marie Bongard: Thanks very much, Kathryn. Speaking as an older woman with a disability, I am deeply concerned about the future of Ontario's health care. Bill 36, which will mandate LHINs, is supposed to be able to improve access to the services and make the system more efficient, but who will it benefit? I feel that too many marginalized Ontarians will have less access to service, not more.

How will people on low, fixed incomes—including working individuals on minimum wage, seniors and the disabled—be able to receive the treatment they might need? Special-needs groups do not seem to be addressed in this proposed legislation. Will they be able to find or even finance the transportation required to travel to these health centres? Will there be any allowance made for these expenses in the act?

How will someone receiving only $536 in Ontario Works benefits be able to afford the cost of travel to some distant community for medical attention, when this allotment does not even cover their living expenses for the month? These recipients have to rely heavily on food banks for their existence.

Seniors, as they become more fragile and incapacitated, move from small, rural areas to urban centres to be closer to medical and health services. Many in our aging population have multiple medical conditions. Under the LHINs arrangement, they may have to travel in various directions to see doctors to get their needs met. Many may be just too sick to make the journey. They are another group on fixed incomes who may not be able to afford the extra cost.

Statistics show that our senior population is living longer. Although some may still drive and be relatively independent, the majority must rely on the support of others. Diseases and other medical conditions will force many of the aged to forfeit their driver's licence and independence. Seniors do not have the income to cover the cost of this travel.

I'll skip some.

Also, the cost of alternative travel will be too much for those who cannot afford it. For instance, to go from Peterborough to Oshawa is $35. This is by Community Care, which is an agency set up for seniors and the disabled. Imagine the expense if the individual had numerous visits to more distant locations. In my case, as a blind person, I would also need assistance to find the doctor's office or area of treatment within the building itself.

Last year, I applauded the government when the ODA 2001 was replaced by the Accessibility for Ontarians with Disabilities Act. This bill was designed to make Ontario a barrier-free society by preventing and removing barriers. When barriers are eliminated for the disabled, everyone benefits. The proposed Bill 36 has the potential to create new and disastrous barriers for marginalized Ontarians. It will simply place undue hardship on the people who can least afford the cost of travel and the expense of services no longer covered by public health.

I will just say that I feel the bottom line will be that thousands of Ontarians will no longer have access to health care because they may not be able to afford it or have any means of receiving treatment.

Anyway, you can read the rest.

Ms. Langley: Thank you. The Peterborough chapter of the Older Women's Network represents women between 40 and 88 of different socio-economic backgrounds. Our membership is quite diverse. We value social and economic justice and community.

Several aspects of Bill 36 trouble us. The restructuring and structural adjustments seem suspiciously like the structural adjustments so praised by the International Monetary Fund, the World Trade Organization and the World Bank and greatly valued by the Canadian Council of Chief Executives because of the profits to be made at

the expense of workers and providers. Structural adjustments widen the already growing rich-poor gap in Ontario and favour the already well-to-do.

Bill 36 appears to give the health minister strong powers to close, amalgamate, redefine functionality and deal arbitrarily with publicly operated service providers. These powers do not extend to making the same changes with private providers. Thus, Bill 36 seems to be a vehicle promoting more privatization of our health care system. The Older Women's Network is concerned about a corporate power grab of our health care system and public services.

We're most concerned about the competitive bidding or lobbying. We question the wisdom of the competitive bidding process because it's well known that corporations have many more assets which can be used for lobbying than the non-profits. The result will be the decimation of the not-for-profit sector, in my opinion done on purpose.

In Peterborough last week, the public was denied access to the bidding information, arguably to protect the private interests. The bids were for moving from our old hospital to our new hospital. If the bids are in order, why the secrecy? Why could the public sector not have the resources to move equipment and people, since there are probably going to be so many hospitals moved in the next four or five years? Why do we need the private sector involved? A recent television show featured a bid being awarded to the offer that was wined, dined and companioned the best. We're concerned about competitive bidding.

We question public dollars for private profits. We feel that the public not-for-profit can provide better services at lower costs because ever-increasing profits and responsibilities to shareholders do not have to be factored in. We're worried about accessibility and the arbitrary boundaries. What about the people who live in the far corners who actually live closer to larger centres that may be a few miles away as opposed to travelling to the other side of their LHINs? We're worried about communication costs: long-distance telephones and messaging services. We're worried about travelling expenses.

My idea of "local" is that when I was 12, I could bike over to visit my grandfather in the hospital and play cribbage with him. My granny could walk over. My grandfather recovered from his operations. That's my idea of local. At the start of my paper, I said "local" was when I was 10 and tripped on my nightgown and fell down the stairs, and when my doctor was phoned he said to my mom, "Apply pressure and ice cubes." She says, "Oh, Dr. Ralph, I defrosted the refrigerator this morning." At 2 in the morning, Dr. Ralph arrived in his PJs and his robe, carrying ice cube trays, adjusted my nose, gave me a pill and said, "If there are any problems, come on over tomorrow." His office was five blocks away. That's my idea of local.

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Back to the Older Women's Network. We're worried about cancellations for inclement weather. We are here today because a Greyhound was leaving at the right time. I would have been terrified to drive. Who pays for cancelled appointments? Doctors' offices in Peterborough say, "All missed appointments will be charged for." Who's going to take into account ice storms and bad weather?

Forced mergers and amalgamations: It was a disaster with the city of Kawartha Lakes and with the Kawartha Pine Ridge District School Board. It was the lowest common denominator, not an improvement at all. There were increased communication costs, distances. It was problematic for accessing personnel services and resources, doing workshops. The distances wasted time, damaged the environment, caused needless stress and increased expenses for travel and communications.

We value, as I said earlier, the common good and the community as a counter to the greed and individualism of the neo-liberal corporate globalization. We're worried about the workers. Quite a few are older women in our communities. People are being asked to work harder for longer hours or they're being asked to work fewer hours. The people in our long-term-care facilities are asked to change their eating, bathing and daily habits and have fewer activities because money is not forthcoming. "Fairhaven Forced to Make Cuts"—that was in this weekend's Peterborough Examiner.

We worry about the people in our community. People who are making good wages, with job security and good pensions to look forward to, can contribute to the life of their communities. People who are making minimum wage—it just doesn't work. We need a healthy balance between private and public, with essential services being publicly provided, not for profit, and paid for through reasonable taxation. We don't need the profit motive in there.

We don't need more delisting. Delisted services are less protected under the Canada Health Act. We don't need more contracting out. We have a good public service sector.

My idea of democracy is not LHINs boards being appointed by cabinet rather than being elected. Brampton presented you with a really good idea for community advisory groups last week.

Funding: Don't throw more money at it. It's how you spend it, and it shouldn't be for profit. The money for health should be spent on health, not large corporations.

We're worried about power in the community. We need more women's health care centres, where we have personal well-being, preventive measures, support groups, exercise groups, nutrition workshops, access to resources and places where citizens can come together, regardless of socio-economic status or ability to pay. We need more funding for community-based—and I mean local—health initiatives.

You know about poverty and social determinants of health, so as the standing committee on social policy, you must recognize the effects of increased poverty, food insecurity and housing insecurity.

We do have some alternatives suggested. We'd like to see the Canada Health Act strengthened. How about a

national dental health plan? How about a national pharmacare plan?

Errors of omission in Bill 36: We know what Minister of Health George Smitherman says, but we'd feel better having it spelled out. Where does Bill 36 say that it won't open the door to privatization and two-tier health care? Where does it say it won't close hospitals? Where does it say it won't extend the competitive bidding model to the entire public health care system? Where does it say it won't result in patients having to travel further for services, and where does Bill 36 say that it won't mean lost jobs and lower wages?

Life as we know it: David Suzuki explains in the film Suzuki Says that we are the environment. We are the air, every breath we take, the water—think about it: 75% of our bodies might be water—the earth, the fire. Together we are life. Everything we do has an effect on everything else. I urge you, the committee, to put the people of Ontario and their lives, their environment, their health ahead of the health of private and corporate interests. Reconsider Bill 36 and its effects, and amend it to protect our local, public, not-for-profit health care in Ontario.

Thanks. I appreciate your letting me finish.

The Chair: Thank you. There's no time for questioning, but we thank you for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1332

The Chair: The next presentation is from the Canadian Union of Public Employees, CUPE Local 1332, Espanola. It's a teleconference. Colette Proctor, are you there? Good afternoon. You can start your presentation, please.

Ms. Colette Proctor: Thank you. Hi. My name is Colette Proctor and I'm the president of CUPE Local 1332. We represent the service employees at the Espanola General Hospital and the Manitoulin Health Centre.

First of all, I'd like to say that we are very concerned that the LHINs do not include the doctors. Physician services are a major part of health care and they should not be excluded. Another concern we have is the vast areas that the LHINs cover. The LHIN 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. The North East LHIN, or LHIN 13, the one we're a part of, goes from Peawanuk in the north to South Algonquin to the south. The North East LHIN's boundaries include the districts of Nipissing, Parry Sound, Sudbury, Algoma and Cochrane. The North East LHIN also includes the eastern portion of the district of Kenora. Just to give you an idea of how far these areas are, it's at least a four-hour drive to Timmins on Highway 144, one of the worst highways you could drive in the north, and it's not a highway that you want to drive in the winter if you don't have to. So you can see that it would be very difficult for the people living within the LHIN to have a significant voice in the direction of that LHIN, even if the LHIN board wishes to listen to them.

The autonomy of the LHIN from the government is very modest. With this bill, cabinet may create, amalgamate and dissolve a LHIN. The government will control LHIN funding, and each LHIN will be required to sign an accountability agreement with the government. Indeed, the government may unilaterally impose one, even if the LHIN does not agree with the agreement. In addition, the LHIN's integration plan must fit the provincial strategic plan. So the LHIN boards will be responsible to the provincial government rather than to the local communities. This is in contrast to 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, hospital boards are not appointed by the provincial government. They have doggedly pointed out the need for better health care in their communities, with significant success. The previous government attempted to cut hundreds of millions of dollars from local hospitals, but when local hospitals helped to point out to their communities the problems this created, the government reconsidered. The cuts were reversed and the hospitals were allowed to continue to provide decent, if still underfunded, care.

Recently, however, the government has found a way to blend criticism of underfunding and privatization. The key was to replace community boards with government-controlled boards. This, unfortunately, is the model for LHINs. The result of this experiment in community care access centres suggests this is a very poor model for LHINs to follow. CCACs were taken over by the provincial government in 2001. CCACs immediately ceased pointing out to the public their need for adequate funding. The result: Their funding was flatlined for years and home care services were cut back dramatically. Tens of thousands of the frail elderly and disabled lost their home support services. In total, the effect was a reduction of 115,000 patients served from April 1, 2001, to April 1, 2003, and a cut of 6 million hours in services—a 30% drop.

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As one government report calmly noted, as prices went up and the funding levels remained constant, CCACs had to discontinue certain services in order to maintain balanced budgets. These changes occurred independently, without provincial coordination and clear communication. The emphasis shifted from homemaking services to the provision of personal support.

My 94-year-old mother, who suffered from congestive heart failure and venous ulcers and was on constant oxygen, was allowed four hours a day, three times a week, of home care services when the VON, a not-for-profit provider, supplied the home care services. Once home care was put up for bids and Bayshore took over—Bayshore is a for-profit health care provider—my mother's home care was cut to 45 minutes twice a week. If not for the fact that her family lived in Espanola, she

would not have been able to remain at home. What happens to seniors without family support? They end up being admitted to hospital, where the cost of looking after them is much higher than home care. Government-controlled regional agencies are a poor model for health care and social service reform, if 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 services will the LHIN provide in each area of the LHIN? Unlike government, LHINs will not be able to increase revenue. Smaller communities may be the first to see their services integrated into other communities. Espanola and Manitoulin, being part of a smaller community, will see service cuts. We're very sure of that. We already have to travel to a larger centre for some services. It's an hour to Sudbury from Espanola; it's an hour and a half to Sudbury from Manitoulin. If we lose the services we have, such as chemotherapy, we will spend hours travelling back and forth. What happens to the seniors who can't drive or the families who don't even have a car? Do they go without treatment? How do they get to where the treatment is? What happens to the people who are too frail and too sick to travel? What do we say to them, "Sorry, can't help you. We don't have the service here"?

Espanola, as I said, is an hour from Sudbury Regional Hospital. The next-nearest major centre is two and a half hours away in good weather. If services are moved, will we be expected to travel five hours to see a specialist? This is the north, and the weather is not very predictable up here.

The LHIN structure puts up significant barriers to local community control of health care. Conflicts between communities within a single LHIN are likely, with small communities particularly threatened. The provincial government will likely respond to complaints by stating, "It's not our decision. It's the decision of the LHINs," yet the LHINs will be largely unaccountable to local communities. These serious problems suggest that another direction must be investigated.

We need to provide for the democratic election of LHIN directors by all residents in the LHIN's geographic area, with selection of the chair and vice-chair by the elected directors. Local members of provincial Parliament should be ex officio directors of the LHIN. There should be a requirement in the bill for extensive public consultation on the existing geographic boundaries of the LHINs. LHIN boundaries should reflect a real community of health care interests so local communities can have a real impact on their LHIN's decisions. We also need a requirement for real public consultation when government proposes to amalgamate, dissolve or divide a LHIN.

We need a ministerial obligation to meaningfully and fully consult the community prior to imposing an accountability agreement on a LHIN. 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 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 decisions or regulations.

Bill 36 gives LHINs and the government a wide range of tools to restructure health care organizations. First of all, the LHINs have the funding power to facilitate consolidation. They also have accountability agreements with health service providers. While these powers may appear sufficient, much more powerful tools have been given to the LHINs, the Minister of Health and the cabinet to force consolidation. LHINs are given the power to issue compulsory integration decisions requiring health care providers to cease providing a service or to transfer a service. The bill gives the minister even more power to order integration directly.

The bill allows cabinet to order any public hospital to cease performing any "non-clinical service" and to transfer it to another organization. This means that the government can centrally dictate how all non-clinical services are to be provided by the hospitals, including through privatization. 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 services, so this definition may be a matter of considerable controversy.

The government refers to restructuring as integration, stating that the goal is the creation of seamless care and a true health care system. But this is misleading. The LHIN restructuring will not unite hospitals, homes, doctors, laboratories, home care providers and clinics, as in other provinces. Worse, the LHINs purchaser-provider model will increase competition between providers, and plans to spin off work to for-profit corporations, private clinics and regionally based support services providers will mean more fragmentation and less integration.

The government's plan is to regionalize hospital support services. With government support, dozens of hospitals across the north are planning to consolidate supply chain and office services by turning work over to a new employer, Northern Ontario Hospital Back Office Services. Likewise, 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 sever roughly 20% to 25% of employees. This is a major change that may have far-ranging consequences for workers in local communities, and more such plans are in the works.

I'm one of those employees, by the way. I've worked at the Espanola General Hospital for 35 years. I work in materials management. I could all of a sudden not be working for Espanola General Hospital, my pension

would be frozen, and I would be working for somebody that I did not plan to end my career with.

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

The hospitals insisted that an exclusive focus on support service would not satisfy the cost savings demanded by the government, that the savings would also require clinical cuts. By April 2005, the government admitted as much, with the health minister publicly calling for the centralization of hospital surgeries: "We don't need to do hip and knee surgery in 57 different hospitals." Indeed, he suggested that about 20, or a 60% cut, would 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 ... with as broad a range of services as they're tending to right now." This squarely raises the prospect of even more travelling to multiple sites for health care services. Therefore, that means now I'm travelling five hours instead of two, because now my services may be moved from Sudbury, where I need to go, to anywhere from Timmins to the Soo to North Bay.

The government has also begun to move surgeries right out of hospitals and place them in clinics. The first instance was the recent creation of the Kensington Eye Institute. This clinic in the recently closed Doctors Hospital in Toronto is supposed to remove 1,700 procedures from hospitals and do an additional 5,000 cataract surgeries. The minister says that this is only the beginning. But the creation of new surgical clinics only fragments health care, creating more employers and more destinations for seniors to run around to so they can get their health care needs tended to.

It also raises the possibility of the establishment of for-profit surgical clinics. Indeed, when the health minister announced his interest in surgical clinics in the spring of 2005, the chosen sponsor of his speech, University of Toronto academic John Crispo, proposed private sector clinics providing two-tier care as soon as the minister sat down.

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A better solution would be to create surgical clinics in the facilities and organizations in which we already have money invested. Hospitals have the infrastructure needed to support these surgical clinics. There is no need to duplicate their human resources, stores, payroll, purchasing, cleaning, food, laboratory and other support services. Hospitals also have the resources to deal with emergencies that may occur during operations, and this would actually help advance the seamless care that this reform is supposed to create.

Consolidation of services doesn't necessarily mean cost savings. The most recent government experiments with consolidation have been associated with increased costs. The merger and closure of hospitals directed by the Health Services Restructuring Commission in the 1990s did not lead to reduced spending on hospitals and health care. Indeed, there has been a significant increase in spending, and many of the Health Services Restructuring Commission's directed hospital restructure projects left a shambles for exhausted and demoralized hospital staff to clean up. Sudbury Regional Hospital was one of those where phase 1 went $140 million over budget, and that hospital still isn't finished.

The LHINs reform does not directly deal with the undisputed real health cost drivers: the soaring cost of drugs and equipment supplied by transnational corporations. Indeed, 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. Reduction in community control and provincial government accountability will make it easier for government to implement these threats. We need fundamental change.

The Chair: Madam, you've already gone over the 15 minutes. Can you come to a conclusion, if you can? Also, if I may, could we please have a copy of your material? We don't have one. We would appreciate it if you could fax one to the clerk so she can provide a copy to all of us.

Ms. Proctor: Yes, I will.

The Chair: Thank you. Please conclude.

Ms. Proctor: In conclusion, with all these concerns, we believe this bill and the government's attempt to restructure health care needs to be rethought. We have made some suggestions on how health care reform could unfold, but we urge the government to take a considered and consolidated approach. We had no sense before the last election that the government would embark on this path it has taken. We believe the better approach would be to consult with local communities, health care workers and the public about how health care should be transformed. That would be a much more satisfactory and much more democratic process.

I'd like to thank the committee for listening to our concerns and suggestions.

The Chair: Thank you, Ms. Proctor. Have a nice evening.

ASSOCIATION OF MUNICIPALITIES OF ONTARIO

The Chair: We'll go to the next presentation, the Association of Municipalities of Ontario, AMO. Sir and madam, you can start any time you are ready. Could we have your names for the record, please?

Mr. Doug Reycraft: Thanks, Mr. Chairman, and good afternoon to you and to members of the committee. My name is Doug Reycraft. I'm a county councillor in Middlesex, a vice-president of the Association of Municipalities of Ontario, and chair of AMO's public

health task force. With me this afternoon is Petra Wolfbeiss, who is a senior policy adviser for AMO.

In September 2004, the Minister of Health and Long-Term Care, the Honourable George Smitherman, delivered a speech in which the province's plan to transform health care in Ontario was trumpeted. The minister stated that the government's plan included creating a comprehensive and integrated system of care that would be shaped by the active leadership of communities and driven by the needs of patients. In his speech, the minister acknowledged that transformation must begin with a new way of thinking and behaving and that the transformation would require a cultural change, driven by a genuine desire to rise above self-interest, which would be leveraged through building mature relationships.

Since the inception of the plan to transform health care in Ontario, AMO has been supportive of the government's vision of health care improvement and the intended outcomes of health service integration, namely, service efficiency, effectiveness and improved access. AMO has participated in a number of working groups involved in the health transformation undertaking, including subcommittees of the public health capacity review and the family health teams working group. The invitation to be involved in these initiatives signals to us the recognition by the government of the important leadership and expertise that municipalities bring to the table when important decisions need to be made.

AMO supports the purpose of Bill 36, but we wish to emphasize a number of points that we believe will act to strengthen the intent and objectives of the bill and the government's plan of action to achieve its vision of health transformation in our province. AMO recognizes the province's jurisdiction and exclusive responsibility for health care. In Ontario, however, communities struggle under a system that forces property tax payers to subsidize the province in the health care field. August 23, 2004, was a historic day for the maturing provincial-municipal relationship. It was the day that the current memorandum of understanding, or MOU, between the province and AMO was signed. It was on this day that the province committed to working as a partner with municipalities and recognized them as responsible orders of government. This is emphasized in the following text from the MOU:

"Effective co-operation between Ontario and municipalities enhances certainty and predictability of government performance, and promotes public confidence and sound planning.... Ontario recognizes municipalities as responsible and accountable governments with respect to matters within their jurisdiction.... Ontario and municipalities share a common goal of ensuring a clear understanding of responsibility so that Ontario and municipalities are accountable for specific policies and effective performance of their respective roles."

Given that the MOU recognizes municipalities as an order of government that is accountable and responsible, it's not clear why Bill 36 does not contain specific reference to engagement with municipalities. The proposed legislation provides the means and objectives of achieving integration of health services and delivery at the local level. Decisions will be made that require municipalities, which are accountable to their communities and which are funders and providers of health care services, to be directly involved in the process. It is precisely, as the Minister of Municipal Affairs and Housing indicated, where the active leadership of communities through municipalities is required.

By now, the province has heard about AMO's position on the current $3-billion gap, which is the imbalance between what municipalities pay for provincial health and social services and the funding that municipalities receive from the province for those services. It is an imbalance that makes the efforts of municipal governments to create and provide healthy and sustainable communities virtually unachievable. AMO has had a long-standing position that health services should not be funded through the property tax base. AMO also continues to hold our long-standing principle of pay-for-say. As long as municipalities are funding provincial services, they must have a say in the governance and the delivery of those services. The signing of the MOU in August 2004 and the Premier's continued recognition of involvement of municipalities in policy and program decisions at both the provincial and federal levels is a testament to our principle.

Bill 36 contradicts the current provincial-municipal context of policy and program development, design and implementation. However, while AMO is advocating for the inclusion of municipalities in Bill 36 on discussion, decisions and actions of health services program integration that have a direct bearing on municipalities on a matter of principle, it must be noted that AMO's fundamental position is that health services, including land ambulance and public health, should be funded by the province.

In short, although AMO is advocating that Bill 36 adhere to the principles of the MOU, true integrity of an efficient, effective and integrated delivery of health care services can only be achieved with the upload of health services funding, including public health and land ambulance, to the province.

Given the scope and the magnitude of the health transformation and integration of services under Bill 36, the need for core oversight mechanisms is recognized and supported. AMO has a number of comments and recommendations that can strengthen this effort. We recognize that Bill 36 does have a number of accountability provisions in place, including the consultation processes, accountability agreements and the duties of the LHIN boards of directors. Unfortunately, special-purpose bodies, as the LHIN boards are, are accountable neither to the communities they serve nor to the service providers in a community. What is lost in this model is an understanding of the integration and coordination that has already taken place at the local level of not only health care services but services between social assistance, social housing, child care and health, all of which

are funded and managed, at least partly, by municipalities. It is recommended that both the LHIN boards and the minister take into consideration local service delivery initiatives in any integration decisions, this being accomplished through open, transparent and timely engagement of municipalities.

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Each LHIN board will be required to develop an integrated health service plan that will include the "vision, priorities and strategic directions for the local health system and shall set out strategies to integrate the local health system in order to achieve the purpose of this act." It says that in subsection 15(2). The integrated health service plans will need to reflect the vision, principles and strategic direction of the provincial strategic plan for the health system. While AMO is supportive of the integration objectives, it must be reiterated that the provincial vision must not discount local realities and the good work that municipalities have carried out in the integration and coordination of local services that meet local needs.

Due to the fact that the LHIN boundaries are not aligned with municipal boundaries, the issues of governance and integration decisions will be even further complicated, and this raises many questions on municipal funding, governance and accountability. Municipal governments are accountable to the local taxpayer for the funds raised through property taxes and fees. How will the LHINs, as special-purpose bodies not accountable to the local residents, make informed and balanced decisions that truly address community needs without consistent and transparent municipal input? How will integration decisions across municipalities be fairly and equitably negotiated? Bill 36 fails to address this.

Municipalities are currently investing in hospitals and long-term-care facilities across the province and municipalities are already involved in the governance of land ambulance services and public health. Additionally, municipalities make enormous investments in infrastructure and promotion to foster economic development within their communities. Given these considerations, it seems counterintuitive that LHIN boards can make unilateral decisions with significant impacts on all of these areas. Therefore, AMO recommends that the legislation be amended to provide for municipal representation on LHIN boards.

Under Bill 36, LHINs have the authority and the responsibility, along with health service providers, to identify opportunities for integration to achieve the objectives of Bill 36. Section 26 of the bill outlines the ability for LHINs to change the scope, location and level of services of a health service provider. This then includes the LHINs' authority to adjust funding to services based on the integration plans and agreements. LHINs do not have the authority for a final decision on the integration of services. This authority appears to be granted to the minister under section 28 of the bill.

There are a number of issues that arise from the above. Most clear is the lack of municipal involvement in the overall decision-making for a service that is funded by municipalities, specifically municipally operated long-term-care facilities and elderly person centres. It's difficult to reconcile the sweeping authority granted both to the LHINs and the minister to make decisions of service integration and funding that can result in significant exposure to municipalities regarding mortgages or other financial obligations. Why would special-purpose bodies, the LHIN boards, be given the authority to decide on issues of municipal governance and funding? Why does the minister have such broad powers on issues of municipal governance and funding, when clearly the current provincial-municipal relationship under the MOU legislates against this? Bill 36 should reflect the principles of consultation of the Ontario-AMO memorandum of understanding, and Bill 36 must consider and provide for the potential of municipal exposure arising from integration decisions.

AMO is also concerned that a final integration decision made by the minister can only be appealed through the Superior Court of Justice. Though Bill 36 contains a 30-day time frame for those affected by an integration decision to appeal, providing the legal system as the only recourse contradicts the spirit of the minister's comments made in September 2004 that the transformation of Ontario's health care system would require a cultural change driven by a genuine desire to rise above self-interest, which would be leveraged through building mature relationships.

Finally, and with great emphasis, the principle of pay-for-say is clearly rejected in Bill 36. Concern has been expressed that Bill 36 will create a dynamic of the survival of the fittest that will set the stage for not-for-profit and smaller providers competing for funding against for-profit organizations, hospitals and other more robust services. This can create an atmosphere of unfair advantage and, ultimately, decrease consumer choice. It must be decided, if Bill 36 is committed to the objectives identified in its purpose, whether some interests will be better served than others.

The government has demonstrated its commitment to improving long-term-care services in Ontario, including recognition of increased funding and ensuring equity in funding across providers. Not-for-profit long-term-care homes will be responsible to and will receive their funding from the LHIN boards, while for-profit providers will continue to receive funding from the province. AMO would like assurance that funding will continue to be equitable under this new arrangement. Consumer choice is an important right, and changes in cost-sharing arrangements potentially resulting in lower co-payments for one sector can have a negative impact on this right.

The government has lauded municipalities as leaders in long-term care services. Why then does Bill 36 not reflect this? Municipalities are ultimately excluded from decision-making on a service they fund and that reflects the needs and sensitivities of their communities. As long as municipalities fund and provide long-term-care services, they should have a say. This applies equally to

health services that may be affected by integration systems related to hospitals.

AMO supports PAIRO, the Professional Association of Internes and Residents of Ontario, and the NOW Alliance in their efforts to address doctor shortages in rural, northern and remote communities. This issue, if no other, speaks to access concerns in health care services. If you consider what has happened since the introduction of regional school boards, with the increased closure and threats of closure of schools in rural, northern and remote communities, you can understand our concern regarding the LHIN boards and the prospect of hospital closures resulting from integration. We are concerned, given the geographic scope of the LHINs, that we will see the same consequences with hospitals in rural, northern and remote communities. In fact, we're aware that this has been the fallout of regionalization of health in some other provinces. Hospitals and schools are vital factors in communities. Hospital closures, as school closures, dramatically impact the viability, health and sustainability of a community.

Mr. Chairman, there are a few other comments included in the brief here. I realize from your signals that we're nearing the end of our allocated time, so I'll stop at that point with our presentation.

The Chair: We went just over, but that's fine. We do have the material here. Thank you for your presentation.

ONTARIO PEER DEVELOPMENT INITIATIVE

The Chair: The next presentation is from the Ontario Peer Development Initiative. Good afternoon, sir. You can start any time you're ready. There are 15 minutes total.

Mr. Shawn Lauzon: I shouldn't be that long. My name is Shawn Lauzon, I'm the executive director of the Ontario Peer Development Initiative. I'd like to just read a quote from one of our member organizations, as we try to have an open consultative process to respond to this bill: "A patient-centred health care system can only be realized with defined engagement with people who have first-hand experience of the mental health care system."

I come to you not only as an individual bringing the voice of the consumer/survivors in Ontario, people who have used the mental health system, but also as a person who has used mental health services in Ontario.

The Ontario Peer Development Initiative is a provincial voice representing 51 community mental health programs throughout Ontario. They are run by, and on behalf of, people who have had or continue to have direct experience with using mental health services. These programs are also known as consumer/survivor initiatives, peer support programs and community economic development programs.

OPDI speaks collectively for consumer-run mental health programs and organizations that in turn represent consumer/survivors. We support a health care system that is based on having access to services and supports close to their communities, which will improve the individual's overall quality of life. As well, OPDI shares the common belief that recovery from mental illness is possible. We speak from a unique position as both mental health consumers and as health care providers. Through our collective experiential knowledge and evidence-based research, we shape what we offer: a wellness-oriented approach.

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The positions we are presenting to you today are based on a year-long consultation process with our member affiliates. They include a June 2005 annual general meeting, with 60 participants attending information sessions, with questions and answers, with regard to the LHINs. In November 2005, at our Creative Directions annual conference, we had 97 delegates from all over the province, with two presentations and more facilitated discussions with our member affiliates. In January 2006, we completed this by providing a membership survey to 51 organizations, and elicited further feedback for the drafts we present to you today.

The potential of local health integration networks under Bill 36: "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 Ontario Peer Development Initiative supports the intent of Bill 36 and the development of LHINs, as it speaks to us as health care users. We do want better access to health care services that are coordinated. We do want those services to be delivered at the local level wherever possible. We do want a system that, by becoming more effective and efficient, is easier for us to navigate.

The Ontario Peer Development Initiative supports the intent of Bill 36, as it speaks to us as health care providers. We collaborated recently with other mental health sector stakeholders in a report called Consumer/Survivor Initiatives: Impact, Outcomes and Effectiveness, which reported the impacts and outcomes of consumer/survivor initiatives in Ontario. This report was mailed to each of the MPPs last fall.

In that context, the mental health programs we offer are already fulfilling the proposed goals and outcomes of the LHINs. We offer a sampling of quotes from the paper:

"CSIs represent a way to both ease and enable people's transition from formal mental health services back into the community."

"CSIs contribute to reductions in the use and cost of services—including community mental health programs, hospitals, psychiatrists, and general practitioners, income support programs and other services—funded by the Ministry of Health and Long-Term Care and the Ministry of Community and Social Services."

"Participation in consumer/survivor initiatives reduces hospital use."

The report documents how innovative approaches, community partnerships and evidence-based research, funded by the ministry, show the leveraged value of the services and supports we offer to hard-to-reach populations.

OPDI's concerns with Bill 36: The legislation lacks clarity. I will quote from the member surveys throughout in dealing with the concerns, as per the following quote: "It's all very difficult to understand." This legislation proposes to create a great deal of change and is stated in a complex and vague way. Our recommendation is that this legislation needs specific details, and in plain language.

Community engagement is not defined. As per some quotes from member surveys: "How will the process of community engagement be fully inclusive, valid and consistent province-wide?" "The extent of community engagement may be a hit-and-miss process depending on the staff hired."

There is no definition of community engagement. The framework of the legislation does not spell out how health care consumers like us will play a specific role in a patient-centred system of care. Our recommendation is that the definition of "community engagement" should be stated clearly and affirm a role for the users of the health care system.

LHINs need to be proactive in considering the needs of people and the agencies they are intended to consult with: "Policies and procedures put in place reflect needs of larger agencies." "Traveling distances makes the community consultation process difficult."

LHINs cover large distances. Community consultation involves travelling expenses and the attendance of representatives. Our organizations' consumer/survivor initiatives are stretched for both resources and staff time. Previous LHIN consultations did not support resources needed by consumer-run mental health programs and organizations. Many of our affiliates were not able to attend those.

Our recommendation: LHINs must be responsive in their community consultations to the needs of smaller organizations and be accessible to populations with special needs. As a consumer, and going to one of those consultations, I know it was very overwhelming for me. In seeing some people with physical disabilities, I could see how they were very much overwhelmed as well.

Governance and funding for organizations are not defined. "If this money is transferred to the community, then there is no commitment that it will be protected as part of the mental health funding envelope or even that a consumer/survivor initiative will deliver these supports, or that the money will be set aside to continue these types of needed supports."

As the oft-described orphan of the health care system, mental health funding needs to be protected and expanded. Investing resources in organizations that work within a wellness-based approach is a wise choice. Keeping people out of hospital and minimizing the long-term use of traditional service providers are stated outcomes of the health care transformation agenda. OPDI has long maintained the position that 5% of all community mental health budgets should be allocated to consumer-run programs or organizations.

Our recommendation: Bill 36 should include mental health explicitly as part of the health care system and ensure adequate funding for consumer-run mental health programs and organizations.

Consumer-run mental health programs and organizations reflect the personal and collective empowerment of individuals. These programs and organizations serve as a complement to the broader health care system. The high degree of membership involvement in decision-making and in the governance of the agency echoes the empowerment and self-directed values grounded in personal choices leading to recovery.

Our recommendation: Consumer-run mental health programs and organizations require autonomy.

Decisions made by LHINs and the ministry must reflect evidence-based best practices. "Operating efficiencies can be justified economically, but 'bigger is better' does not apply to mental health consumers who require tailored services for specific needs and based in their own communities."

Evidence-based research confirms the leveraged value of consumer staff, known as peer support workers, collaborating with mental health professionals in the institutional setting and in the community programs.

Our recommendation: Investment in research, education and training is required to promote best practices of consumer-run mental health programs and organizations.

Thank you very much.

The Chair: There is about a minute left. The last time, I recognized the government, so to the opposition. Only one minute, please.

Mr. Arnott: Thank you very much for your presentation. We've heard a lot of concern about the lack of explanation by the government as to how community engagement is going to work. I've asked this question to another group today, and I would ask you the same thing: What should be the guiding principles, as far as you and your organization are concerned, of how that should work?

Mr. Lauzon: I've heard we're supposed to have a patient-centred system, and I feel it's really necessary to start with the patient first in all respects of the health care system. That kind of consultation should lead the way to the LHINs' development and their understanding of how to proceed with consultation to the service providers and other stakeholders in their community.

I do believe that it should be the person first. If we're looking at having a system-wide response to people's needs, then we have to really clearly see what people's needs are in every part of their lives, not just physical health care, but down to the person using mental health services.

The Chair: Thank you very much for your presentation.

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SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.ON

The Chair: Next is a teleconference from Donna Lehman, Service Employees International Union Local 1.on. Ms. Lehman, are you there?

Ms. Donna Lehman: Yes, I am.

The Chair: Would you please start your presentation? You have 15 minutes in total.

Ms. Lehman: Good afternoon, Mr. Chair and committee members. My name is Donna Lehman, and I am a support services worker at my local hospital, Bingham Memorial, in Matheson, Ontario.

Matheson is a small community about 40 kilometres south of Timmins. I live in a rural community in northern Ontario, and our hospital serves at least three other smaller communities, along with a reserve to the east of us and mines within our district.

I am speaking to you today because of the concern to my family and the families of our communities who depend on our local health care services. I would like to feel assured that the health care services now being provided locally do not deteriorate or lessen because we are put into a large LHIN area. We have gone through one hospital amalgamation in our area, which meant cuts to some of our local services, and also to the care given because of heavier workloads with fewer health care providers and support workers.

Health Minister George Smitherman has said that no hospital will close as a result of this legislation. What he has not committed to is whether hospital services in smaller communities like mine will be downgraded to walk-in clinics or be converted into nursing facilities or long-term-care centres. The health minister also said, in his opening remarks to these committee hearings, "In an environment where we all agree there will be fewer resources than we might prefer, it's just common sense that we ask people from local communities to help determine which local priorities must be supported first."

My LHIN, LHIN 13, the North East LHIN, stretches from North Bay to James Bay. It stretches from the Quebec border on the east to Lake Superior on the west. It includes Manitoulin Island, the cities of Sault Ste. Marie, Sudbury and Timmins. This LHIN includes 34 hospitals, 48 long-term-care centres, 40 mental health facilities and organizations, 30 addiction treatment centres, four children's treatment centres, six community care access centres, three community health centres, and 75 community support service organizations. Geographically, the LHIN carries an area as large as western Europe.

Our LHIN, like every other LHIN, will have a board of directors comprising nine unelected Liberal government appointees who, at this point, if not nameless, are totally faceless to the citizens of this LHIN.

Section 26 of Bill 36 allows a LHIN enormous power to cease any health service, transfer any service, or integrate any service. With the vast geographic area of LHIN 13 and many services and facilities within the LHIN, it appears that this LHIN is ripe for any integration plans the Minister of Health may have, but what on earth is local about this LHIN? The community of Little Current on Manitoulin Island has as little to do with Moosonee or Wawa or Kapuskasing as the price of gasoline in China has to do with a person filling up the tank of his snowmobile in Kirkland Lake.

That this legislation will give greater control to local communities is just plain false. This legislation is all about giving greater control over health care to the Minister of Health and the Ontario cabinet.

What chance does a small community like Matheson have against the larger communities such as North Bay, Sudbury, Sault Ste. Marie and Timmins in this vast geographical expanse? Section 16 of Bill 36 states that the LHIN is to engage the community. For the North East LHIN, there is no way that decisions could be carried out in any democratic way. What community interests are to be taken into account, and to what degree?

Reconsideration of LHIN decisions only allow an affected party 30 days to appeal. This is a very short time frame for any party to make a submission for reconsideration or to study the impact of a LHIN decision. Anyone wanting to appeal a decision would, I assume, need to travel the LHIN administration location to submit an appeal. What citizen in the North East LHIN could drive more than six hours over icy roads to make an appeal to save a specific health service in a small community?

I really want this committee and the health minister to understand that under this legislation, the communities of Gogama or Chapleau will have no local input into what type of health care will be available in their communities. The size of our proposed LHIN area for northeastern Ontario worries us. Services we have and need will be amalgamated, transferred or merged to a larger centre, leaving patients in small communities such as ours travelling long distances—anywhere from four to six hours, depending on the weather conditions—to receive care for a health service they require. This will prove to be a hardship on the sick and elderly in our communities, who have most services available to them locally, along with the support network they need at a time such as this.

Communities should have services available to them close to home. Patients deserve the services within their communities to enable them to be close to their families and friends. It seems this legislation does not focus on the patient, but rather on how to save money by consolidating, amalgamating and privatizing health services.

The public needs to have a voice in how this legislation will affect them: the large areas to be covered by the 14 LHINs. Why are these decisions being made for them without their input? Health care should be accessible to the public locally, within their communities, and should not ration patient care to save money.

As a health care worker, I am also concerned about what Bill 36 will do to my job. I have already said that in our area, we have been subjected to one hospital amal-

gamation. Bill 36 will further exacerbate that. The Minister of Health or a LHIN must not have the power to transfer a public service to a for-profit operator. Competitive bidding must not enter into the hospital sector to drive down wages or eliminate jobs.

I earn about $32,000 per year. It is not very much money to live on in northern Ontario, yet as a hospital worker, up to now I have been fortunate to keep my job when many in the resource sectors of the economy are losing theirs. No form of competitive bidding for our jobs must be allowed. Non-clinical service positions such as mine are vital to the quality of the health care system. We ensure the highest standards of cleanliness. We will not go the way of British Columbia health care workers, who lost their pensions and their benefits and now work for $13 an hour. It is not right that health care workers paying the new McGuinty health tax deserve to carry the burden of a government determined to balance its budget on our backs. Public health care dollars must not go to for-profit companies.

Thank you for the opportunity of making this presentation.

The Chair: Thank you. We have about a minute each for questioning. I will start with Ms. Martel.

Ms. Martel: Thank you, Ms. Lehman, for joining us in Matheson today. I live in your LHIN too, but you are about four hours away from me in my LHIN, and that's not even covering half the north-south distance of the entire LHIN; I live just a little bit north of Sudbury.

Folks from our part of the world, when they hear "amalgamation" or "integration," think what's going to result is that essentially the bigger hospitals in North Bay, Timmins, Sault Ste. Marie or the regional centre in Sudbury are going to get even more services, at the expense of small community hospitals like yours. I'm glad you raised the point today that, as someone from Matheson, you're concerned about that.

1540

Folks from Matheson already travel to Timmins now for a number of services. If we see some of those services now offered in Timmins transferred to the regional hospital in Sudbury, what is that going to mean for folks who now access services either at your own local hospital, which is right in the community, or already have to travel at least an hour to get to Timmins? What's it going to mean for all those people who are seeing a service in their own community hospital amalgamated or transferred to or integrated somewhere else? What's that going to mean in terms of them travelling? What's it going to mean for their health care and support services, which they really want as close to home as possible?

Ms. Lehman: A lot of them won't be able to travel that far. It's going to be hard on them.

Ms. Martel: Are you concerned about what that's going to do to their own health care?

Ms. Lehman: Their own health care. How will they be able to get to their appointments? A lot of people in smaller communities don't even drive. Getting to Timmins is hard enough, but to get to Sudbury or somewhere else would be even harder.

The Chair: Ms. Wynne.

Ms. Wynne: Hi, it's Kathleen Wynne. I just wanted to make a comment. It seems to me that right now, where you are in Matheson, all the decisions about health care that for the most part will be made by the LHINs are being made now in Toronto. It's like we have one great big health decision-making body, and that covers the whole province.

Our thought, as the government, is that it would be way better to have some people from some of the communities away from Toronto sitting together and talking about what the gaps are, what needs to be kept in the community so people can get to those services, what could be put into a specialized hospital. It's having people who really know the areas. And not all the people on these LHIN boards will come from one community. For example, we were in Thunder Bay the other day, and of the people who have been appointed to the board, one of them came from Thunder Bay but the other five came from communities far away from Thunder Bay. We're trying to put together some people who will make decisions based on what's needed in the communities, so with luck, you won't have to travel as far for those services you need on a regular basis. Does that make some sense to you?

Ms. Lehman: So there will be people chosen from communities such as ours?

Ms. Wynne: Absolutely. That's happening now. Obviously, there won't somebody from every community in the province, but there are people being chosen not just from the big communities but from the small ones. That's one of the ideas of this.

Ms. Lehman: So how are they being chosen? Are we able to say?

Ms. Wynne: There's a public appointment process. Of the nine board members, the people on the board are being asked to identify three community members themselves. But the people who have been appointed already by the provincial government are people who are from those small communities.

Ms. Lehman: So they've already been appointed?

Ms. Wynne: Some of them have. The process isn't completed. But the point I'm trying to make is that what we're trying to do is get people from outside of Toronto making decisions about health care outside of Toronto.

The Chair: Mr. Arnott, please.

Mr. Arnott: Thank you very much, Donna. This is Ted Arnott. I'm the Conservative MPP for Waterloo–Wellington. I represent a riding that has a lot of small towns and also a part of the city of Kitchener, and I can certainly understand many of the concerns you've expressed. In our small towns in Waterloo–Wellington, we think of "local" as meaning within the same town you live in, not a vast geographical expanse the likes of which you were talking about here in terms of northeastern Ontario.

The fact that you've made this presentation is very important to this committee. I hope the government pays attention to it.

Ms. Lehman: I hope so.

Mr. Arnott: The government is telling us that they're trying to appoint members of the LHIN boards who will represent the smaller communities. Time will tell as to whether or not that is true. If our small rural communities have a strong voice, like what you've expressed today, I think there's a better chance that we're going to be heard.

The Chair: Thank you, Ms. Lehman.

GTA/905 HEALTHCARE ALLIANCE

The Chair: The next presentation is the GTA/905 Healthcare Alliance, Tariq Asmi and Kirk Corkery. Good afternoon. Thank you for coming. You can start your presentation whenever you're ready. There's 15 minutes in total.

Mr. Kirk Corkery: Thank you very much, Mr. Chair. It's good to see you again. Thank you very much, committee members, for inviting us this afternoon to present. My name is Kirk Corkery. I'm the chair of the GTA/905 Healthcare Alliance. Beside me is Tariq Asmi, who is our executive director. I believe you have our foils in front of you.

The Chair: Yes, we do. We were given a copy.

Mr. Corkery: If you wish to follow along, that may make it a little easier for you.

The GTA/905 Healthcare Alliance represents hospitals in Halton, Peel, Durham and York. These regions currently make up more than a quarter of Ontario's population. We are among Ontario's fastest-growing regions, accounting for more than half the annual population growth in Ontario.

Bill 36 is truly watershed legislation for the planning, funding and decision-making of health care services in Ontario. It's also watershed in terms of the potential impact on access to health care services in the GTA/905. The alliance is fully supportive of Ontario's move towards local health integration networks.

However, Bill 36 is also a great opportunity to make LHINs about more than transferring, merging, amalgamating and ordering health care providers to cease operating. The alliance does not believe that the transferring, merging, amalgamating and ordering of health care providers to cease operation will alone bring about a more integrated and accessible health care system. We think you can do better. Bill 36 and LHINs can also, and should foremost, be about patients—better access to health care services and better access primarily within a LHIN.

In a nutshell, our concern is about making sure that the word "local"—to MPP Wynne's immediately prior comments, the issue of local is important. It must be local. It has to be balanced with the word "integration." So while we are fully supportive of the move towards local health integration networks and will work towards making the LHINs successful, we have some concerns about Bill 36 as it's currently written because it could mean less local access.

Our concern about less local access stems from the fact that the four GTA/905 regions are among the lowest-funded, if not the lowest-funded, regions in Ontario on a per capita basis for health care. Without this balance between local and integration, coupled with a lack of growth funding for the 905, it could mean the 905 LHINs may experience a disproportionate pressure to transfer, merge, amalgamate etc. This means that the LHINs may not result in improving access to health care services for over a quarter of Ontarians; rather, it has the potential to do just the opposite.

The amendments we offer you today would make Bill 36 more about improving population health status, maximizing local access to health care services, allocating resources on the basis of population needs, and having LHINs work on behalf of their residents. We think these are the goals that we all share.

If you'll turn to slide 5 in your handout, we'll just quickly start through a few of the recommended changes that we have. Bill 36 makes clear that to integrate means transferring, merging and amalgamating. The definition of "integrate" should also speak about improving patient care. The key foundation here is that we have to think of the patients first. So we are suggesting that it also be defined to improve the continuity of patient care, to increase health care service provider collaboration within a LHIN, and to increase the information-sharing within and across LHINs.

Slide 6: In the bill, it talks about the definition of "public interest," to do things for the benefit of the public interest, but "public interest" is never defined. On slide 6, we have defined some of the things we think should be included in the act with respect to defining the public interest. Let's not leave it undefined.

1550

Slide 7 talks about the objects of the LHIN. At the present time, it's talking about making decisions to transfer, merge, amalgamate. These are all wonderful things in terms of efficiency; they do not speak to patient care. We need to talk about things that are patient care. We need to talk about optimizing LHIN residents' health. We need to talk about their access to local health services. As such, we're recommending that those specific objects be included in the bill, and we've listed four there for your consideration.

In terms of slide 8, the minister has been clear that to improve the decision-making in Ontario's health system, it has to devolve to the regions. We agree. No problem with that. However, the bill does not at the present time ensure that the board members are members of the local LHIN. We think it should be enshrined in the legislation that they need to be chosen from within the community. Let's say they have to be chosen on the basis of skills. There are lots of people out there who've got the appropriate skills. Let's state that in the legislation, so that it's based on merit. Let's make sure they represent the communities they serve.

Tariq, I'll let you take the rest.

Mr. Tariq Asmi: Thank you, Kirk.

I'd like to refer to slide number 9. There are two recommendations on this slide. First, Bill 36 gives the

minister full power to allocate provincial funding based on "terms and conditions" that he or she sees fit, but really, this is only half the equation. For Ontarians who live in communities with differing characteristics, differing population sizes and rates of population growth, we believe it's also essential that the minister is required to also fund LHINs on the basis of population size and population characteristics; that is, population-based funding.

Some of the most successful experiences with health care services regionalization across Canada make explicit use of population-based funding formulas for the regional authorities. Population-based funding is not just about meeting the health care needs of Ontarians as close to home as possible. It's equally important in terms of equity, in terms of fairness and accountability.

In addition, we think stakeholders should know how funding is actually allocated to LHINs. Currently in Ontario's health care system, there is no such transparency for health care funding. As such, we recommend that you amend subsection 17(1) by adding that the minister must also provide funding to a LHIN based on the health service needs of LHIN residents based on population size and population characteristics of the residents. We also think you should add a subsection that says the minister will make a document available to the public through the ministry that outlines the criteria, the formula and all the other information that we use to allocate funding to LHINs.

The second recommendation is about incenting the health care system to pursue further efficiencies. Hospitals in the GTA/905, having to do more with less, are already some of the most efficient hospitals in Ontario and perhaps Canada, and we will continue to seek out efficiencies. But right now, Bill 36 does not guarantee that some of the savings and the resources freed up through efficiencies will remain in the LHIN. Therefore we have concern about whether we will continue to incent further efficiencies within a LHIN. We think you need to amend subsection 17(2) to say that the minister shall reinvest the savings generated in a LHIN in one previous fiscal year in future fiscal years.

I now go to slide 10. Slide 10 is in terms of planning for health care services in Ontario. Bill 36 makes it quite clear that the minister's provincial strategic plan for the health system will directly shape the integrated health services plans of the LHINs. They must be consistent with the minister's strategic plan. Therefore, LHINs will have to issue orders to transfer, merge and amalgamate based on the minister's strategic plan. We think we should amend section 14 to say that when the minister, he or she, develops this provincial plan, they should do it in consultation with health system users—patients and consumers—and service providers and have time to maximize local access to services within a LHIN and maximize high-quality health services.

In terms of the integrated health services plan to be prepared by LHINs, we would recommend adding a subsection that the integrated health services plan shall plan for local access to a range of services that are prescribed by the Minister of Health that are based on the population of the LHIN and the population characteristics of that LHIN.

Slide 11 is with regard to due process. There are four criteria that make a decision ethical: You need to communicate, you need to share with the stakeholders, you need to make that public and offer an opportunity for review of appeal. We offer you several recommendations for making this section a more ethical, more accountable and transparent process when LHINs will be issuing their integration decisions.

Our last recommendation for improving Bill 36 pertains to the historic autonomy of hospital foundations. Given that foundations really are not part of the scope or the objects of LHINs, we recommend that you delete subsection 50(11) that proposes to amend the Public Hospitals Act.

I'll now pass it back to Kirk Corkery.

Mr. Corkery: Respecting the time, I'll make just a couple of quick concluding remarks.

We're fully supportive of the move toward LHINs. We'll help make it work. Our 11 hospitals are committed to making the best they can of the resources they're given. As it's currently written, we have a couple of concerns about local access to make sure that what is intended does in fact happen, and the suggestions we've made here today, we believe, will go toward that end. I ask you today to please put back into this legislation two things: the patient and the concept of "local." Enshrine it there. If you don't enshrine it, it will not happen.

On that note, Mr. Chair, members of the committee, thank you very much for allowing us some time to speak with you and put our ideas forward. We're obviously open for questions.

The Chair: Thank you. We have about 30 seconds each. I'll start with Ms. Martel.

Ms. Martel: Thank you for pointing out that, in truth, subsection 17(2) doesn't say that savings are going to automatically go back to the LHINs. There was a discussion about that last week in the committee when I asked the Association of Community Care Access Centres about that. I'm glad to see that you have made a point of saying that it should be very specific in the legislation that those savings will be reinvested; otherwise, my concern is that the savings will just be deducted or that the overall pot will be deducted by the savings amount in the next fiscal year.

With respect to "local," I'm looking at the amendments you've put forward to making sure that "local" will be highlighted. Does that cover essentially all the sections you were concerned about where there needed to be a very specific reference to ensure that access is local and services are local? Does that cover the concerns you had with respect to the bill?

Mr. Corkery: We believe that if the decision-makers on the board come from the local area, that will go a long way towards ensuring that the appropriate things happen. Care can be better delivered in your local infrastructure.

You get better faster. If your family and all the people you know are around you, you get better faster than being shipped away or having to travel greater distances.

As it currently sits today, people in Brampton or Markham or wherever—people say, "Just go to downtown Toronto." No. That's an hour-and-a-half taxi ride, or worse. In other parts of the province it's an even worse situation, as you're much more aware. At this stage of the game, we would be satisfied if initially in the legislation it ensures that the people making the decisions come from the local area. That's the specific change we're asking to be made. Broadly, the funding level needs to account for all the people in the LHIN. It needs to be population-based so you get funded for your health care where you live. That's the other piece we're asking for in the changes.

1600

Mr. Levac: Gentlemen, thanks for your presentation. You made some very smart and well-thought-out recommendations. Let's make something clear: We're talking about differentiating between how hospitals operate inside of the LHIN versus the LHIN having control over the hospital. Those are the two sectors. For example, the hospitals in the LHIN that I represent have already collectively decided to put a VP in charge of communication and IT, so therefore, we're going to get those efficiencies and savings in transporting information back and forth, simply going from a doctor to a hospital to a second hospital. Those are the good things that are happening. When you say health care services, I think it's also important to distinguish between what hospitals provide and the patient, versus the upfront hope that what LHINs do is help us get preventive enough that we will lessen the burden on the hospital structure.

You also mentioned the minister. In the legislation, I think the minister has to consider that, and you're requesting that the savings must be poured into the local LHIN. I hope I've got that right.

As to population, if it doesn't go hand-in-hand with the characteristics, I think we've got a major problem. We've got the north, but my LHIN has a notorious number of senior citizens, and we would have to design our LHIN based on that information, and that needs to be local. Am I capturing exactly what you're trying to talk about here, for example?

Mr. Asmi: What we're suggesting is that if it's going to be local health integration networks, the "integration" and the "local" need to be given equal emphasis. When you fund, you fund on the basis of population needs, which is size and characteristics. So you're bang on. As well, in any efforts to achieve savings, those who accrue the savings should receive the benefits. The notion is just making explicit in the legislation exactly what you're saying, so when it comes to future governments, they too will abide by the intent of your legislation. Let's put it in the legislation.

Mr. Arnott: Thank you very much for your presentation. I want to ask you a question about the point you made on page 12 of your slides, the autonomy of hospital foundations. This is an issue that has come up in the last couple of days. I unfortunately had to step out for a minute while the Ontario Hospital Association was making their presentation, but I understand that they expressed a similar concern about whether or not hospital foundations would be able to keep the money they've raised as opposed to having the money redistributed by the LHIN as it sees fit. I'm wondering if you've had any assurance from the government that the bill is going to be amended to ensure that this will not happen.

Mr. Corkery: We have received no such assurance, sir.

Mr. Arnott: I would ask if the parliamentary assistant is in a position to speak to this, because this is a really serious concern.

Ms. Wynne: I'm not in a position to say whether or the exact nature of the amendment that will come forward, but I am in a position to say that it is being considered as something that the minister and the ministry are well aware of.

The Chair: Thank you for your presentation.

HOSPITAL FOR SICK CHILDREN, EATING DISORDER PROGRAM

The Chair: We are going to move into the next presentation, from the eating disorder program, Hospital for Sick Children. Dr. Leora Pinhas. Have a seat, doctor. Thank you for coming and joining us. You can start whenever you're ready.

Dr. Leora Pinhas: I'm coming with a specific reason and a specific topic, which is the area of eating disorder services in this province. I don't need to tell you that eating disorders are a very serious chronic illness that occur in children as young as five or six now and can be life-threatening; about 5% to 8% of people will die from their illness. Even though most people recover from their illness, they do require on average about five to seven years of health care services, not only to help them recover from the psychological aspects of the disorder but also to help them either recover or prevent the physical disturbances that come with this disorder. It's not unusual for us to see children who are stunted in their growth, who have growth delay, who have osteoporosis. Osteoporosis, as you know, is an illness that happens to 80-year-olds. It's a very poor prognosis if you're 16 with osteoporosis and have to face a whole lifetime with that kind of morbidity.

I also want to say that over the last 10 years, the eating disorder health care providers, along with consumers across the province, have worked hard to develop an integrated provincial network that is basically built on logic and on patient demand. We have worked hard to try to develop primary care services locally across the province that then feed into more centralized, secondary, tertiary and, finally, quaternary care services.

I will give you the example of Sick Kids. We have a nine-bed in-patient unit, and we're the only in-patient unit in the province. That already is not enough: nine

beds for all the children and adolescents in the province. I can tell you that we regularly have quite a long waiting list. However, while I do think that we need to increase this, it presents two problems.

First of all, it doesn't make sense to have an in-patient eating disorder program in every LHIN. So how do we decide where those programs will be placed? And who will take this on, as an in-patient program for eating disorders is extremely complex and expensive in terms of per capita cost?

My worry with the LHINs that don't reflect the past regional development of the network—two things. One is that for a system that is already in crisis, meaning there are people who die on the waiting list and there are numbers of people who have to be sent to the States, how will that continue to be funded when it comes up against local primary health care issues? We're talking about small numbers. Who will take that on? Also, how will the centralized services be funded if we're focusing on providing local treatment? It's impractical to provide these kinds of services locally when you're getting to the higher levels of service. For instance, if the Toronto LHIN funds the program at Sick Kids, what happens if a child from Sudbury shows up at the door? Who pays for that? It's already hard to figure out who pays for that, and we already are turning away people who require treatment.

So those are my concerns. One is a system that's already dramatically underfunded and is the orphan of medicine and psychiatry—a disorder that is increasing in numbers but also has attached to it a significant stigma. My patients aren't going to be knocking on anyone's doors, complaining. How are we going to make sure that this service continues in an integrated way?

That's it.

The Chair: Thanks very much. Ms. Wynne.

Ms. Wynne: Thank you very much for coming. We did hear about this issue earlier. One other presenter came to us and talked about this specifically. When I look at the objects, Dr. Pinhas—it's section 5(g)—one of the objects of the LHIN is "to develop strategies and to co-operate with health service providers, other local health integration networks, providers of provincial services and others to improve the integration of the provincial and local health systems and the co-ordination of health services."

That's where I would look, to one of the goals of creating LHINs to make sure that a service like this is provided. I think it's an incredibly serious issue. One of the big concerns about what goes on in the province now is that there are huge gaps, so that a kid or an older person in Toronto has way more access to an eating disorder clinic, for example, than someone who lives in another part of the province. I would see this whole process as trying to ameliorate the situation that you're dealing with, and I would see that section as being the one that specifically points to the obligation of the LHINs to do that. Can you comment on that?

Dr. Pinhas: Sure. Two things: One is that you're mistaken. In fact, an adult person in Toronto probably has less access to out-patient services and to primary care services than someone in Barrie, and this is part of the problem. Toronto General Hospital is seen as the quaternary or tertiary care centre; all of their resources have gone to support their in-patient unit, and because of funding deficits, they actually had to close their out-patient program.

Ms. Wynne: But it's uneven. My point that it's uneven is accurate.

Dr. Pinhas: It is accurate. However, I guess my concern is that while these treatment centres are very important to us and to the people we serve, we're small potatoes compared to everything else. My sense is that this issue, unless it's protected in some way, will fall by the wayside, and the more fragmented the decision-making becomes, the more likely it is to fall by the wayside. My LHIN may think it's important, but another LHIN that happens to have fewer patients that year, when they're looking at this issue, may choose not to focus on this service.

1610

Ms. Wynne: Do you have amendment language that you're suggesting?

Dr. Pinhas: I don't.

Ms. Wynne: Okay. If there were—

Dr. Pinhas: I would be happy to forward you some suggestions, absolutely.

Ms. Wynne: That would be great. Thank you.

Mr. Arnott: On behalf of the Progressive Conservative Party of Ontario, I want to thank you for your presentation. I'm looking forward to reviewing the Hansard when we get an opportunity to do so. You've made a number of very important points.

I think you're not alone in your concern. As the government pursues this agenda of reorganizing health care, there's a great deal of concern about whether or not the new structure, the new LHINs, will see fit to carry on many of the important programs that have been funded in the past. So by coming here and speaking up about the important work that you're doing, you have a better chance of ensuring that it will carry on.

Ms. Martel: Thank you very much for your participation here today. Joanne Curran made a presentation to us from Hopewell in Ottawa, and in the question-and-answer that went on I made the point that there is no duplication in this network. In fact, the network is grossly underfunded and people within the network—I'm going to focus mainly on providers—have already made very serious decisions about allocating resources to specific hospitals, for example CHEO in Ottawa, at the expense of other hospitals and other services, to try and make the system work. So what is not needed here is a LHIN to deal with duplication; it's money—cold, hard cash—to actually make sure we can sustain the services that are in place, which are grossly underresourced right now, and provide some enhancements so we stop sending patients, 50 of them a year at least, to jurisdictions in the States for treatment, and then they come back and have no support

and they go again the next year, which is exactly what has happened in this last year.

Can you tell me, with respect to the proposal that went in from Gail McVey, was the original request for about $20 million, and that went in in December 2004?

Dr. Pinhas: Yes.

Ms. Martel: Okay. And still we have no response from the ministry, although I do know that the group was asked to very significantly pare down that amount of money. If the network were to get a couple of million dollars—$2 million or $3 million—what's that going to do for patients who need services at all levels in this province?

Dr. Pinhas: Basically, $2 million would probably help us solve some of our deficits. It's probably not going to provide any increases in services. I just want to comment that if you look at the rates of kids, and adults as well, who are going to the States, that number is actually increasing exponentially. It's not increasing in a linear fashion. Two million dollars will help us survive with what we have right now. It's certainly not going to increase our funding.

I am aware that Joanne did present here and I do also concur with her. One of the models I would like the committee to consider is the idea of having some kind of special provincially protected position for programs like this that are intense, that service a lot of people, but because they service particular parts of the community, they're small compared to other kinds of numbers. This would be the same with any kind of life-threatening illness that happens to a minority of people in the province.

You're right, there is no duplication. In fact, essentially what we do—I have to say, to the credit of the network, that we do get together as a whole province when we get these small pots of money and say, "Okay, we've got this much money. How can we best meet the needs?" The first year we got money we decided it would go to primary care. This most recent time, we're really noticing that the increase in primary care has flushed out of the communities the important need for quaternary and tertiary care. So where would we put a little bit of money? I think the province, in terms of the health care providers—the patients and their families are best situated to make that decision, but that decision needs to be viewed across the province, from a provincial perspective, not just from a local perspective.

The Chair: Thank you very much for your presentation.

The next presentation is at 5. One of the two people is present, so we're going to have maybe a five-minute break until the second person arrives, and then we will be able to end the day.

The committee recessed from 1615 to 1622.

ONTARIO COMMUNITY SUPPORT ASSOCIATION

The Chair: We are all—oops, we lost the other two parties. Oh, I guess we can start; Ms. Martel is here. This is the last presentation of the day. We thank you for coming earlier so we can go back to our offices. From the Ontario Community Support Association, it's Tony Pierro and Kaarina Luoma. You have 15 minutes. You may wish to start your presentation.

Mr. Tony Pierro: First of all, let me thank the members for allowing me to be here. I know there was a bit of an issue in terms of making time, so I really appreciate it. I also know that we're the only things that are between you and probably a well-deserved dinner, so we're going to be very quick. We'll go through the front part of it very quickly and focus in on the recommendations.

Getting things rolling, on page 1, in terms of who we are, the Ontario Community Support Association represents 360 not-for-profit community support services. We have about 25,000 staff in the sector and roughly 100,000 volunteers, which I'll get into in the next little while because that's one of the key issues with the LHIN legislation that we want to protect. These volunteers deliver roughly seven million hours of services on behalf of your parents, your aunts, uncles and grandparents—a very valuable resource.

The Ontario Community Support Association members receive approximately 1% of the Ontario health budget. We're the front end of the system. What we do is actually avoid people going into what I consider to be the high-end, the high-expense portion of the health system.

On page 3: What we do are the kinds of things that you hear a lot about in your own community: Meals on Wheels, transportation for the elderly to medical appointments, attendant care, adult programs, security checks, friendly visiting, caregiver support—all these kinds of things that allow an individual to stay within their own home and not have to move into institutional care.

On page 4: The OCSA and its members are actually quite happy about the LHIN legislation. We really like the restructuring that is occurring in the health system. We have some common goals in terms of equitable access based on client-patient need, measurable results-driven outcomes. We're really moving as a sector to start to measure what we do, how we do it and what the benefits are to the system as a whole. A number of reports have been written, which I'll actually chat about in about two seconds.

OCSA members are looking forward to working with the health care partners. It's almost like the assembly line of the health care system, making sure that everything is working well, that we invest the right resources in the right areas to get the best outcomes. Again, we really are encouraged by the direction that everything's going.

We also support the changing culture that's required to actually make the health care system more efficient. In terms of the overarching requirements, note page 5. Some of the key principles that LHIN legislation has to embrace are the Canada Health Act, Ontario's Commitment to the Future of Medicare Act, 2004, and consultation with service providers—and this is one of the things that we'll actually get into in a few minutes—which is critical when we're establishing the whole

LHIN organization. Every partner in the health system has to be at the table and represented at the table.

On page 6: One of the key things that we're emphasizing is that consistent criteria as to what is community engagement should be clarified. OCSA looks for a real broad-based, inclusive engagement process, with a strong voice from the local communities,. That's really the basis for the LHINs being created: to move them to the local communities, get community involvement and engagement.

The system planning across the whole health care system also has to ensure that human capacity and skills to deliver the care are there when needed.

The last point is that information technology needs to be supported so that we can actually input into the system as a whole.

As I was mentioning before, the not-for-profit agencies have approximately 100,000 volunteers. This is one of the key areas that the legislation has to support. If we lose this resource—they provide roughly about $100 million worth of resources to the system. This is again everything from Meals on Wheels to attendant care to taking individuals to health appointments. The health care system cannot afford to lose this very valuable and critical resource.

On page 8: When we talk about integration, that's something that our members and our association strongly believe in. We feel that every health care provider needs to have that obligation to coordinate the needs of individuals through the system.

So system navigation—it's actually mentioned in the legislation—isn't a job responsibility of one organization; it's the responsibility of all the health care providers in terms of supporting individuals through the system. If a client contacts an organization, they need to be navigated through the system by that organization.

On page 9: We believe every door is the right door. I'm going to skip that page to get into some of the recommendations.

In terms of efficient management at the local level, which is one of the premises of the LHIN legislation, we really need a strong home and community care system to maintain people in their community. A number of reports have been written. In fact, I think it's time to stop writing reports and actually implement the recommendations from these reports that basically say keeping people in their own home is the most efficient way of doing things from a dollar perspective and also provides the best health outcomes. People want to stay in their own homes. They can stay in their own homes and they want to be there. It's just a matter of having the dollars to do that.

Again, numerous studies indicate that countries with the best health outcomes and lowest expenditures of GDP have strong primary health care systems. That's something that we really encourage the whole process to create.

On page 11: From an investment perspective this gives you an idea of what it costs an individual to be accommodated, whether it's in a hospital, long-term care or in the community side of things. There's a real good investment to keep people in their own homes.

In terms of the recommendations, starting on page 12: In the legislation it talks about creating advisory committees. We feel very strongly that the advisory committees must be inclusive. There must be broad-based representation from all parties in the health care system, all the partners who actually deliver the health care, and not, as the legislation currently says, advisory committees related to regulated professions. Our sector does not have as many regulated professionals, but we feel that we have to be part of that advisory committee that is advising the local LHIN. OCSA strongly recommends that the community support sector have equal representation on these health advisory committees that are advising the local LHINs. Don't just keep it to the health professionals.

Accountability agreements, on page 13: The essence of LHINs is local responsiveness based on province-wide strategic goals. To achieve this, I think what the OCSA would like to recommend on behalf of its members and the thousands of seniors and persons with disabilities whom we actually serve, is that the LHIN legislation actually speak clearly to the development of outcome indicators for all of the sector. Right now, it's very heavily based on institutional care, but on the community support side of it we really need to ensure that there are health indicators that measure the whole health system and not just certain components of it.

We recommend that the definitions of "efficient" and "effective" must be clearly defined in the legislation or in the regulations to ensure that quality outcomes are defined, that it actually creates innovation and flexibility in service and program delivery. We need to ensure that we're not only doing things right, but we're also going the right things in the health care system.

For the next two recommendations I'm going to pass it on to my associate Kaarina Luoma, who's going to be speaking to actual on-the-ground experience.

1630

Ms. Kaarina Luoma: Hi. My remarks address the recommendations on pages 15 and 16 of the OCSA response before you, specifically: (1) that the local health care services must continue to preserve local community connections, community-based governance and consumer choice, and avoidance of service disruption to clients; and (2) that all health care providers have a role to play in assisting each client/patient find their way through the integrated system.

In respect of the LHINs' efforts to engage communities, our common goals include people-centred, community-focused care that responds to local population health needs; and shared accountability between providers, government, community and its citizens.

I want to illustrate for you how the residents of our city, Toronto, whether as health care providers or as volunteers, contribute to the work of only one agency, and that's my agency, in the downtown east core. Mid-Toronto provides programs and services that bring care

home to seniors and adults with disabilities or illnesses. We serve the community of downtown—St. James Town, Moss Park, and Regent Park—high-need areas with approximately 20% of the city's population but 40% of those living in poverty. We help approximately 1,000 citizens annually through such programs as Meals on Wheels, community transportation to medical appointments or treatment and adult day programs such as Alzheimer care.

I think the story of Mrs. S. is the best way to capture for you what on-the-ground experience is with an agency like ours. Mrs. S. is a 57-year-old who has been on our Meals on Wheels program for over five years. She has received a hot, nutritious meal every day. She has severe arthritis and a history of depression. She's alone in the world with no family or friends nearby, so her only support was the human touch, the hand out that our agency was able to provide.

She was not home one day for her noontime delivery, so the volunteers immediately alerted staff, which is our protocol. The staff tried desperately to reach her. They couldn't. She has no emergency contact other than the superintendent. When the superintendent was finally contacted, he indicated that she had been behaving quite strangely for about two weeks at that point. She hadn't been staying in her apartment at nights. She had been urinating in the streets, hallucinating, acting paranoid and starting to threaten some of the other residents. We were able to contact mental health professionals, whom we consulted with, and they helped us present her case before a judge. Then the police were able to pick her up and get her the treatment she needed. She was in hospital for approximately two months, but then she was returned home and went back to receiving her meals once her mental health condition was stabilized.

It illustrated for me, as one of the people who work in this sector, how vulnerable we all are to quirks of fate and what can happen, and how that community agency is on the ground, seeing the meals go out, bringing your parents to a seniors' day program, or sometimes even your children, because unfortunately that's the only thing that's available out there at this point. Seniors and adults face a multitude of burdens: Alzheimer's disease, cancer, heart disease, depression, HIV/AIDS. It's too common to listen to her story, so I won't go on about it, but it just shows you that it also resurrects the housing issue in this city and the lack of affordable homes for people to reside in.

It is the support of over 1,000 volunteers, who contribute more than 16 staffing positions to my agency alone, and the due diligence that that support carries through to our funding partnerships: the Ministry of Health, the United Way, the city of Toronto etc.

During SARS and the August blackout, we never closed our doors. St. Mike's was on a generator; they were able to provide our hot meal entrees. Staff and volunteers carried meals up 26 flights of stairs in the pitch black. I remember delivering that day as well—actually it was three days, I think. A little woman was asking, "Kaarina, do you think I could go to the hairdresser today?" I said, "No. Today is not a good day. The city is little bit shut down today." It's that human touch that people need, who have no other means of getting out to social kinds of situations.

This is how Mid-Toronto, which is just one agency in this whole network across this province, delivers services to clients and improves access to services within our diverse communities. It's through the strength of our volunteers, accountability to those in need in our community and integrating our resources and expertise with other providers when needed. We do this constantly.

We have a 40-year history of collaborative efforts. Currently, one of the bigger projects before us is the Senior Pride Network, which is quite a collection of mainstream agencies and age-specific providers teaching each other and learning from each how to reach out to these populations so that nobody stays isolated in their own home because they're too threatened to access what care might be out there. Again, we try to bridge those kinds of realties.

To strengthen and grow integration effectively, we fully support the OCSA recommendation of establishing a requirement for LHINs to incorporate an analysis of the impact of any integration plan on the community, volunteerism, people being served and the health service provider. By building on our strengths, we will move Ontario to a health system that can afford every Ontarian the care they deserve.

In closing—you've probably heard this before if you heard the city presentation—I would like you to picture Toronto supported by an invisible fabric that is really, when you look closely at it, an incredible network of agencies that support each other. Somebody might have more capacity there; somebody, less. But some are crippled right now. They are really at the point of not going on, and that's something that I hope this legislation is going to be able to address.

It is my hope that the LHIN legislation will preserve the ability of local not-for-profit agencies to continue to reach out to those at risk and vulnerable. People need to be supported at all points, starting with their first point of contact with the health care system, and the community support sector is often the first point of contact for clients.

Thank you. I talk too fast.

The Chair: Thank you to both of you for your presentation. There is no time for questions, but if somebody wants to ask a question, they can certainly do that; otherwise, thank you.

We will resume deputations tomorrow at 9 o'clock at the same place. Good night.

The committee adjourned at 1638.

Continued from overleaf

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