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## **Official Report of Debates (Hansard)**

**Tuesday 7 February 2006**

## **Journal des débats (Hansard)**

**Mardi 7 février 2006**

**Standing committee on  
social policy**

Local Health System  
Integration Act, 2006

**Comité permanent de  
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**STANDING COMMITTEE ON  
SOCIAL POLICY**

**COMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE**

Tuesday 7 February 2006

Mardi 7 février 2006

*The committee met at 0905 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.

**ONTARIO FEDERATION OF LABOUR**

**The Chair (Mr. Mario G. Racco):** Good morning. I think we should start since all of us are present. This is our sixth day. The first presentation this morning is from the Ontario Federation of Labour, Terry Downey. Good morning. Please start whenever you're ready. There are 15 minutes allocated for your presentation. If there is any time left, we'll be happy to ask some questions.

**Ms. Terry Downey:** Great. Thank you.

Good morning. My name is Terry Downey. I am the executive vice-president of the Ontario Federation of Labour. The OFL welcomes this opportunity to appear before the standing committee on social policy to discuss the proposed legislation, Bill 36, the Local Health System Integration Act, 2006. The OFL constitutes the largest provincial federation of labour in Canada. Our 700,000 members are drawn from over 40 unions. Our members work in all economic sectors and live in communities across Ontario, from Kenora to Cornwall, from Moosonee to Windsor.

We believe that committee hearings are a vital part of our parliamentary democracy which allow interested individuals and organizations the opportunity to share their perspectives on proposed legislation with their elected representatives. Given the importance of this proposed legislation, there should have been extensive public hearings in communities across Ontario. There have not been, and that is a sad reflection on the government that won an election on the slogan "Choose change."

This proposed legislation will have a profound negative impact on the quality of health care available to and delivered by Ontarians across our province. We are not alone in this assessment. Like members of the committee, we have attended all of the committee hearings

across Ontario: in Toronto, London, Ottawa and Thunder Bay. Like you, we have heard the concerns raised by Ontarians. It is incumbent on the committee members, especially members of the government, to use their influence to alter this proposed legislation to better address the concerns of Ontarians. We will briefly discuss a number of concerns regarding Bill 36.

Our vision for health care draws on the experiences of dedicated health care workers who provide needed services and who are profoundly troubled by the misdirection of public policy and the failures of the institutions which employ them; and workers and their families who in the past used, or continue to use, the services of Ontario's health care system.

Recent examples of our advocacy in health care include the discussion and endorsement by delegates to our recent convention last November of a comprehensive paper called Rebuilding Health Care. Another example is our campaign on understaffing. In May and June of last year, the OFL organized meetings in 15 communities across Ontario with workers from all sectors of health care. They came to the mutual conclusion that all sectors and workplaces have been hard hit by understaffing and that the problems associated with understaffing are systemic and serious. The report, *Understaffed and Under Pressure: A Reality Check* by Ontario Health Care Workers, was released in October 2005, and a copy was sent to every MPP. The report concluded:

"There is no health care without people. The Ontario government must immediately and significantly increase staffing members in all sectors.

"For starters, the provincial government must:

"Declare an immediate moratorium on layoffs in hospitals.

"Establish a required minimum standard of 3.5 hours per day of nursing and personal care for residents in nursing homes and homes for the aged.

"Establish required minimum standards for staffing with appropriate complement of full-time workers in all health care sectors."

The work of health care economist Armine Yalnizyan illustrates that there are financial resources available to the government to address this issue. The Ontario labour movement has and will continue to lobby for positive and immediate action to address the issues and impact of understaffing, which we consider a fundamental issue in health care. This proposed legislation will do nothing to address this important issue.

Bill 36 is an Orwellian exercise, the latest instalment of this government's vision of health care in Ontario. The preamble of the bill contains noble words that do not reflect the intent of this proposed legislation, which gives little power to health care providers, the people they serve or local communities to make decisions concerning health care. Instead, Bill 36 transfers control of such decisions to the Minister of Health and Long-Term Care and cabinet through their creation of the local health integration networks, the LHINs.

The LHINs are presented as a made-in-Ontario solution for challenges facing our health care system. From our perspective, the government has pre-determined that LHINs are the "cure" which will be imposed on patients in Ontario. This cure is based more on faith and ideology, we believe, than on the reality of the needs of Ontarians.

#### 0910

We view Bill 36 against the backdrop of what the state of health care is in our province. An important part of this cure is concern with costs.

We find it odd that given the goals found in the preamble already cited, whole sections of our health care system are not included under this proposed legislation. Physicians, the gatekeepers of the system, are left out. Hospitals are included but ambulance services are not, a fate they share with public health. Hospital labs are in but not private ones. Psychiatric hospitals run directly by the ministry are out but divested facilities are in. Independent health facilities are out, as are provincial drug programs. Long-term-care facilities are in but homes for special care are out. There is a provision in the proposed legislation to move services around, but this present configuration suggests to us that there will be a disconnect between services.

The Orwellian nature of Bill 36 is most evident in the issue of governance. The LHINs are local in name only. This is an exercise in the centralization of power and decision-making. The board, chairs and vice-chairs of the 14 LHINs are chosen by cabinet and serve at their pleasure. The cabinet may create, amalgamate, dissolve or divide the LHINs. LHINs are defined as an "agent of the crown." LHINs enter into accountability agreements with the ministry on such matters as performance goals, measures and plans for spending. Each LHIN must develop integrated health service plans within the time and form specified by the minister which are consistent with provincial strategic plans. It is obvious, though, that the LHINs are creations and creatures of the provincial government.

The LHIN structures will be politically beneficial to the provincial government. The most obvious benefit is as a vehicle for the implementation of government policy. Given the nature of appointment to the LHINs, they will be unaccountable to the local community and unlikely to oppose provincial government initiatives. If community opposition to these initiatives develops, the provincial government will insulate itself from criticism by simply pointing out that the LHINs, not the provincial government, made the decision in question. The same

tactic will likely will also be used against opposition MPPs who may wish to question members of the government.

Through Bill 36, this government has turned its back on a long tradition in Ontario of locally elected representation who carry out their responsibilities while still being responsible to their local community. It appears this government believes that "a community's health needs and priorities are best" determined without the local democratic involvement of "community, health care providers and the people they serve."

The proposed legislation makes a mockery of the already quoted preamble. Fourteen LHINs cover the province of Ontario. Five of them serve populations larger than five Canadian provinces. As a provincial organization, we have an appreciation of the size of Ontario and the distance between communities, an appreciation which seems to be lacking among those who have created the LHINs. Some examples of the distance and travel between communities in the same LHIN are: Scarborough to Haliburton, 203 kilometres, 2.5 hours; Cornwall to Pembroke, 248 kilometres, three hours; Parry Sound to Timmins, 468 kilometres, six hours; and Kenora to Thunder Bay, 491 kilometres, 6.5 hours. I think this illustrates the point yet again that there is little local in the LHINs.

The current LHINs boundaries do not make sense to Ontarians. For example, Ontarians who live in the city of Toronto find themselves in a number of different LHINs. Common sense suggests that this will be a disaster for everyone involved: the users of the service, the workers who provide the service and the city of Toronto itself.

Communities with little historical connection are lumped together in the same LHIN. Given the size and diversity of the areas covered by the LHINs, there will be significant conflicts over resource allocation. The most likely scenario will be that smaller communities will see their existing services integrated into the larger centres in the LHINs. The loss of these services in the community will force Ontarians to travel to where the services are available. It will be destructive for their families and likely result in increased costs for travel and lodging. Communities will lose their economic and employment spinoffs of having these services in the communities. Communities without a range of services will become less attractive as destinations for economic development.

The francophone community in Ottawa made this committee aware of the needs of their community for French-language health care services. The Canadian Hearing Society shared with the committee the need of deaf and hard-of-hearing Ontarians. These are two examples of the needs of Ontarians of particular communities that could be overlooked in this current LHINs model.

Bill 36 gives the government and LHINs a range of tools which can be used to restructure existing health care organizations. The LHINs are given the responsibility to provide funding to the health service providers for the provision of services.

I'm just going to kind of wrap up because I know I'm getting along, but there are some sections of concern that you'll find in our report about sections 28 and 33. For the labour movement, these sections of Bill 36, taken together, are clear indications of the thinking of this government: It's the appeal of competitive bidding, a bias for profit over non-profit models and for privatization of services. This approach, we believe, will be disruptive for the lives of our members who provide the needed services and Ontarians who need these services.

The OFL has worked closely with our affiliates on the issue of understaffing in health care. There's an obvious need for a human resources strategy for our health care system, but this seems to be overlooked in the proposed legislation. The recommendations from our OFL report should be part of such a strategy. The issues of retention and recruitment of qualified personnel are critical. Rumours and talk of amalgamation and transfer of services within the LHINs boundaries will make it more difficult to find people to move to where their expertise is needed.

A provincial strategic plan should be the starting point of building and sustaining the kind of health care system in terms of what we want in our province. The active involvement of the labour movement, especially our affiliates in health care, would be most helpful to this process. In Bill 36, section 14 mentions a provincial strategic plan, and section 15 notes that each LHIN will develop their own strategic plan. The government appears to want to rush the LHINs into service prior to the development of a provincial plan. Perhaps a strategy is to enact change first and then develop a plan. However, it makes little sense for LHINs to spend time on resources to develop a plan which must be consistent with a provincial plan that has not yet been developed.

In conclusion, we share the concerns raised by our affiliates. The all too brief public hearings undertaken by this committee have given you a clear indication that Ontarians are very concerned about the LHINs and the impact on our health care system.

To the government we would say, withdraw Bill 36 and commit yourself to an inclusive process to involve Ontarians in the development of a provincial strategic plan for our health care system. Thank you.

**The Chair:** Thank you. We have this lovely book. All of us have one. All the information is here. We thank you for your presentation.

ONTARIO FEDERATION OF  
COMMUNITY MENTAL HEALTH  
AND ADDICTION PROGRAMS  
CANADIAN MENTAL HEALTH  
ASSOCIATION, ONTARIO  
CENTRE FOR ADDICTION  
AND MENTAL HEALTH

**The Chair:** The next presentation is from the Centre for Addiction and Mental Health, the Canadian Mental Health Association of Ontario, and the Ontario Feder-

ation of Community Mental Health and Addiction Programs. There are three of you: Karen McGrath, Gail Czukar and David Kelly. Good morning. You can start any time you're ready, please.

**Mr. David Kelly:** I just wanted to indicate, just to clear up a little bit of our side that it is Karen McGrath, CEO of the Canadian Mental Health Association; I'm David Kelly, executive director of the Ontario Federation of Community Mental Health and Addiction Programs; and Gail Czukar is executive vice-president, policy education development for the Centre for Addiction and Mental Health. You may ask, why are we here together to present to you? In reality, we came together as a sector about two years ago, realizing that people with mental illness and addictions were being sidelined in the health care system. We came together, realizing that we had to put some of our differences aside and work and clearly be focused on clients and how they work through the system. So we're very proud of what we've been doing, and we have been at the forefront of the transformation agenda since that time period.

**0920**

We also want to take this opportunity to thank all members of the Legislature for the support that they have brought to mental health and addiction services. We know it impacts all of our families, and without you and your support, we would not be able to go forward and really address key social issues.

We're not going to go right through our presentation. We know you have copies of that. We'd like to have some interaction with you, if possible, but we want to just highlight some of our major concerns.

The first one that we're going to go to is about getting "health" to include mental health. So when we go into the preamble of the legislation, we would really recommend that the preamble should define "health" as inclusive of both physical and mental well-being. I just would like to highlight that the government saw the wisdom of this action in the Commitment to the Future of Medicare Act, where we, as three organizations, came together to make that.

Secondly, we want to just talk about and touch on local communities and that local communities know best. In the mental health and addictions sector, consumers, family members and volunteer boards all play key parts in supporting our system. Their involvement is crucial to the success of moving an acute-care-focused system back down to a community level. All of those groups, people and participants strengthen the system. They know they are on the front lines. They are the first ones to see issues, and they are really key to making a success.

I'm going to turn it over to Karen McGrath now to highlight some other issues.

**Ms. Karen McGrath:** I'm going to ensure that everybody is awake this morning by pointing out a typo, first of all, in our presentation. On page 5 of the presentation, under the title which reads "Suggested Amendment," we recommend adding a clause in section 15, not 14. The first eight words should be removed and it should start

by: "That health services include both physical as well as mental health and addictions services." So I just want to make sure.

While we said we weren't going to read, continuing with the key messages, we also want to make sure it's understood that this partnership has been very supportive of the transformation agenda of this government. So our key messages are in the spirit of bringing forth issues that we believe should be addressed by revision to the legislation.

The first one is that we would urge the committee to recommend a broad definition of "health service provider" to facilitate integration and comprehensiveness. It's not clear that they're excluded in the legislation, but it's also not clear that they are included.

I want to talk a bit about planning and the references to planning in the legislation. First of all, we would strongly urge the government to coordinate both the provincial and local strategic plans. This is essential for this initiative to be successful. You need to ensure that consumers, families and local providers have meaningful input into the plans, and then ensure that LHINs have regard to that input. So there have to be mechanisms that keep the LHINs accountable to the communities that they serve. We also would strongly urge government to require plans to address mental health and addictions specifically, that those elements of the plan be identified in each of the local plans.

I'll now pass it over to Gail.

**Ms. Gail Czukar:** I'm going to address the integration sections of the bill.

We feel that the bill overemphasizes strategies that lead to mergers and amalgamations and consolidations at the expense of other kinds of integration initiatives that providers, families and consumers might take on on their own.

That's a function, I think, of section 27 and the definition of "integration." So the definition of integration is very broad and really talks about any partnership or any effort on the part of organizations to work together. If organizations want to do that, even two organizations, they have to give notice to the LHIN, and they have to wait 60 days before they can implement anything. I think this has been raised previously by Steve Lurie, who is from the CMHA in Toronto. I would suggest that the bill be amended to exempt the application of that section, or at least the 60-day waiting period, where there's no transfer of a program or a budget so that the people in local communities can continue to take initiative and be active in coordinating and integrating their local system.

The last parts of our brief talk about the sections that others have addressed before you about the power of the minister in section 28 to actually close organizations. We would suggest that that be deleted. That's certainly an exceptional power. As counsel in the Ministry of Health for many years, I worked on a lot of legislation. This is an exceptional power of the minister, to actually close the operation of an organization altogether. It's one thing to order programs to merge or cease operations, but to close an organization is quite exceptional.

The other issue would be equalizing the field between for-profit and not-for-profit providers. Again, a lot has been said about this. There's been talk about discrimination against not-for-profit providers. I've looked closely at those sections of the bill. I can see that it's positive in the sense that it means that not-for-profit services can't be transferred to for-profit providers, but I don't understand why the services of for-profit providers that are supported by public funds can't become the subject of integration orders, which is the effect of that section.

Those are our submissions. We'd like to have an opportunity for questions.

**The Chair:** There is plenty of time. We have about four and a half minutes total. I'll start with Mr. Arnott.

**Mr. Ted Arnott (Waterloo-Wellington):** Thank you for your presentation. We were all awake when you came in, after several days of this. I thought your presentation was excellent. I want to focus on your suggestion on page 8 about section 28, asking that the section which allows the minister to order an organization to close be deleted. You had indicated that you'd worked a lot of health legislation in the past. Why do you think this was included in Bill 36?

**Ms. Czukar:** It would be hard to conjecture what the intent of the drafters was. It's not a LHIN power, it's a ministerial power, so it would obviously be exercised judiciously, I'm sure. I suspect it's because if you order the integration of services of two organizations, what is that resulting organization going to do? But our law allows for corporations to exist under the Corporations Act or the Business Corporations Act. That's a fundamental legal tenet.

**Mr. Kelly:** I would just add to that that a dollar invested in the not-for-profit community sector results in approximately \$1.43 in services. Oftentimes, the government is not the sole funder or support for those organizations. There are whole components that are run off that not-for-profit because of their connections in the community, how they operate and the support from their local community in building that organization.

**Mr. Arnott:** And that needs to be respected.

**The Chair:** Ms. Martel.

**Ms. Shelley Martel (Nickel Belt):** Thank you to the three of you. The last time I did see you together was for Bill 8.

Can I follow the section a little further with respect to the integration of only for-profits and nothing with respect to not-for-profits? The suggestion has been that we either include for-profit providers under that section or delete the section altogether. What would be your preference in that regard? I'm not trying to test you. Do you have a preference?

**Ms. Czukar:** Sorry, to delete which section altogether? Section 28 or 27?

**Ms. Martel:** Section 28. You said that the power to close be deleted. I just want to be clear that that would be the preference versus having orders apply to the for-profit sector as well.

**Ms. Czukar:** This is obviously off the top, but I would say we would prefer to see it deleted. I think ordering mergers of for-profit and not-for-profit organizations does run into a lot of problems and would raise the concern, which I think is not here at the moment, of having services transferred from the not-for-profit to the for-profit sector.

0930

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

**Ms. Kathleen O. Wynne (Don Valley West):** Thank you very much for being here. I wanted to ask you whether, in your conversation about section 27, the 60-day provision—obviously your organizations have seen the benefits of working together, not just to come and talk to us, but on service delivery and communication around clients. Are you saying that you see, possibly, a barrier in this legislation to some of the informal co-operation that can happen spontaneously in the community and that we should be careful not to hobble that?

**Ms. McGrath:** Create obstacles? Yes, absolutely.

**Mr. Kelly:** Absolutely. There's planning, coordination, improvement in access going on right across the province in mental health and addiction fields right now. We have groups that are literally hitting the ground running in trying to work through some of the support dollars that have come in and make the system function better. Our concern was around that saying, "You have to get approval for 60 days," would stop some of that. If there's no transfer on the funding and it's not having a negative impact upon clients or outcomes within the service field, then these groups should be encouraged to do that.

**Ms. Wynne:** I am absolutely sure it was not the minister's intention to put up barriers to that kind of co-operation. But you're saying that your legal advice is that there would be a restriction on that kind of coordination or co-operation if this legislation passes the way it is?

**Ms. Czukar:** I think the other option would be for the LHIN—I mean, the intention of this, obviously, is for the LHIN to manage the system, so that where there's activity that's going to have organizations working together, they know what that is. Over time that may be possible; I don't think initially the LHINs are going to be in a position to so actively manage the system.

The other possibility would be for either the minister or the LHIN to have discretion to exempt organizations from that so that in the beginning, at least, they can say to a group—say they wanted to say to all the mental health and addiction organizations in their area, "We want you to work together on coordinated access to the system. We'll give you six months or a year to come up with a plan", organizations could go ahead and initiate projects without waiting for approval from the LHIN. You don't want to paralyze the system as we go through this transition.

**Ms. Wynne:** I completely agree with you and that's certainly something that I will take back, because I would hate to see that kind of barrier. Since I'm sure it wasn't

our intention, we'll try to figure that out. Thank you very much.

**The Chair:** Thank you for your presentations.

#### CANADIAN MEMORIAL CHIROPRACTIC COLLEGE

**The Chair:** The next presentation is from the Canadian Memorial Chiropractic College, Dr. Jean Moss. Good morning, doctor.

**Dr. Jean Moss:** Good morning, everybody. I'm Dr. Jean Moss, president of the Canadian Memorial Chiropractic College, commonly known as CMCC. It is a private, not-for-profit, degree-granting academic institution that has been providing post-secondary professional education to the majority of Canadian chiropractors since 1945. CMCC is a leader in chiropractic health research and provides excellence in clinical care in multi-disciplinary environments. We have a number of very interesting relationships with other organizations which I think this legislation does not cover. We're pleased to comment on the proposed legislation, Bill 36.

CMCC's commitment to health care renewal has been demonstrated by our provision of chiropractic care in multi-disciplinary environments to patients in the community in which they live and work.

The proposed LHINs legislation does not contain provisions that address health care renewal through integrated primary health care delivery and inter-professional care. We believe that, through LHINs, there should be improvement in access to a variety of health care services, improvement in quality and continuity of care, increased cost-effectiveness, and increased patient and provider satisfaction, while the effective use of our health care resources is ensured.

CMCC has demonstrated experience working in an integrated manner. As an academic institution, we provide clinical training through community-based chiropractic clinics, including clinics located inside community health centres, such as Anishnawbe Health Toronto and South Riverdale Community Health Centre. We provide clinical services in hospitals such as St. John's Rehabilitation Hospital and St. Michael's Hospital family and community health department. We provide services to other in-need populations such as at the Muki Baum Centre, a centre for adults and children who are behaviourally, mentally and physically challenged, and for the Donwood Institute, which is associated with the Centre for Addiction and Mental Health. We also operate two community-based clinics, one at our campus on Leslie Street at Steeles in north Toronto and the other at the Sherbourne Health Centre, a health centre dedicated to providing accessible care in an environment that supports traditional and complementary therapies to service the needs of the community, including the HIV/AIDS patient group. Our clinics are located within the Central Health Integration Network and the Toronto Central Health Integration Network. Sorry, that's a bit of a mouthful.

Our clinics operate under principles similar to those of the LHINs. We provide patient care to improve population health by implementing wellness and disease-prevention strategies; evidence-based practice to achieve positive health outcomes; integrated health care services at the community level; continuum of care through health promotion and wellness; education as the cornerstone for inter-professional and interdisciplinary care; access to primary health care for certain population groups to whom it is traditionally limited; and services that are culturally diverse for the aboriginal population and disadvantaged groups.

It is with this background and experience that we offer the following comments on the proposed legislation:

The legislation does not provide for input by Ontarians into the development of an integrated health service plan, or IHSP;

The legislation excludes some health services, such as chiropractic, from the definition of health service provider. This definition appears to be inconsistent with definitions in existing legislation and makes it difficult to assess how coordination of services across a local health integration network could be possible;

The composition and mandate of the health professional advisory committee is unclear;

The legislation does not provide a framework to identify how funding will be provided to meet the local community's needs;

The legislation does not provide meaningful and accountable oversight of integration and funding decisions to ensure that patients' needs are met in their own communities. Several of the LHINs will be very large in terms of both population and geographically, and I think we've already heard comments to do with that. It calls into question their ability to address health service needs within their diverse communities;

The legislation is unclear on the extent of public consultation that must be entertained by each LHIN in determining community needs and priorities;

It is also unclear on the role for community engagement in the development of IHSPs and in setting priorities on how the community engagement shall occur;

It is unclear on how community health centres will be integrated into LHIN priorities, including their funding; and

The legislation is silent on the importance of patient choice in access to inter-professional care and on the role of academic health science centres.

Based on these shortcomings in the legislation, we offer the following recommendations:

Regulations should outline how the general public and health professions will have input into the development of an integrated health service plan for Ontarians. All providers and patients of existing community-based programs should be consulted and their feedback should be included in health care renewal decisions. An amendment to the legislation should include a description of the specific elements or components of the IHSP—scope,

timeframes, resources, expected outcomes and implications for providers.

The legislation should ensure that appropriate and complete input is provided into health transformation decisions within the LHINs through community engagement. The community with which LHINs must consult regarding the development of IHSPs should include citizens, stakeholders, educators and health care providers. The consultative process will be critical in determining what programs and services will be offered within a community and will ultimately have significant impact on health care providers.

#### 0940

The definition of health service provider should include all health care providers and, at a minimum, those regulated under statute in the province of Ontario who contribute to maintaining and promoting the health of Ontarians. The exclusion of chiropractors as health service providers is an oversight in the legislation. Chiropractors are primary-contact health care professionals, regulated by legislation in every Canadian province. They are one of the most frequently accessed non-physician provider groups in Canada, with about 12% of the Ontario population and about 35% of those suffering from musculoskeletal disorders seeing a chiropractor.

Funding allocations should be made to health professions, services and programs which contribute to the IHSP in the most effective manner. For example, government and health care reports reveal that chiropractic health care can be cost-effective in the treatment of musculoskeletal conditions. Delivery of health care should be realigned to ensure that musculoskeletal conditions are managed by those health professionals trained to provide such care in the most cost-effective manner. Lack of funding for these services particularly impacts those in most need, typically the financially challenged. Chiropractic could offer relief to the health care system by appropriate triaging of care. To date, health care transformation initiatives have failed to take into consideration the roles that chiropractors can play as members of the health care team.

CMCC has successfully demonstrated its ability to collaborate with other health professionals in managing patient care in a number of its community-based clinics, including some in hospital settings. Preliminary results on a demonstration project where chiropractors are on staff at St. Michael's Hospital have shown a reduction in wait times for physiotherapist service at the hospital. This project within the hospital has been a huge success. This is a result of the development and implementation of a collaborative patient care model to improve continuity and coordination of interdisciplinary care in a hospital-based primary care unit.

The legislation should be clear on how the services currently offered through community health centres will be maintained within the framework of the LHIN. CMCC currently operates chiropractic clinics within two CHCs, and I've already mentioned those. These communities are mainly underserved and economically challenged, with



the result that CMCC's ability to charge for its patient services is restricted and thus we absorb the cost for these health care services. Our clinics provide universal access to chiropractic health care services for patients, when and where they need it. Amendments to the legislation should include guiding principles for funding that will ensure funding of providers and programs that build towards inter-professional care, equitable access to the continuum of care, and effective and efficient use of health care resources.

The legislation should be amended to include criteria for issuing decisions that take into account patient choice of access to health care providers; quality and access to health services such as rehabilitation, teaching and research; facilitating inter-professional care, and availability of health human resources.

Integration is key for health care system renewal. It is important that integration decisions are based on best practices, evidence and research and that all LHINs are working from the same principles or criteria. The professional advisory committees within LHINs will have a significant role in contributing to the process of integrating decision-making with the development of the IHSP plan. As such, the composition of such committees should include health providers, health science academic groups, researchers and educators.

Integrated primary health care delivery and inter-professional care will improve access to health care services, improve quality and continuity of care, increase cost effectiveness and increase patient and provider satisfaction while ensuring the effective use of our health care resources. Once the gaps in this legislation are addressed, we look forward to working with the two local health care integrated networks that impact directly on our community-based clinics, and sharing the successes and positive outcomes we have experienced through working collaboratively with other health care providers.

Thank you for allowing me this time.

**The Chair:** Thank you, Doctor. We have two minutes total. I will ask Madame Martel; 30 seconds, please.

**Ms. Martel:** Thank you for your presentation here today. I am looking at the recommendation, or point number 3, that says, "The exclusion of chiropractors ... is an oversight in the legislation." I would assume that you want chiropractors included in the legislation.

**Dr. Moss:** Well, the legislation doesn't really include any of the health professionals unless they're working within the organization within the LHINs. I can see lots of problems coming. It's very unclear, for example, with the CHCs. Some physicians are going to be inside the act and some of them are going to be outside of it. Chiropractors don't appear anywhere and yet we're offering services within those environments and would like to see other community health centres start to offer those services. What we find when we offer those services in those types of environments is that economics is a huge barrier to patients accessing us, and that the patients the chiropractors see in those environments are far more complex cases, with a lot more co-morbidities, and the

success rate therefore is that much higher. It gets them back into work.

**Ms. Wynne:** Thank you very much for being here. I look at section 16(2), where it states, "Each local health integration network shall establish a health professionals advisory committee consisting of the persons," blah, blah, blah, "of those regulated health professions." So the regulated health professions are included in those committees. You see chiropractors as part of that group, presumably.

**Dr. Moss:** Absolutely.

**Ms. Wynne:** So you're reflected there as much as any other regulated health professional. You're satisfied with the composition of the advisory committee?

**Dr. Moss:** Yes, we're satisfied with the composition; we just want to make sure that chiropractors are actually on those advisory committees.

**Ms. Wynne:** I guess I see the regulated health professionals, including chiropractors, and so that would make sense.

The other piece is the community engagement, and you've suggested that regulations should outline community engagement on the provincial plan. For sure, regulations will outline community engagement on the local plans. I guess if you have specific ideas about what that community engagement should look like and what should be in the regulations, at some point in the future you might want to let us see that.

**Dr. Moss:** Absolutely.

**Ms. Wynne:** Thank you.

**Mrs. Elizabeth Witmer (Kitchener-Waterloo):** Thank you very much, Dr. Moss. Just about the whole issue of chiropractic: Since the Liberal government delisted chiropractic services, what impact do you think it's had on the health of Ontarians? I think you're speaking here about the fact that those who obviously don't have the financial wherewithal are not able to have access to the services.

**Dr. Moss:** Absolutely. I think there has been a significant decrease in the patients seeking chiropractic services. A study was done by Deloitte & Touche before the decision was made showing that those patients would be seeking other health care services and actually increasing costs in other areas. I can tell you specifically for our institution what the delisting has meant: It has meant that the institution is providing health care services in many cases for free, so indirectly our students with no OHIP coverage are actually bearing the cost of those services.

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

#### INDEPENDENCE CENTRE AND NETWORK

**The Chair:** The next presentation is from Sudbury. It's a videoconference. We have on the line Valerie Scarfone and Tyler Campbell, and on the screen too.

Good morning. Please proceed with your presentation. You have 15 minutes total time.

**Mr. Tyler Campbell:** Thank you very much, Mr. Chair. I would like to start by thanking the committee for using videoconferencing this morning to allow smaller organizations like ours to present to you without having to travel to Toronto.

ICAN, the Independence Centre and Network, is a non-profit organization incorporated in Sudbury in 1979. ICAN was founded in response to a need for support for individuals with physical disabilities in order to avoid institutionalization. As a result of hard work on the part of parents and concerned citizens, programs and services were created to afford individuals with physical disabilities the opportunity to live an independent lifestyle. Since 1979, the organization has developed life skills training programs, respite services, supportive housing and outreach for adults with physical disabilities. More recently, ICAN has added a life skills program for teens with disabilities and a volunteer-driven peer support program.

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ICAN is governed by a group of volunteer directors, made up of members of our community with diverse backgrounds. All directors on the board are committed to the principles of independent living.

We value full participation in community life, respect for individuals, shared responsibility and partnership, excellence and innovation.

ICAN services are provided with the independent living philosophy, which means we promote consumer choice and control. Services provided are non-medical and individuals supported are not sick but have permanent physical disabilities, which necessitates ongoing support. Services are provided in the person's home, at work or school.

Members of ICAN felt that it was important to provide this committee with feedback on Bill 36 in order to provide the perspective that community support services provide essential, non-medical support in the larger health care system.

ICAN is an active member of three provincial associations: Independent Living Service Providers, the Ontario Community Support Association and the Ontario Non-Profit Housing Association. These provincial associations are a collective voice to effect a positive change in our capacity to provide services and to network through peer support and professional development.

We welcome the opportunity to provide you with insight into each section of the act from our perspective.

**Ms. Valerie Scarfone:** Section 1: The government is to be commended for the goal of making our system more effective and efficient with the development of the LHINs. The current health care system is difficult to sustain in its present model. Keeping more resources in the non-profit sector would improve accountability and put every dollar into service.

Health improvement for people with a disability means access to reliable daily supports that allow for full

participation in community life. Supports from attendant care facilitate enrolment in post-secondary education and promote working in competitive employment and living independently.

We are in support of the general purpose of the act. Our agency has given priority to the development of partnerships and alliances with other organizations to meet our client needs. We have formal partnership agreements with the Canadian Paraplegic Association, Ontario division, our local branch of the Canadian Mental Health Association, and we have a purchase-of-service agreement with the Manitoulin-Sudbury Community Care Access Centre to ensure the right service, at the right place, at the right time. In Sudbury, we are currently co-located with the local brain injury association, as they rent our facilities at cost. Those are just some examples of our integration efforts.

ICAN also has a strong, well-established working relationship with Sudbury Regional Hospital. The past two individuals accessing our supportive housing services have come from the hospital setting. One individual came from rehab and the other person came from continuing complex care, and she lived there for over six years. These are young citizens who need to live an independent life and make contributions to our communities, and they can do that by living in a supported environment in the community.

We have an informal referral protocol with the hospital that provides individuals coming from there with immediate service in our Independence Training Centre, and we share all necessary professional reports and avoid the duplication of service.

Enshrining principles like this in legislation is critical to system improvements.

The LHIN corporation: The objects of the LHIN corporation need to have increased emphasis on quality. The quality of services provided in our health care system needs to be a priority for the LHINs. Having quality standards and measurement tools for health service providers is key to system improvements, including community standards, not just institutional standards. It will be important for the LHINs to involve the community support sector in the development of these quality standards and for all sectors of the health care system to be partners in the decisions and the development of those standards.

The mention of client-patient consumer choice could not be found in the legislation. Individuals requiring life-long support need to have a choice of provider and options for independent living. Long-term-care homes, for example, are not appropriate options for young people with disabilities. The power of this legislation to order integration even at the expense of the demise of the service provider could very well threaten the quality of service and, at minimum, could have a negative impact on the issue of choice for individuals needing service. Services provided in the community operate under the model of support that promotes wellness of the individual, lifelong supports that allow individuals to be active and contributing members of our community.

The issue of research needs to be addressed. The importance of evidence-based decision-making through appropriate research needs to be highlighted in the legislation. Research needs to be an integral part of system improvement, with an emphasis on best practices. Currently, ICAN in Sudbury is involved in a research project with the Sudbury Regional Hospital and the Manitoulin-Sudbury Community Care Access Centre. The research is on providing community supports to individuals who have had a stroke. Research like this will provide the LHINs with evidence-based documents that will assist in planning functions.

“Community” and “community engagement” need to be defined. Community-based planning needs to include extensive input from providers, consumers and individuals from all walks of life. Community engagement must be accessible to individuals with ranging abilities. Mobility factors must be considered, and the need for interpreters for both individuals with augmentative communication needs and for individuals with hearing or visual support requirements. Community engagement needs to include connections with multiple associations, groups, committees and individuals and their communities, including the most vulnerable, like individuals with physical disabilities. Community engagement needs to include cross-sectoral participation and cross-government ministry participation. The community engagement must take into account different parts of the province and the inherent geographical challenges that presents for northern Ontario.

The health professionals advisory committee: We strongly recommend the addition of unregulated health care professionals; for example, personal support workers and social service workers. The health care system is broader than those professionals identified as regulated health professionals. Expanding membership of the health professionals advisory committee removes existing silos and gives all professionals equal input. In order to be inclusive of community support agencies, quality, trained staff at every level need to be included in the health professionals advisory committee.

Funding: In order to have a stable health care system, multi-year funding is required not only from the Ministry of Health to the LHINs, but from the LHINs to health service providers. Currently, community support agencies are funded on an annual basis, with little or no increases to account for inflation or rising costs. Funding for the community support sector needs to be protected and have the same benefits as other sectors. We need to have multi-year funding commitments from the LHINs. The community support service sector has the capacity and the ability to provide more services in the community. We need the financial resources to make it happen.

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It is encouraging to see the inclusion of a section in the legislation that speaks to crossing LHIN boundaries for services. ICAN commends the government on no restrictions on patient mobility.

Integration: Integration decisions and orders need to be supported by a strong business case, taking into account the impact on the people served, the community, volunteers and the health services providers. The approach to integration must be transparent and fair. There must be due process to object to integration decisions and integration orders. Currently, the legislation allows for 30 days to make an objection to integration orders. This does not provide enough time for service providers to engage their boards of directors and required legal counsel.

In relation to integration orders, many organizations do not receive 100% of their funding from the Ministry of Health and Long-Term Care, and removing a portion of an organization’s funding could cause the collapse of service to clients. It is of paramount importance that integration orders be given due consideration and time for extensive input.

Finally, having a stable employment base is important to the provision of quality services. Employees need protection of their work, benefits and pensions in order to keep them working in this sector. Long-term, committed employees are the backbone to organizations like ours. In all integration decisions and orders, maintaining a stable workforce must be a consideration.

**Mr. Campbell:** In closing, we would like to thank the committee for the opportunity to present to you today. We hope you will find the recommendations useful in your considerations for amendments. Thank you.

**The Chair:** Thank you very much for your presentation. We don’t have time for questioning, but we would love to have a copy of your presentation. If you can send it to the clerk, we will all get a copy.

Can you see us from your studio?

**Mr. Campbell:** Yes.

**The Chair:** Terrific, because we can see you very well. We thank you again for your presentation.

That’s a nice and cheap way of being able to reach the entire province, eh?

#### CANES HOME SUPPORT SERVICES

**The Chair:** The next one is CANES Home Support Services. Velma Jones and Gord Gunning, good morning. You can start any time you are ready, please.

**Ms. Velma Jones:** Good morning. Thank you for giving us the opportunity to come and speak to your committee this morning. I’m Velma Jones, president and chair of the board of CANES Home Support Services. With me this morning is our executive director, Gord Gunning. I’ll just give you a little background on the CANES organization, Gord will talk to some of the concerns we have and then I’ll wrap it up. We’ll try to keep it brief.

CANES Home Support Services is a not-for-profit health service provider, as defined in Bill 36. We have been providing services in central and northern Etobicoke for 23 years, and focus on providing home support services to seniors and adults with physical disabilities. We

offer a range of services, including personal care, respite care, caregiver support and counselling, supportive housing, homemaking, seniors' luncheons, home maintenance and newcomer elderly outreach. Our mission, as stated in our document, is to provide excellent support services for seniors and adults with physical disabilities to enable them to remain in their community environment in safety and dignity. We are active members of OCSA, the Ontario Community Support Association, and VITAL.

CANES is located in the Central West LHIN, which covers a large area, including northern Etobicoke, Malton, Brampton, Caledon, Orangeville, Shelburne and Dufferin county. Our catchment area covers seven planning neighbourhoods in northern Etobicoke, and the characteristics of our population of approximately 142,000 persons in northern Etobicoke include high poverty, high unemployment, a large immigrant population and a large percentage of single-parent families.

We believe that the implementation of the transformation agenda, including the move to create 14 LHINs throughout Ontario, will benefit our clients, our community and our unionized workforce. We also believe that Bill 36 will provide the government of Ontario with the mechanism to implement the transformation agenda.

We feel that there have been many province-wide attempts to restructure the health system in Ontario and that legislation is now required to provide the appropriate powers at the local level. With the legislative authority and associated funding, we believe LHINs will have the tools to effect change in the best interests of communities across the province. But we do have a few concerns that we would like to share with you today, and I'll ask my associate Gord Gunning to address those with you.

**Mr. Gord Gunning:** We've identified three basic areas in the legislation that we would seek some clarification on from you, and to consider in your clause-by-clause.

The first is community engagement. What will it look like, and will the community support sector have an equal voice at the table with the LHINs? The extent to which communities will be involved and consulted with respect to decisions about the local health system is referenced in Bill 36, but we are concerned that the details of that engagement are left to be addressed later by regulation, so we wanted to flag that issue. It is an issue with our colleagues through the Ontario Community Support Association.

Given that the stated purpose for introducing Bill 36 is to move toward community-based care and enable local communities to determine local priorities, we believe this matter should be addressed in the legislation and not left to the regulation-making process.

The second point is around health service providers, of which we're one, or will be under the legislation, if it's passed, and the proposed service accountability agreements, or SAAs, as they're referred to.

We're concerned that there's no model or standard accountability agreement at this point for the delivery of home and community care. We believe there should be a

requirement in Bill 36 to ensure that it is a centralized, standard accountability agreement, with some common outcome indicators or accountabilities for the whole sector so that there aren't 14 templates across the province, that there's one, and that they're based on goals articulated in a province-wide strategic plan, which the Ministry of Health and Long-Term Care is working on.

We believe health service providers should be invited to be an integral part of the process of developing these common outcome indicators. We have a concern that these could be developed in a head office environment, if you will, to go to the minister and then be rolled out to the LHINs without an opportunity for community engagement and input. We would prefer to have the community support sector invited to assist in the development of the outcome indicators rather than have them written into the regulations prior to an implementation process. That's point number 2.

The third one: As Velma has mentioned, we are a unionized agency. Bill 36 provides for an override to existing collective agreements. Just for the committee's information, CANES has a long history of bargaining in good faith with our union—that's Local 3808 of CUPE. We are now entering into negotiations for a new two-year agreement, which will be April 2006 to March 2008. So we have some concerns that Bill 36 could provide the LHINs with the power to override any agreement we might enter into in good faith with our unions at the time of bargaining.

As Velma mentioned, we view the legislation as a positive transformation agenda item that we think will benefit our agency and our workers going forward. We see opportunities for expanded contracts in the future, and that will be good for our workers. So we wanted to honour whatever agreements we enter into in the next couple of years.

We've got a couple of recommendations we'd like to leave with you as future food for thought.

The community support sector needs further investment in technology to ensure that we are successful in tracking and reporting what we expect will be both the financial and program performance indicators going forward with the LHIN service accountability agreements.

We believe there needs to be an ongoing commitment to clear and frequent communication, information-sharing and knowledge transfer from the Ministry of Health and the LHINs to the community support sector in order for us to develop the capacity to integrate service delivery within our defined communities.

Third, we believe there should be consideration of a mechanism to analyze the impact of the integration plans on a community-by-community basis, based on the patients and clients who will be served. If you were to take 2006-07 as a baseline year, say, then going forward, how is the implementation process working from a patient perspective in terms of their satisfaction index?

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**Ms. Jones:** Just to wrap it up, I'll give a short quote from Ted Ball, the then chairperson of Quantum Solutions. In 1995, he stated, "Until government has had time to develop a coherent strategic approach to the transformation of our public services, the only instrument they have available is a meat cleaver."

Seriously, as I stated at the commencement, CANES Home Support Services believes in Bill 36, the Local Health System Integration Act. We believe it will move the health sector into an integrated model that will better serve the patient and client. We think that if the legislation is implemented in a thoughtful, fair and resourceful way, the future health care needs of Ontarians will be met.

We believe that Bill 36, in combination with the re-organization planned for the Ministry of Health and Long-Term Care, will give the health system the tools it needs "to develop a coherent strategic approach to the transformation of our public services."

We know that not only our agency, but a majority of our colleagues in the community support sector, support the intent of this bill. The LHIN initiative has created a wellspring of collaboration, co-operation and communication within our sector and across sectors, as all health service providers attempt to grapple with the proposed integration.

At a recent visioning day on January 16, some 38 community agencies serving seniors in Toronto came together to discuss the health transformation agenda. This group identified a number of ideas for moving forward, including central access to services, developing infrastructure, integrating services and agencies, and exploring integration opportunities with other sectors, such as hospitals, family health teams, community health centres and community care access centres.

Our agency is actively involved in a service integration pilot project with three agencies at present, and also a back office pilot project with seven agencies. These projects are supported through funding from the Ministry of Health and Long-Term Care. The lessons learned from these projects will inform our sector on new opportunities for service delivery integration and back office efficiencies. These are just some of the examples of new collaborations that have started as a result of the transformation agenda. As you can see, we are rapidly moving with it.

If the Local Health System Integration Act passes third reading and receives royal assent, we will look forward to working with the new boards of directors and CEOs of the local health integration networks as we enter into a community engagement phase to develop an integrated service delivery plan for the Central West LHIN.

Thank you very much for hearing us this morning. We wish you all the best in your clause-by-clause review of the legislation.

**The Chair:** There is about a minute each for each group for questioning. Ms. Martel, please.

**Ms. Martel:** Thank you for your presentation this morning. Let me go to the section on community engagement because you and many others have said that the mechanisms for this should be clearly articulated and stated. Can you give the committee some ideas of how this should be approached?

**Mr. Gunning:** We're engaged in and we're supporting a process in the Mississauga Halton LHIN and central west LHIN—you may have heard of it—called Metamorphosis. It was started a year ago, almost a year and a half ago. It's following on from the initial workshops the ministry sponsored in terms of looking at local health integration. That could be looked at as a potential model where it has brought together all the sectors initially for some training and some information-sharing. We're now actively talking to the board chairs and CEOs of those two LHINs as to how that could be used as an example for community engagement with all sectors at the table. It's called Metamorphosis. There is a website and I can send you an e-mail on it, if you'd like.

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

**Ms. Wynne:** Thank you for being here this morning. I just wanted to clarify the issue of collective agreements. This legislation doesn't invalidate collective agreements, but where there's a conflict between a collective agreement and a LHIN decision to integrate, there's a power to override just that section in order to allow the integration. So it's a very narrow power. I wanted to clarify that. It's certainly not the intention to override collective agreements holus-bolus. I just wanted to make that point.

Secondly, it's interesting that you've said that even in anticipation of the LHINs there is increased co-operation and collaboration. I've seen that in my own riding, where organizations are saying to me, "We're getting ready." There's that happening. Can you just elaborate on that a bit?

**Mr. Gunning:** I think it started in the central west LHIN with some of the initial forums bringing a broad range of sector providers together in Brampton, Mississauga, Orangeville. That was the start of a lot of us realizing we were operating in silos too. So seniors' agencies would collaborate with seniors' agencies, but we might not necessarily collaborate well with our mental health partners, our CCAC partners, our hospital partners and so forth. That was the start of it, kind of an eye-opener.

**Ms. Wynne:** That's great; that's very good news.

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

**Mrs. Witmer:** Just briefly, you've expressed concern that the bill is going to override any agreement that you might enter into. What do you think the consequence of that could be, if it did override that agreement?

**Mr. Gunning:** I guess the major concern, and it's hypothetical, obviously, at this point—

**Mrs. Witmer:** Yes, but we've heard that concern expressed before.

**Mr. Gunning:** I guess our concern would be that it wouldn't be just our local that would rise up against it, but it could be precedent-setting for all of the union or a variety of the unions that I'm sure you've heard from

directly. So in our world, we do have a lot of long-term loyal employees that we feel we treat fairly with wages and working conditions and benefits. I guess it's just more of an anxiety at this point, without knowing what the result might be.

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

**Mr. Gunning:** Thank you for the opportunity.

**The Chair:** Mr. Ramal, would you mind taking the chair, please?

#### FAMILY COUNCIL: EMPOWERMENT FOR FAMILIES IN ADDICTIONS AND MENTAL HEALTH

**The Chair:** The next presentation is from the Family Council: Empowerment for Families in Addictions and Mental Health, Betty Miller. Good morning. The Vice-Chair will chair for a few minutes.

**The Vice-Chair (Mr. Khalil Ramal):** Good morning. You can start whenever you're ready.

**Ms. Betty Miller:** Thank you and good morning.

My submission is brief. Sirs and madams, Mr. Chair, thanks so much for this opportunity to address the standing committee on social policy on the very important topic of the provincial government's health care transformation plan, specifically the development and design of the new local health integration networks, known as LHINS. I can only imagine the complexity of this ambitious and vital undertaking and wish you well in your upcoming endeavours.

I am the coordinator of a small—actually, a very small—membership-driven, incorporated non-profit organization. We are the Family Council: Empowerment for Families in Addictions and Mental Health. We are just under four years old and we have about 150 members. Each one is a family member or a loved one of someone who has received service or is receiving service at the Centre for Addiction and Mental Health, known as CAMH, or one or more of the family has received help from CAMH. We are funded by CAMH and we work pretty much exclusively with them on behalf of their clients and their families, but we have an independent voice. I am accountable to the membership and to my board of directors, all of whom are family members. I report on all of this to CAMH, but I am strictly accountable to the families.

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So it's an interesting and dynamic relationship we have with CAMH. We collaborate, sometimes loudly and not always smoothly, but we do indeed collaborate. Our mutual goal is to improve health care outcomes for clients and their loved ones. We are, if I may say, highly successful and skilled at this. We are results-driven, and the positive results are compelling. In the three and a half years of our existence, standards of practice have significantly increased. Furthermore, the costs for the increase are low, really low. It's a win-win situation.

CAMH has come to understand, from their own experience at integration and amalgamation, that families and patients or clients want in everywhere. We want to be engaged in the delivery of health care, from the design of the buildings to the delivery of services and programs, the creation of policies, evaluation instruments and, in fact, governance.

Perhaps it's a little overpowering to hear that clients and families want in everywhere in health care, but it's true; we do, and not just in Canada. In fact, our Canadian experience at including clients and families in health care is generally far behind countries like England and other EU countries, parts of Asia, Australia, New Zealand and the United States. Extensive research bears witness to the fact that when patients, consumers, clients and their families are actively and substantively engaged in the delivery of health services, you wind up with a higher standard of health care and more cost efficiencies. I have attached a seven-page bibliography in our submission to highlight this very distinctive and fundamental fact. Include families in a meaningful and substantive manner in all aspects of your process, and especially include clients. You will develop a better system. This has been proven. We cannot and should not be subsumed only within the context of community as stated in the legislation. Clients and families are different. We need to be partners, serious stakeholders and absolutely involved.

Families have provided unpaid and unsupported care to their loved ones—especially in the orphan child of health care, addictions and mental health—for centuries. The system would collapse if families and loved ones abandoned it. We know this intuitively. We know that families live the intimacies and obstacles of the broader determinants of health: housing, income, access to health care, education and justice. Families provide all of this and advocate for access to all of this, and really, this is just the tip of it. Yet, unless I missed something, the word “family” is not even mentioned in Bill 36—not once. Talk about a thankless and invisible moment in history. If you know anything about the incredible amount of health care we do, then perhaps you can understand why it hurts us to be passed over and go unmentioned.

Families have had to do this incredible amount of care because mental health and addiction services have been ignored and underfunded forever. This is true despite the myriad of government-led commissions and task forces and LHINS consultations that point out the glaring gap in the system and the chronic unmet needs of our people.

It's like the elephant in the living room. No one can get past it and no one talks about it, but it hangs over everything like a massive desert thunderstorm. It clouds and squashes words like suicide, schizo-effective, alcoholism, psychotic episodes, crack cocaine, accidental death, depression, hallucinations, delirium tremors and prescription drug addiction.

And we whisper to one another, “Who in your family? Who among your friends? Who in your workplace?” Do you know anyone with an addiction and/or a mental health problem? Of course you do. Certainly you do. We all do. This is the elephant in the living room.

You have probably already figured out that I am no expert on LHINs or Bill 36 or public health policy. I am here as the coordinator of a small, but provincial, family mental health and addiction organization. I'm also a family member and I'm also a consumer of services. So I won't embarrass myself by pretending any technical or sophisticated knowledge about the legislation or about the complexity of your assignment.

Suffice to say that I am here to persuade you to do a better job at including families in the legislation and to push the mandate of LHINs to address the issue of the chronic neglect of mental health and addiction services. As such, the Family Council offers the following recommendations:

(1) That families be acknowledged in the legislation as providing informal and crucial health care and as important stakeholders in the delivery of formal health care;

(2) That the development of a formal and ongoing consultation process with families and clients be mandatory in each region and not subsumed in a general process of community engagement;

(3) That the legislation mandates the establishment of an addiction and mental health advisory committee for each LHIN in each region;

(4) That small, local self-help and mutual aid organizations, consisting of client and family volunteers, be selected for protection from amalgamation with larger institutions;

(5) That the important contributions of regulated professionals, such as occupational therapists, recreation therapists and social workers, be given equal standing and recognition as that accorded to regulated health professionals;

(6) That the provincial government be allowed to withdraw their funding from organizations but not be able to force closure on organizations that receive funding from other sources.

The Family Council also acknowledges and supports the submission to this committee by the Family Mental Health Alliance.

These are my thoughts on the matter of LHINs. Thanks very much for listening. I'm happy to answer any questions if we have any time left.

**The Vice-Chair:** Thank you very much for your presentation. We have five minutes. We will divide it equally among the three parties. We'll start with Ms. Martel.

**Ms. Martel:** Thank you for making the presentation today and for the focus that you made, which was, frankly, different from all of the others that we've heard to date. Thank you for bringing the perspective of families, their search for health care, their need for health care and their need for participation.

I'm looking at the recommendations that you have made, particularly number 4. I think that's a very valid concern. In the legislation, which permits integration, there is a very legitimate concern that has been expressed by others as well that what will happen here is that smaller, particularly not-for-profit, organizations will be

swallowed up because someone will claim that the work they provide is a duplication of somebody else's work. With respect to point number 4—you've got a small, not-for-profit organization—what's the case that you can make for why it shouldn't be swallowed up or integrated because of the unique services that you're providing to families and clients?

**Ms. Betty Miller:** I think the small organizations are extremely cost-efficient, to begin with. Most of us are run 60% on volunteerism and volunteer boards of directors. You hire a volunteer coordinator and then you get 150 volunteers working for you. There's a cost-efficiency there that is locally based and community-based, so if a family phones or a client or consumer phones, they can receive service immediately, and in their own culture, in their own language. We are partnered with all kinds of smaller organizations. There is not a bureaucracy to go through.

If you phone one of the larger organizations today, most likely you'll get a voice message and you'll be lucky to get contacted in 48 hours. But with the smaller organizations, they're there; they're on the ground. They're run primarily by volunteers with a small staff. They will bend over backwards because they've been there. They're consumers, they're families. It matters to them that they're giving of their own time.

They're not duplicating service. On the contrary, when you receive mutual aid and support from somebody who is a mental health survivor, such as myself and hundreds of thousands of other people, then I think you're going to get good service. You're going to get it locally and quickly. It's not a duplication.

**The Vice-Chair:** Mrs. Witmer?

**Mrs. Witmer:** I think your presentation today probably is reflective of some of the wishes of people throughout the province of Ontario, who, seeing the introduction of this new level of bureaucracy called LHINs, have high hopes that some of their needs, obviously, are going to be reflected. The way it's presently structured, when you've got LHINs, some the size of 1.5 million people, it doesn't appear that organizations like yourself are going to have any voice unless there's a big change. There's certainly no process. Hopefully, the government will listen to your concerns. I want to thank you and I appreciate what you do on behalf of individuals and their families.

1030

**Ms. Betty Miller:** You can certainly contact the Family Mental Health Alliance if you want to talk about process and engagement. There are lots of recommendations for that and lots of us who would be happy to help with that one, for sure.

**Mrs. Witmer:** We hope the government will take those into consideration. Thank you very much.

**Ms. Betty Miller:** It's a pleasure.

**Ms. Wynne:** Thank you very much, Betty, for being here.

Following up on Ms. Witmer's comment, I want to reassure you that there are structures being removed from

the system, like the district health councils and regional offices, and the LHINs are being put in place. So it's not that we're building more bureaucracy; we're actually replacing structures with a new structure. Our hope in doing that is that we'll actually be able to connect with groups like yours and with the public.

You make a point about families that I think is really very germane. Here's the conundrum: Yesterday we had a presentation from a seniors' group, and I know we're going to have another presentation today. They would, for example, like to see a seniors' advisory council mandated. I know that other groups would like to see advisory councils dedicated to them. My concern is that we not create such an unwieldy process for LHINs that they're mandated to have 15 different advisory groups in place. I'm hoping that what we'll be able to do is have enough of a public engagement process that groups like yours will be part of the process de facto because it's a broad enough group.

I'm wondering about the family piece, though. Do you think that somewhere in the legislation there needs to be mention of families as one of the groups that at least should be heard from? Is that essentially what you're saying?

**Ms. Betty Miller:** Yes. One of the things I'm essentially saying is that families constitute a particular and specific and extremely important piece of this puzzle as providers, as receivers, as the underpinning in lots of ways, as we all know when somebody in our family gets ill. So yes, I think there needs to be a specific process to engage families in the consultation.

**Ms. Wynne:** As part of that broader public engagement process.

**Ms. Betty Miller:** I think you need to pull out this segment of the population, families, and consult with us—not just as broader, but as particular and specific and as regulated in the act. I believe that, and also, to address your other concerns about unwieldiness, yes, I think you could get unwieldy and at the same time I think some subcommittees or advisory committees are likely going to be necessary. If you look at your LHINs consultation across the province and the priorities that came out of that, one would think that those would be perhaps the priorities set for an advisory committee, seniors being one and mental health and addictions being another.

**Ms. Wynne:** I really appreciate your coming. I don't know that we're going to be able to meet all the requirements you're laying out; I'm just not sure we're going to be able to do that, but the fact that we've had seven days of hearings means we've been able to hear you, and I'm not sure we would have heard you if we hadn't done that, so it's very important. Thank you very much.

**The Vice-Chair:** Thank you very much.

CANADIAN UNION OF PUBLIC  
EMPLOYEES, LOCAL 3202

**The Vice-Chair:** Now we have the Canadian Union of Public Employees, Local 3202, Toronto, Robin Miller and Peter Paulekat. You can start any time you want.

**Ms. Robin Miller:** Thank you. My name is Robin Miller. I am the president of CUPE Local 3202. With me is Peter Paulekat, national representative for the Canadian Union of Public Employees. Thank you for the opportunity to have the time to make this presentation to you this morning.

Local 3202 of the Canadian Union of Public Employees represents approximately 50 employees of Senior Link. Senior Link is a non-profit social service agency serving east Toronto for 30 years, assisting thousands of seniors annually to provide homemaking, home support, transportation, medical escorts, shopping, housing and advocacy. We provide a continuum of services to assist seniors to enable them to remain in their homes within their own community, rather than be institutionalized.

I would go through the history of our concerns regarding the timelines and how quickly all of this has come about, but I think everyone is quite familiar with that and I won't take up my time reiterating that to you. I would like to say, however, that we certainly would expect that in a democratic society, legislators have a broader obligation to the public and to public participation in the political process that would simply not allow a bill to proceed with this unnecessary and undemocratic haste.

The LHINs cover vast and very diverse areas. The LHIN boundaries have been formed in such a way as to override municipal and social boundaries. The proposed LHINs are not local, they are not based on communities and they do not represent communities of similar interest. So it will be very difficult for the people living within a LHIN to have a significant voice over the direction of that LHIN, even if the LHIN board wishes to listen.

The actual extent to which communities will be involved and consulted with respect to decisions about local health systems is referenced in Bill 36, but the details of that engagement are left to be addressed by regulation at a later date. Given that the ministry's stated purpose for introducing Bill 36 is to move toward community-based care and to enable communities to determine local priorities, we believe this matter should be dealt with in the legislation and not left to the less scrutinized regulation-making process.

The autonomy of the LHINs from the government is very modest. With this bill, cabinet may create, amalgamate or dissolve a LHIN. A LHIN is defined as an "agent of the crown," and acts on behalf of the government. LHINs are governed by a board of directors appointed by cabinet and paid at a level determined by cabinet. The government determines who will be the chair and vice-chair of those boards. Each member continues on the board at the pleasure of cabinet and may be removed at any time without cause.

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 this even if the LHIN does not agree to the agreement. In addition, the LHINs' integration plans must fit the provincial strategic plan.



Where is the responsibility to the community? LHIN boards will be responsible to the provincial government, rather than local communities. This is in contrast with a long history of health care and social service organizations in Ontario, which as a rule are not appointed by the provincial government.

There are no provisions in the bill that ensure, require or even encourage LHINs, the minister or cabinet to preserve the public, not-for-profit character of our health care system or community-based social service providers such as Senior Link. Indeed, these bodies would now be armed with the legal authority to privatize large parts of our publicly delivered system. Moreover, LHINs will create a split between the purchasers of health care and social services and the providers. The LHINs will purchase services, and hospitals, homes, community agencies and for-profit corporations will provide them.

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Community care access centres, as an example, were originally comprised of community boards. It was not uncommon for these boards to be vocal proponents to the public regarding the need for adequate resources in order to ensure a healthy array and level of services within their community. This led to blunt criticism of the government in regard to underfunding, which resulted in privatization. The government's response to this was to replace the community boards with government-controlled boards.

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 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 six million hours in services—a 30% drop. As one government report calmly noted:

“As prices went up and 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.”

Under CCACs' restructured referral process, coordinators no longer call service providers or organizations with new referrals. Referrals are spat out by computers to alternating agencies based on percentages. Thus there is no continuity of care.

This raises troubling concerns about the role of LHINs. Government-controlled regional agencies are a poor model for health care and social service reform. This, unfortunately, is the model for LHINs, and this is what we are facing.

LHINs are effectively flak catchers. LHINs will insulate government from decisions to cut back or privatize services by creating another level of bureaucracy that will catch much of the flak. The government will control

LHINs, but the LHINs will actually implement decisions. They will be the first targets for popular discontent, even if their actual autonomy from government is more imaginary than real.

The large, socially diverse areas covered by the LHINs also suggests 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.

The LHIN structure puts up significant barriers to local community control of health care and affected community support services. Conflicts between communities within a single LHIN are likely, with small communities particularly threatened. Likely, the provincial government will respond to complaints by stating, “It was not our decision—it was a decision of the LHIN,” yet the LHIN will largely be unaccountable to local communities. These serious problems suggest that another direction must be investigated:

(1) We need to provide for the democratic election of LHIN directors by all residents in the LHIN geographic area, with selection of the chair and vice-chair by the elected directors. Local members of the provincial Parliament should be past directors of the LHINs.

(2) There should be a requirement in the bill for extensive public consultation on the existing geographic boundaries of the LHINs. LHIN boundaries should reflect real communities of health care and community-based not-for-profit social services interest, so that local communities can have a real impact on LHIN decisions.

(3) We also need a requirement for real public consultation when government proposes to amalgamate, dissolve or divide a LHIN.

(4) We need a commitment from the ministry to offer meaningful consultation with the community prior to imposing the agreement on a LHIN.

(5) We need to eliminate cabinet's authority to enact regulations closing LHIN meetings to the public.

(6) We need to ensure the right to seek reconsideration, and for full judicial review, by any affected person, including trade unions, of any LHIN, ministry or cabinet decision or regulation.

Another area of immediate concern for our members is the impact on bargaining units and collective agreements. The change in health care delivery contemplated by Bill 36 reforms opens up possibilities for enormous changes in bargaining units, collective agreements and collective bargaining. The bill would extend the coverage of the Public Sector Labour Relations Transition Act, 1997, to many of the potential changes in employment that could result.

Health care and social service workers have been through many rounds of restructuring already, and we were always assured that the various changes were for the best. But too much restructuring simply consumed enormous energy and resources, exhausting health care and social service workers. Yet we face change on an even broader scale now.

We are not convinced that the government fully recognizes the can of worms it is opening. As the workers faced with this change, we deserve, at a minimum, a fair process that will provide reasonable employment security and protect working conditions, collective agreements and bargaining unit rights.

We are concerned that the Public Sector Labour Relations Transition Act may not be applicable in cases where the entity receiving the work is not a health service provider and where the primary function of that entity is not the provision of services within the health sector. This may allow LHINs or government to transfer work without providing health care workers the right to a union representation vote. We would also like to make crystal clear that employment security protections in our collective agreements cannot be overridden by this bill.

**The Vice-Chair:** Excuse me. Your time is over—if you have something to conclude.

**Ms. Robin Miller:** Bill 36 is an extremely complex piece of proposed legislation in and of itself, a complexity that is magnified many times over by virtue of the number of pieces of existing legislation that it amends. Given that the time allotment in these public hearings limits presenters to a maximum of 15 minutes, I have only focused on several key areas of concern for my members. Other concerns exist.

We believe this bill and the government's attempt to restructure health care and affected community-based social services needs to be rethought. We have made some suggestions that we urge you to seriously consider. I am sure that other presenters prior to me have put forth suggestions, and I trust you will be hearing more from those who follow. We had no sense before the last election that the government would embark on the path it has taken. We urge the government to consult local communities, health care workers, service agencies and the public in advance of making decisions of this magnitude. We believe these avenues would be very beneficial in assessing how health care should be reformed. That would be a much more satisfactory and democratic process.

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

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

#### BAYSHORE HOME HEALTH

**The Vice-Chair:** Now we have Bayshore Home Health. I believe we have with us Janet Daghish, Stuart Cottrelle and Stephanie Buchanan.

**Ms. Stephanie Buchanan:** Hi. My name is Stephanie Buchanan. I'm a clinical practice leader with Bayshore Home Health. I've been a provider in the community for the better part of 12 years, providing direct and indirect care. I'd like to thank the committee for allowing us to speak to Bill 36 today. I'd like to also introduce Janet Daghish, my colleague, and Stuart Cottrelle, our president, with over 20 years of community experience. Right now I'd like to turn it over to Janet.

**Ms. Janet Daghish:** I'm Janet Daghish. I'm director of community partnerships at Bayshore. I have eight years of community experience and 10 years in consulting.

At Bayshore, our goal is to provide quality service to CCACs in Ontario. It's for this reason that we're here today. Since his tenure as Minister of Health and Long-Term Care, the Honourable George Smitherman has created a strong vision for the health care system in Ontario. This has been reflected in the Local Health System Integration Act.

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To give a little bit of background about Bayshore so that you know where we're coming from, Bayshore is 100% Canadian-owned. We provide home care services in all provinces across Canada. We also operate two independent health facilities. We've worked with many regionalized health care systems in various provinces.

It's interesting that just recently the Conference Board of Canada published some research, which you may have been aware of. The most significant finding was that throwing money at a health care system does not necessarily lead to improved outcomes.

We feel that the LHIN model in Ontario is significantly different from other provincial systems and worth the investment of effort and resources. For example, one thing we applaud is that LHINs will not be providing direct health care services to people, but will be overseeing the strategic planning, funding and integration at the local health system level. This is the critical difference we find in Ontario that we want to ensure is supported through this legislation.

We provide home care services to over 12,000 Ontarians on any given day of the year. We become part of the community to meet individual needs of each CCAC client case load. We've built community partnerships in other provinces to ensure that we're really well linked with the local hospitals and other community support services. We want to continue to develop this relationship with the acute care sector here in Ontario. My position as director of community partnerships has been developed to support the promotion of integration initiatives between sectors.

**Ms. Buchanan:** I'd like to begin by saying that we agree with the concept of system integration focused on providing better service, more efficient service delivery and effective transitioning of clients from hospital to community, be it from hospital to long-term-care facilities or from hospital to clients' homes. However, our concerns lie with the process of community engagement, the planning process and the need to update the Long-Term Care Act to better reflect this government's vision for our health system.

Although we are a contracted provider to the CCACs, we are not considered a service provider under the current legislation. We are the nurses and personal support workers providing care to the clients. We are afforded the perspective of knowing the client's individual struggles, such as dealing with busy physicians, lack of physicians, limited system access and complex system navigation. In

light of this, we'd like to be actively engaged in the participation process.

Currently, we are not equal partners at the table. We would like to give feedback to the LHINs regarding clinical issues. For example, for elective surgeries such as hip and knee replacements, early discharge of clients into the community could be facilitated if we were involved at the point of admission, as opposed to being involved at the point of discharge, but this cannot happen if we are not participants at the planning table.

**Ms. Daghish:** I'd like to focus for a moment on the Long-Term Care Act. The Long-Term Care Act was introduced back in 1994 under an NDP government. The focus was to reflect an aggressive agenda to eliminate all community service providers and their boards, regardless of whatever their corporate status was. Section 4 of the Long-Term Care Act allows for the minister to provide direct community services.

At Bayshore, we've had experience in various cases before the Ontario Labour Board, and I've provided some examples in the written submission here, but basically, the cases focused on defining who the employer is, whether it be the CCAC or the service provider. These cases were dropped before precedents could be established. Significant funds have been poured into this issue at the labour board, dollars that could have been spent on community care.

We respectfully request that the Long-Term Care Act be reviewed and the definitions of "employer" and "multi-service agency" be redefined. The Long-Term Care Act must be cleaned up to reflect the 2006 vision of an integrated health care system and not a 1994 vision.

Basically, we have three recommendations that we bring to you today and that we'd like you to consider.

First, please engage community service providers working directly with clients in their homes in the planning process. We care deeply about the health and well-being of Ontarians receiving home care. We want to be part of the process of ensuring quality health care throughout the system as opportunities for integration are realized.

Secondly, we've found a discrepancy between the two acts with respect to definition of "employer" and "multi-service agency." We'd recommend strongly that this committee look at the implications to the labour board. This could have a significant effect on the cost to this government. We leave it with your experts to review. We'd be happy to assist as necessary.

Our third recommendation: Our focus today has been on community, but as an operator of two independent health facilities, we also feel that independent health facilities should be part of the LHIN system in order for this to work from a planning and a funding perspective.

Thank you.

**Ms. Buchanan:** Once again, we applaud the opportunity for health system integration. It is long overdue. We'd like to thank the committee again for the invitation to participate in community consultation.

**The Chair:** Thank you. There are a few minutes for each party for questioning. I'll start with Ms. Martel.

**Ms. Martel:** Thank you for your presentation today. I wanted to focus on the independent health facilities, because it is true that they aren't part of this, and I'm not sure why that is. From your perspective, because you operate two, can you explain that rationale or give us some indication of why they should now be incorporated into the bill?

**Mr. Stuart Cottrelle:** Our two independent health facilities are dialysis centres, and 99% of dialysis in the province of Ontario is delivered through methods other than independent health facilities. It doesn't make any sense. If we're going to have integration, integrate the entire system, not just portions of it. To us, those independent health facilities should be part of that integration process. We offer great client outcomes, lower cost of care. All the LHINs that we've talked to are very interested in the model, but they're saying, "You're going to be outside of the LHIN model." We think it's important to have independent health facilities as part of it.

**The Chair:** Ms. Wynne.

**Ms. Wynne:** Having said that, do you see the possibility for your voice to be heard as part of the engagement process that each LHIN is going to have to undertake?

**Ms. Daghish:** We certainly would like to be at the table—invited to be at the table—as part of the planning process. We have many innovative projects that we've worked on with CCACs. We have tremendous experience in providing care to clients in their homes. We would like to be included so that we can build a better system together.

**Ms. Wynne:** And your voice is heard through the CCACs as well.

**Ms. Daghish:** Correct.

**Ms. Wynne:** Thank you.

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

**Mrs. Witmer:** So you are a private provider, but publicly funded?

**Mr. Cottrelle:** Yes.

**Ms. Daghish:** Correct.

**Mrs. Witmer:** You feel that it would be of benefit to you to be part of the LHIN system, I hear you saying.

**Ms. Daghish:** From a system planning perspective, absolutely. You cannot plan for a health care system with integration unless all of the partners are at the table and are included in the planning process, or else you'll always have some disenfranchised part. It has to work together for this to be successful.

**Mrs. Witmer:** I would agree with you. In fact, we've heard from physicians. Part of the concern they have is that, as you know, they're not part of LHINs either, and they do believe there's a need for some sort of physician advisory committee. If you're going to have an approach where everybody is working on behalf of people in this province, you're going to all need to be at the table at some point in time.

Thank you very much for your presentation.

**Ms. Daghish:** Thank you.

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

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ONTARIO LONG TERM CARE  
ASSOCIATION

**The Chair:** The next presentation is from the Ontario Long Term Care Association: the executive director, Karen Sullivan, please.

**Mr. Brent Binions:** Hi. I'm not Karen Sullivan.

**The Chair:** Could I have the new name?

**Mr. Binions:** Unfortunately, Karen is caught in traffic and probably will be here just as we finish this process. I'm hoping that the presentations she has with her will arrive within five minutes, and we'll pass them around when they get here. My apologies.

**The Chair:** There is no problem. We can always get it later on.

**Mr. Binions:** My name is Brent Binions. I'm a member of the association, the vice-president of finance. My apologies for not having the information in front of you, but I know things have to proceed on time, so away we'll go.

Good morning and thank you for hearing our presentation today.

The Ontario Long Term Care Association represents the private, not-for-profit, charitable and municipal operators of 428 long-term-care homes that provide care and services to some 49,500 residents throughout the province of Ontario. Although we're more well known for representing almost all of the private sector operators, most people do not realize that we now represent about one in four, or 25%, of the not-for-profit sector. In nearly all cases, these operators have decades of experience in working with the community to deliver a provincial program on the government's behalf. As a result, our comments on Bill 36 address the opportunities, concerns and solutions for residents and operators in all types of long-term-care homes in the province.

Let me state at the outset that we support and are encouraged by the potential and the vision of the goals of Bill 36. A more integrated, resident-focused system of health care delivery is something that all of our members hope for. For this vision to be realized, however, it has to work for all health service providers, including the province's 630 long-term-care homes. Right now, we have some concerns that it may not. Instead, it could create some risk of inequities and instability in the delivery of the provincial long-term-care program, and the potential for costly confusion and duplication in various areas related to program delivery. We believe this was not necessarily the intention and that these issues can be fixed, and we are here today to propose solutions. A full and detailed list of our solutions is contained in the written submission that we have for the committee.

Bill 36 is about the delivery of health services. In your hearings in London and Ottawa, you have heard from our members, both private and not-for-profit, that in the long-term-care sector, our services are in fact our beds. We receive a per diem—or per-bed funding—rather than

global funding like most other health service providers under this legislation. Unlike for others, this per diem is a combination of funding from the province and from the residents themselves through a copayment. As a result, our residents and their families have an expectation that the services will be the same regardless of the type of operator or the location of the services.

Control over beds equals control over service, and currently that control rests with the Minister of Health and Long-Term Care, who issues a licence to private, not-for-profit and some charitable homes for the number of beds they can operate. The other charitable and municipal homes operate the number of beds approved by the minister. Operating funding is determined by the number of licensed or approved beds. So too, then, is the amount of service a home can provide. In the case of licensed beds, there is also a direct link between the licence and the financial community's decisions to approve and renew mortgages, and the terms under which they do so.

We believe it is appropriate that the ultimate control over a provincially standardized care program that provides care and services to the most vulnerable members of our province rests with the minister and not with the LHINs. We believe the ministry agrees and that this will continue to be the case under the new long-term care act, which we understand is coming soon.

It is critical that there be consistency between Bill 36 and both the current and emerging long-term-care operating environment. This may not be the case, however, because Bill 36 in its current drafting devolves authority for service to the LHINs. Part IV, section 20, provides no assurances that LHINs will fund all of a home's licensed or approved beds. To maintain service access, equity and stability in communities across Ontario under the LHINs, we urge changes to Bill 36 requiring LHINs to fund homes consistent with their provincially licensed or approved bed capacity, utilizing a standardized funding framework with built-in accountability. Specifically, part IV, subsection 20(1) should be amended by adding "where a health service provider is a long-term-care home, the service accountability agreement shall provide funding for the home's total capacity of licensed or approved beds."

Section 20 goes a step further by adding an additional risk that no funding could be forthcoming at all. It specifically indicates that payments "may" be made rather than the current language in the Nursing Homes Act, which says they "shall" be made for the services that are actually provided. Since we're paid in arrears, that creates a greater risk for us. It is not likely the intention of the government that they abandon their responsibility to fund this vitally important health care program, so we question why the change in language to allow for this risk to occur.

Centralized funding tied to provincially licensed or approved bed capacity provides a base for homes to pursue the opportunities to provide local solutions without compromising core service delivery. We already see examples of this with initiatives such as the recent

provincial program to convert 340 long-term-care beds to convalescent beds to help move patients out of hospitals. It is key that the funding provided for this program was an addition to the base funding for those beds. Other types of specialized programming could be offered by long-term-care homes, based on local identified needs and negotiated by the individual LHIN and the long-term-care home. We would encourage that a fair, transparent and consistent process be utilized to determine the most appropriate provider of these services.

Over the past few days, we have watched with interest the reaction of others to the section on minister's orders. Many groups would have you believe that the solution is to include the private sector under section 28 for fairness and equity purposes. Currently, long-term care is in fact the only health service provider covered by the legislation that includes the private sector. So that reference in section 28 of the bill is to long-term care. Including us in section 28 is somewhat redundant since it's already been established that the minister has, and will continue to have, control over licensed and approved beds under long-term-care legislation. The real solution isn't to add the private sector to section 28, but to exempt all licensed and approved long-term-care bed operators from the section, because that control already rests with the minister and you can't have two agencies controlling the same entity. We believe providing that control as well to the LHIN is redundant and could cause conflicts.

Accountability is a major focus of Bill 36. Here again, we believe improvements are required for alignment with both the current, and shortly anticipated, long-term-care reality.

Specifically, this bill creates the potential for two parallel accountability processes: one from the local service accountability agreements between the LHIN and the operators, and the other provincial from a standardized compliance and inspection program we have every expectation will be continued under the new Long-Term Care Act. If that's allowed to occur, we would have confusion, more bureaucracy and increased costs.

This potential can be eliminated in Bill 36 with provision for a single and consistent service accountability agreement similar in concept to the existing standardized service agreements between the ministry and the homes. We ask that the committee add language to part II, subsection 20(1), and part IV, subsections 47(7), (8) and (21), to ensure this standardized agreement is developed in regulation.

Further, we ask that sector associations be consulted in the development process. We could help ensure that the agreement accommodates our various governance structures, be it private operators, not-for-profit and charitable boards and municipal governments.

Accountability for local specialized services can then be accommodated by adding amending agreements between the LHIN and the individual providers in order to provide whatever services are needed locally.

Just as our multi-governance structures have implications for the application of Bill 36, so too does the fact

that over 60% of long-term-care homes in Ontario are operated by multi-site organizations. In many instances, these organizations span LHIN boundaries.

Internally, they have already achieved many of the elements of the ministry's vision of back office integration. This would include everything from group purchasing, which is standard across our sector, and shared management and professional resources to information technology platforms and payroll systems.

In many organizations, this integration also incorporates functions beyond long-term care and beyond the scope of Bill 36. For private, not-for-profit and charitable operators this could include retirement homes, assisted living, life lease, home care services, supportive housing services. For municipal operators, it includes municipal fire and police departments and services, among others.

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As currently written, the broad definition of "service" in part V, section 23, will directly impact on these internal integrated processes and functions. If LHINs begin to exercise the full authority that now exists in this definition, they could create significant business and operational issues for all multi-site providers, issues that will have the opposite of the intended effect and could actually increase inefficiency and costs.

We therefore urge that this risk be removed by changing the language of part V, section 23(c), to exempt the functions that support the operations of licensed or approved long-term care beds from the definition of "service."

I would like to wrap up my remarks this morning by commenting on transparency. It is fair to say that Bill 36 has the potential to create significant change, provincially and locally. It's obvious from the presentations to this committee that the expectation of that change is creating a significant amount of angst. While the long-term care association supports the overall direction of this bill, we believe that individually and collectively our members share some measure of this concern. As Bill 36 is implemented and LHINs begin to function, the potential for this concern to grow or dissipate will be significantly determined by the degree of transparency in the LHIN decision-making and operating processes.

Bill 36 speaks to this now, but it does so in ways that leave many unanswered questions. We accept that some of those answers will occur with actual experience; however, we believe that there is room for improvement and clarification within the legislation.

For example, community engagement is currently very loosely defined in terms of who and how. Further definition would add transparency to ensure that providers, who already have limited administrative resources, have an equal opportunity to participate in service integration, and that the process is accountable.

Similarly, we think a lot of the current concern relates to a lack of assurance of transparency in the decision-making process. The assurance of transparency can be further supported by language in part II, section 9(3), to ensure that the conditions under which a LHIN board can

hold in-camera hearings are defined in regulation. It's critical that key decisions, particularly those related to service integration, not be made behind closed doors. This would include the opportunity for parties impacted by an integration decision to have the opportunity to present their case for reconsideration in a public board meeting.

In closing, we would like to say that we understand that Bill 36 is a bold initiative and that it will bring change. In those changes, we see a potential to move closer toward our capabilities to make a larger contribution to a more effective and efficient health care system. It's clear, however, that we need some changes to recognize the realities that the public expects, and that the ministry continue to signal through other initiatives that basic long-term care in Ontario is a universal program in order that its full potential be realized.

We thank you for listening to us today. I will answer any questions.

**The Chair:** There is about a minute left. Ms. Wynne, 30 seconds, please.

**Ms. Wynne:** Section 20—I just wanted to check. Country Terrace in London and Specialty Care Granite Ridge in Ottawa I believe came forward with the same recommendation.

**Mr. Binions:** That's correct.

**Ms. Wynne:** Okay. Also, on section 47, are you suggesting—I apologize; I didn't have the written piece.

**Mr. Binions:** I apologize.

**Ms. Wynne:** Service accountability agreement: Are you suggesting that is where the amendment should be? You're looking for a consistent accountability agreement?

**Mr. Binions:** We're looking for a requirement that the agreement be standardized for the base services. Beyond that, they can be changed by the LHINs to add any other services.

**Ms. Wynne:** Just quickly, the problem if they're not?

**Mr. Binions:** The risk, if they're not standardized, is that we could get into about 14 different service agreements across the province, with different rules for the provision of exactly the same service that the resident is paying exactly the same amount for.

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

**Mrs. Witmer:** Thank you very much for your excellent presentation. What would be your overriding concern? What is the one amendment that absolutely must happen for you to be able to continue to provide the services in an integrated fashion?

**Mr. Binions:** I guess our overriding concern is around the issue of licensing and funding. We believe that the ministry has structured a program that's consistent across the province. It is licensed, and therefore controlled, by the Ministry of Health. If you were to devolve the funding separate from the licence, it would mess up the system tremendously. That would be our biggest concern.

**The Chair:** Ms. Martel.

**Ms. Martel:** Just to be clear, the money remains with the minister. It's not devolved to the LHINs to then pass on to you.

**Mr. Binions:** What we're asking for is that the funding for the core services of long-term care be mandated. If we have a standardized program, we ask that that portion of it be mandated to be delivered as it is now through the LHINs, but anything beyond what the LHINs want in a local service be a separate pot, and they can add in. They would contract directly with the homes on that.

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

## TOWNSHIP OF SCUGOG

**The Chair:** The next presentation is from the township of Scugog: Her Worship Marilyn Pearce, Dr. Bill Cohoon and Bette Hodgins. I apologize if I didn't pronounce it properly.

**Ms. Marilyn Pearce:** Chair and members of the social policy review committee, on behalf of my community, the township of Scugog and the residents of North Durham, my colleague Dr. Bill Cohoon and I thank you for the opportunity to speak to you about Bill 36. I would like to address the whole issue around local community input to the LHIN's decision-making process and to the provincial strategic plan on which your decisions will be based, as I believe good two-way communication is important during a time of such systemic change. Dr. Cohoon, who is with me, will be available, should you have any questions about the delivery of rural health care.

The township of Scugog is definitely a rural community in the northeast part of the GTA, entirely within the greenbelt planning area and north of the Oak Ridges moraine. We are an agriculture-based economy. Port Perry is the major urban area, and in Port Perry, there is a 20-bed hospital that is part of the Lakeridge Health Corp. Since the formation of that corporation in 1997, there have been numerous changes to the services in Port Perry—some good and some not so good.

It is important to note, though, that this hospital services a very large rural area to the north, including parts of Brock township and the city of Kawartha Lakes, as well as a First Nations community, the Mississaugas of Scugog Island. As such, it also services a significant tourism population, as the Great Blue Heron Charity Casino attracts over a million visitors a year.

It is also home to a rural residency teaching program in co-operation with the University of Toronto. This program has been in effect for about five years and trains doctors in all aspects of rural care. In fact, it has just adopted a first-of-its-kind rural health services program for Lakeridge Health.

Why, then, are my residents concerned about this bill and the creation of local health integration networks? I would suggest history has a lot to do with our concerns. Since 1998 and the last hospital restructuring, the loss of local control has become a way of life. Trying to understand the process by which residents can have input into hospital care changes has become frustrating and at times emotional. LHINs must allow for better stakeholder communication and local consultation before decisions

are made. The bill needs to address these issues, and I don't believe it does.

Changes in health care delivery and the devolution of decisions from the minister's office to the LHINs is something that needs clear rules around transparency of action and appeal mechanisms so that the residents of the local area can at least have an opportunity to ensure that all aspects of the decision have been weighed.

Our local area, as defined by the central east LHIN, has a huge geographical area to service. I believe it is the second-largest LHIN, with an area larger than the province of Nova Scotia and a rather complex mix of urban hospitals, rural areas and even isolated communities, stretching from Scarborough to Algonquin Park. Nova Scotia, by the way, has five networks for that area. It does give new meaning to the word "local." Having said that, it also has the complexity of numerous hospital corporations, health care providers and boards, all with different strategies about service delivery.

The provincial strategic plan, which includes a vision, priorities and strategic directions, is part of Bill 36, and that is welcomed. What isn't clear is how the public, the consumer, will be involved in setting the priorities for that strategic plan.

**1120**

Good stakeholder communications require that the consultation take place before the decisions are made and that communities have an opportunity to digest and discuss issues in advance of decisions. The creation of LHINs boards should be an opportunity for the public—the actual consumer—to have effective communication with the board responsible for funding decisions. It should also allow for decisions affecting a community's hospital and health care to be open to appeal. Who becomes the community advocate, as the LHINs board is not elected but rather appointed?

The rules around meetings should be clearly defined. Simply posting integration decisions on a website after the decision has been made is not acceptable, especially since the only appeal is by the health-care-provider party to the decision. Shutting out the general public will have huge consequences, from hospital fundraising and community commitment to health care agencies. Health care costs could actually rise as public resentment is expressed in the withholding of donations and volunteerism. If we really want this new model to work, clearly define who the public is and that they have a right to appeal if the funding envelopes that the LHINs designate are inequitable or unmanageable. What sort of accountability will these boards have to provide that all communities needs are being met, not just the large, powerful urban areas?

There are some who may argue that the LHINs will create another level of government bureaucracy, and they may, but I would hope that by dissolving district health councils and regional offices, the government in fact is streamlining and clarifying roles and responsibilities and allowing for the devolution of authority. But for that to happen, changes to the bill are required. The list of major

providers of primary health care does not include family doctors, dentists, laboratories and public health. How can we achieve an integrated health care system without them?

Back to my community, though, and the 30 years of integrated health care we bring to the table. Our family doctors, in co-operation with Lakeridge Health, have developed a vision for primary rural care that could be a provincial model, but under this bill, those ideas may be lost. True integration of care across traditional barriers needs the family physician to be part of the equation. Rural health care that is family-practice-focused and led and that includes the support services in the general specialities such as general surgery, internal medicine, and outpatient consultation and surgery is a template for other rural communities in this province. But how can that be accomplished without family practitioners at the table? In my opinion, the present model of health care integration is in fact hospital-based. Amend the bill to include a broader range of health care providers. Leaving family doctors out is a mistake. Setting up effective community advisory groups that include community representatives as well as family physicians and nurses would resolve some of the resentment and mistrust that surrounds the creation of these new boards.

Finally, the funding of the new LHINs is a real issue for my community, as we are part of a LHIN with a huge deficit. How will the government fund the new boards—from a new-beginning position or from a transfer of old funding problems to a new entity that is still underfunded? The last hospital restructuring did not really address a flawed funding formula, and we must do better. Bringing forward all the former debt will create huge battles between communities, just as amalgamation of former municipalities has. Form must follow function, not lead it.

In summary, I believe that Bill 36 should be amended as follows:

(1) The provincial strategic plan should include a primary rural care vision, and family doctors should be part of that exercise. Public input to the provincial strategic plan needs to include the general public and true dialogue prior to the minister adopting the plan.

(2) Any decision that affects in a significant way the health care of the people in a community must be subject to appeal by the general public. Determination of what is considered significant is needed. Is it the loss of beds, the loss of a service that is critical to community health care stability or is it the distance that the sick and elderly must travel for care? Will travel times be considered along with wait times? In the central east LHIN, distances and weather conditions can be great problems.

(3) LHINs must be open to the public, and clear rules around when a meeting can be considered in camera need public debate. Transparency and accountability to all residents and users of our health care system are required. Minutes of those meetings should be posted on the website. We would also request that timelines on the posting of an issue to be discussed at LHINs meetings be

available at least two weeks prior to the meeting and that LHINs board meetings be moved around the various local communities, as driving distances in the central east LHIN are significant. This will truly bring decisions closer to the local communities they represent.

(4) The governance role of the present hospital corporations and their relationship to LHINs needs to be better defined. My community has already voiced to the minister our concerns on how these corporations carry out business. I believe we are not the only community across this province expressing non-confidence in the present model and its lack of consultation and transparency to the public.

I hope that as a committee, you will listen to the public. In many of the presentations I have heard, the same thing is being stated. There is a real fear in the communities that local control is being further eroded. As a community that prides itself on financially supporting our hospital, our community health care providers and our physician recruitment and doctors, any further erosion of having consumer input in the services being delivered and the decisions being made could have significant consequences. Thank you.

**The Vice-Chair:** Thank you, Your Worship. We have about five minutes. We'll divide it equally between the three parties. We'll start with Mrs. Witmer.

**Mrs. Witmer:** Thank you very much. I'm quite impressed with your presentation. I guess your comprehension of what's contained within the bill is certainly reflective of some of the other voices of concern and interest that we've heard.

You mention here that there is a fear that you're reading from the public in presentations that local control is going to be eroded. I would agree with you. I think there is genuine concern, because when you have LHINs that are the size of the central LHIN, for example—one and a half million people—I don't think you're going to know many members of that board; even in the smaller LHINs, you're not going to.

What do you think is most critical in order for these LHINs to clearly understand the will and desire of communities and be able to reflect that in their planning?

**Ms. Pearce:** I think it is a real need for advisory committees at lower levels of consumers and doctors, as I've stated. Rural communities are very close to their doctors. They are the front line, they're part of the community. There's a tremendous trust in the medical profession, the family practitioner. You talk about me being well versed; it's because the doctors certainly keep me well versed in all the issues around health care. I think, especially in the large LHINs, there has to be a role for rural advisory committees, and you have to get back to the people, to the consumer, before you make decisions.

**Mrs. Witmer:** So you're suggesting a number of different advisory committees that would report to the LHIN organization, the board?

**Ms. Pearce:** I think they have to take advice not only from the health care providers but also the consumers, and you can do that through advisory committees.

**Mrs. Witmer:** Okay. Thank you very much.

**Mrs. Maria Van Bommel (Lambton-Kent-Middlesex):** Thank you for your thoughtful presentation. As a member who represents a fairly large rural riding—it's actually 92% the size of PEI—I certainly understand the concerns about delivering health care to rural communities. I want to just go a little bit further. You talk about a rural advisory committee to the LHIN. Wouldn't it be better—you also mentioned in your presentation things such as elected versus appointed. I know that in one of the LHINs within my riding, five of the six appointees to the LHIN are rural. If we were to go to an election, I'd be more afraid that the urban part of that LHIN would probably weigh heavily in what the structure or what the appearance of that LHIN would be. I think being able to appoint rural people to the LHINs is more important sometimes than getting an election. Do you think that having appointees to the LHIN itself who have a good strong rural background is better than even having a rural advisory?

1130

**Ms. Pearce:** No, I still think there's a role for a rural advisory. But I don't think our community would have any difficulty in the appointing of the LHIN members. In other words, we have not been totally comfortable in a multi-site urban-rural with how hospital corporations elect members, because that situation you explained is exactly what happens. I don't think there's any doubt that we hope that those in the position look at that rural mix that's required and do the appointment.

What I'm suggesting, though, is that the LHIN board itself cannot get their only advice from the more well-organized health care providers who might be in the more urban areas. They also have to hear from those rural communities. You take any hospital corporation that's in a rural area and you look at a whole system whereby that community makes their concerns known directly to the health care provider about the level of service they want.

I find, especially in rural communities, if you were to look at a per capita funding of us giving to the local hospital, I'm sure it's much higher than it is anywhere else. In fact, we're looking at a major campaign at our hospital right now, and the municipal governments will probably be on the hook for a third of that campaign. But if we have no say, if we have no way of making our concerns known, I'll tell you, that will dry up very quickly.

How do you get that advice? How do you hear from the community? I'm not talking about the people who are necessarily even consumers of the system yet. They're just the people who may be consumers of the system in the future. How are you going to hear from them if you only hear from the providers?

**The Vice-Chair:** Ms. Martel.

**Ms. Martel:** Thank you for driving here today. I was in the Port Perry hospital early in December with one of your councillors and I appreciated that visit. I was struck by two things: first, the level of effort that had been made with many partners to provide a broad range of services



in the hospital, clinical services and services that traditionally might be outpatient but would be hard to access somewhere else because of distances. I was very impressed with the myriad of partnerships that had already been established for a broad range of services. Second was the commitment of the community to the hospital. You've got a long list of community involvement in terms of various campaigns, fundraising and how much money had been raised, both from individual citizens and then the portion that was put in by the municipality. So I had a very clear sense of people's attachment to the hospital.

This leads me to this particular question. This LHIN is very large. There are major centres. I come from a LHIN that runs from the James Bay coast right down past Parry Sound: 34 hospitals. When we hear terms like "integration," "transfer," "amalgamation," we see that as smaller hospitals losing their services to a larger regional centre. There are 34 hospitals in our LHIN, and the fear is that those services will go to North Bay, Timmins, Sault Ste. Marie, and some of the other services just directly to Sudbury, which is already the regional centre.

Given the commitment that your folks already have and given the changes you've already seen with restructuring, which have been very significant, should you be worried and are you worried about the potential in this bill to see even more services move to larger regional centres at the expense of smaller community hospitals like your own?

**Ms. Pearce:** Yes, we are. One of the concerns—and Dr. Cohoon might want to speak to it—is that people really underestimate the requirements around a rural residency program that operates in co-operation with our hospital and our medical associates but offers a full range of services. If you're going to train doctors in rural health care, they have to know, if they're in a rural setting, not only how to deliver a baby but how to do a bit of general surgery. They have to know a whole realm of things. We can train people like that in our hospital. Sometimes, when you're just looking at the numbers, you don't realize—it's, "Well, we might as well cut obstetrics, because they only do 350 births a year. They should take it to a bigger site." What happens, though, is if you cut that, you cut the rural residency program. When you cut the rural residency program, you cut the training of rural doctors—fairly close to Toronto but far enough away that they still feel like they're in a rural area. If you cut that training of rural doctors, you get down to a whole system where doctors who want to move into rural areas, wherever they are, then don't have a full range of training.

Each one of those little cuts—they look little—is a domino effect that impacts the whole hospital. They impact whether we have a surgeon now, because if you take away the little bit of obstetrics, you take away some of the general surgery and things that accompany that. So if you do that, it has a domino effect. Sometimes you can't make that position very clear to big hospital corporations that simply say, "Sometimes in our mind bigger

is better, and this is how you fix it," when in fact you can offer those services closer to home in a rural integrated model that works.

**The Vice-Chair:** Thank you very much, Your Worship.

#### ALLIANCE OF SENIORS

**The Vice-Chair:** Now we have the Alliance of Seniors: Derrell Dular, coordinator, and Jack Pinkus, past president. You can start whenever you are ready.

**Mr. Jack Pinkus:** Good morning. First of all, I'd like to thank the committee for giving us the opportunity to express our views on Bill 36. My name is Jack Pinkus. I'm a member of the executive committee and past chair of the Alliance of Seniors. Along with me is Mr. Derrell Dular, our executive director.

I first would like to go on record saying that this brief submission reflects only our personal thoughts and those of the Alliance of Seniors and their affiliate organizations.

Now some background about the Alliance of Seniors: Founded in 1993, the Alliance of Seniors is an active, diverse and growing non-partisan coalition of individuals and organizations representing over 300,000 older adults residing mainly in the greater Toronto area.

Our mission is to preserve and enhance Canada's social programs on behalf of present and future generations, so it's not only for seniors; to promote a society where all persons have an equal opportunity to realize their potential, to participate in a democratic society, and to live with dignity; and to educate the general public in the greater Toronto area about the concerns of older adults.

The Alliance of Seniors participating organizations include the Association of Jewish Seniors, Bernard Betel Centre for Creative Living, Canadian Institute of Islamic Studies and Muslim Immigrants Aid, Canadian Pensioners Concerned, Care Watch, Caribbean Canadian Seniors, Concerned Friends of Ontario Citizens in Care Facilities, Congress of Union Retirees of Canada, Elder Connections, Habayit Shelanu Seniors, Jamaican Canadian Association, Korean Inter-agency Network, Older Women's Network, Ontario Coalition of Senior Citizens' Organizations, Ontario Federation of Union Retirees, Ontario Health Coalition, Riverdale Seniors' Council, Toronto Health Coalition, Toronto Seniors' Assembly, and Yee Hong Centre for Geriatric Care. So, indeed, it is quite diverse.

The Alliance of Seniors, its affiliates and friends endorse the principles of the Canada Health Act: comprehensiveness, universality, accessibility, portability, and public administration. We are concerned that under the proposed Bill 36, as stated in the preamble, the government of Ontario and its Ministry of Health and Long-Term Care are held only to govern and manage the health system in a way that reflects an undefined public interest, efficiency and high quality.

Now I'll turn it over to Derrell.

**Mr. Derrell Dular:** Our presentation, with your indulgence, is of a general nature because for the past year many of our affiliate organizations have expressed a great deal of concern and studied quite thoroughly the provisions of the proposed Bill 36.

We have many concerns. We're concerned with the obvious disconnect between the otherwise admirable preamble and what appear to be the onerous provisions of Bill 36. We fear that something has been lost in the translation. There appears to be a substantial difference between the letter and the original intent.

**1140**

In the name of efficiency, the provisions extend the questionable competitive bidding process and exhibit, we believe, an ideological bias against not-for-profit, community-based and user-sensitive service providers in favour of for-profit market privatization and the corporate-industrial model of service delivery.

There appears to be little public accountability and even less provision for democratic input, as some of our previous presenters have mentioned, for community control or for a fair appeal process of decisions made by either the local health integration networks or the minister himself, regardless of the impact on communities, families or individuals.

There is no protection against the arbitrary reduction or complete withdrawal of various health services provided currently under the Ontario health insurance plan.

Bill 36 seems to centralize, rather than regionalize, control over the health system, with all control going back to the minister. There is no provision for adequate public scrutiny and input into the formulation of the crucial strategic plan which will determine the very nature of health care in Ontario.

Bill 36 represents the second major restructuring of health care in Ontario in a decade. Like the previous Conservative government's hospital service restructuring, there appear few checks and balances to ensure real efficiencies and improvements in health care delivery. However, with the establishment of a cumbersome new bureaucracy, there will be an obvious increase in administrative and legal costs that will divert significant money from the actual provision of quality health care services.

Finally, we are very concerned about the possible unintended legacy of Bill 36 and its implicit increased centralization of power and authority in the present government. Would a successor government use it well and in the greater public interest?

In the best interests of all who would be served, we, the Alliance of Seniors, request that the government of Ontario withdraw Bill 36 pending substantial revision. Thank you.

**The Vice-Chair:** Thank you for your presentation. We have about four minutes left. We'll divide it equally among the three parties. We'll start with Ms. Wynne.

**Ms. Wynne:** Thank you very much for being here today. A couple of things. I want to ask you first about the unintended legacy of Bill 36 and the increased

concentration of power that you speak about. In fact, what we're trying to do is exactly the opposite of that.

I just want to read a quote from the minister in the Daily Press in Timmins today. "The (local) mayor ... will be able to pick up a phone and speak directly to the LHIN director," he said. "Where before they would have to hope that their local MPP would be able to get them a meeting with the health minister."

I guess the point we're trying to make, and I'd like you to comment on it, is that right now we've got a centralized bureaucracy in Toronto. We're getting rid of district health councils, and that planning function is going to the local health integration network. We're dismantling the regional offices, and those functions will be absorbed into the local health integration network. And then \$21 billion which is now basically allocated from the centre, from the ministry, is going to be in the hands of the local health integration networks and in the hands of that person that the mayor can pick up the phone and speak to. I just don't get how that's centralization. To me, that's decentralization and that's engaging the public. That actually, to me, is the check and the balance on a subsequent government trying to change that structure, because the public will be more engaged. Could you comment on that?

**Mr. Dular:** It appears from our reading of the provisions of the bill that there is not an adequate appeal process. Local representatives, politicians, may be able to pick up the phone and address a particular individual about their concerns, but there's no provision that that individual, upon hearing those concerns, will actually act on the concerns raised.

**Ms. Wynne:** But how is that a different or worse situation than we have now? We're trying to improve that engagement.

**Mr. Dular:** I don't think it's necessarily different or worse than what we have now, but I don't think it's substantially better.

**Ms. Wynne:** Except that you have that connection that's not there now—that would be the improvement, from our perspective.

**Mr. Dular:** I guess it's the element of, "It's okay. Trust me."

**Ms. Wynne:** We're trying to make structural changes that would actually put the change in place. The other thing is that there's nothing in the bill that extends competitive bidding, so I just wanted to make that point. There's nothing in the bill that does that.

**Ms. Martel:** Thank you for being here. Of course, there's nothing in the bill that prohibits competitive bidding either; there's no particular amendment that says that the LHINs will not use competitive bidding to acquire the services in their LHIN area. I've challenged the government: If they mean what they say, then they will bring in an amendment and say very clearly that competitive bidding is not going to be used.

Here's my concern. Let's be clear: The LHINs are not accountable to the communities they're purported to serve. That has been the big joke about the legislation.

The minister would like to say that this is about community control over all of this money. If you look at the legislation, it's very clear that the minister controls the LHINs, not the community. The minister creates, amalgamates or dissolves the LHINs. The LHINs are appointed by the minister. The chair and the vice-chair are appointed by the minister; they serve at the minister's whim for as long as the minister decides that's going to be. The LHIN is explicitly defined as an agent of the crown right in the legislation. Each of the LHINs enters into an accountability agreement with the ministry about what they do; there's no similar accountability agreement with the community that they're purported to serve. The LHINs are funded by the ministry on the terms and conditions that the minister considers appropriate. The LHINs have to develop an integrated service plan, but that plan has to be consistent with the provincial strategic plan, and we don't even know who's involved in the development of the provincial strategic plan at this time; we certainly haven't seen it, and we haven't found any groups that are actively engaged in its development right now either. So to say that this is all about money going to the community and the community making decisions is just ridiculous.

In terms of the concerns you've relayed—and I noticed that you're not a group of folks whose jobs are going to be impacted, so you're not some of these union yahoos who the minister would like to portray as only coming here and providing us with misinformation because their jobs are going to be affected. You've done a pretty clear analysis that says, "Jeez, we're concerned about competitive bidding; we're concerned about the disconnect between the preamble and the onerous provisions of the bill." You even suggest that it should be withdrawn. Is there anything else you want to comment on in terms of your concerns with this bill from a group which isn't actually impacted, because your jobs aren't even on the line here?

**Mr. Dular:** Thank you for so articulately expressing so many of our concerns and reasons why we arrived at our particular conclusions. In Mr. Pinkus's initial comments, he used the phrase "for present and future generations." That is certainly the emphasis that the Alliance of Seniors and its affiliated organizations use. We're very concerned about where this is going and who it might negatively impact on.

**Mrs. Witmer:** Thank you very much. I would certainly agree with my colleague Ms. Martel, who has very eloquently pointed out the huge powers of the minister under the LHINs. Despite the fact that the government likes to keep telling people that we're now going to have 14 LHIN CEOs who are going to have board chairs, the reality is that these people aren't going to be any more accessible, and at the end of the day, even if some of them might be accessible and would be prepared to listen to somebody, the minister still has absolute control to do whatever he or she would wish. This tries to deflect some of the criticism away from the minister. Everybody is going to be blaming the LHIN's CEO and the LHIN's

board. There's a buffer there now between the public and the minister, and they can say, "Well, that was the LHIN," whereas in reality, we know that it would have been the minister and it would have been the government that made the decision.

I'm surprised that you haven't bought into Bill 36 and you are so strong in your request that the bill would be withdrawn. You actually are that concerned, and you feel that it needs substantial revision. You're happy with the preamble, but you don't support the rest of it.

**1150**

**Mr. Dular:** Thank you very much for your comments. As I said earlier, we very strongly feel that something has been lost in translation. The ideals are laudable, but the substance of the bill raises our hackles. We've been talking about this, ever since it first came to light, among our various affiliated organizations and their representatives and seniors' groups. We're very worried. Please reconsider.

**The Vice-Chair:** Thank you very much.

**Mr. Pinkus:** If I may just interject, as you may realize, we represent over 300,000 seniors in this province, which is a considerable number. We feel that this bill will impact negatively on the senior population. That has been expressed to us by our various seniors' organizations. Hopefully, we can allay their fears by having this revised or looked into again.

**The Vice-Chair:** Thank you very much.

#### CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 786

**The Vice-Chair:** We have with us right now the Canadian Union of Public Employees, Local 786, St. Joseph's hospital, Hamilton. We have the president with us, Mike Tracey. Welcome, Mike.

**Mr. Michael Tracey:** Thank you very much for the opportunity to speak here today. I am employed as an electrician at St. Joseph's Healthcare in Hamilton, and I've been there since April 1984. In these more recent years, I have been working as full-time president, as you mentioned, of Local 786, CUPE.

If passed, Bill 36 will give the government new and worrisome powers to enable the restructuring of Ontario's public health care system and its social services. Bill 36 declares in its preamble, paragraphs (a) and (b), to "acknowledge that a community's health needs and priorities are best developed by the community, health care providers and the people they serve" and, by establishing LHINs, "enable local communities to make decisions about their local health systems."

This bill does not reflect these sentiments, which is what they really are; rather, it transfers control over local community-based health services providers to the minister, cabinet and, subsequently, the LHINs, thereby centralizing, not localizing, control.

The LHIN boundaries are vast and override all municipal, provincial and social boundaries. The LHIN forward boundary for our area stretches across southern

Ontario, from Lowville in Burlington to Turkey Point in Norfolk to Crystal Beach in Fort Erie to Niagara-on-the-Lake. This large area contains over 150 municipalities and communities. But we don't have to worry; the LHIN will engage them all.

The LHINs are required to engage the community in decisions regarding their local health systems. How can communities respond to the LHINs if the definition of "engagement" is left to regulation? Even public access to LHIN meetings is left to regulation. This is going to compound the newer problems of travel times and distances. These vast boundaries actually act as a deterrent to public input.

LHINs are defined as agents of the crown and act on behalf of government and therefore are responsible to and accountable to the provincial government, not the local community.

The bill identifies the powers that the LHINs have and also the powers that the LHINs do not have. It also makes it obviously clear that decisions on integration, specialization, privatization and contracting out, which all refer to restructuring, will be made by the minister and cabinet, and that the LHINs are in place solely to act as a buffer between the public and government. The fact that, at this stage, anyway, it is evident that LHINs are unaccountable to local communities suggests that the following initiatives should be considered: Eliminate the cabinet authority to have in camera LHIN meetings; a provision for full consultation with the community prior to imposing an accountability agreement on a LHIN; and a provision for extensive public consultation on LHIN boundaries and when the status of a LHIN is altered.

The minister will allocate funding to the LHINs "on the terms and conditions that the minister considers appropriate."

The LHINs will develop an integrated health services plan, or IHSP, that is consistent with the provincial strategic plan. The LHINs will then enter into an accountability agreement with the minister. If there is no agreement on the accountability agreement, then the minister can set it unilaterally. The LHINs will then enter into service accountability agreements with all health service providers that receive funding from the LHIN. The LHIN funding formula will expose the health system to purchaser-provider competition or competitive bidding models that were used with the community care access centres' restructuring. That was an experience that had a profound negative impact on health care workers.

The minister has the power to order integrations directly. Specifically, the minister may order not-for-profit health service providers to cease operating, amalgamate or transfer all of their operations; that's in section 28. But for-profit health service providers are exempted from these threats, and we'd like to know why. Obviously, if one wishes for privatization, one must not upset the privateers.

The minister and cabinet have the power to order any public hospital to cease performing any non-clinical service, which is still yet to be defined, and to transfer it

to another organization, meaning government can dictate how any and all non-clinical services are to be provided by hospitals via contracting out or integrated restructuring. The IHSP will open the door to privatization. The transfer of unionized staff from one facility or organization to another will have a devastating impact on the staff and the system as new voting will have to be held to establish which union will represent whom, in what organization.

If St. Joseph's Healthcare Hamilton is ordered to cease and transfer its non-clinical services to another organization, and if my interpretation of this bill is correct, then the health care workers there are facing a very bleak future. At St. Joseph's Healthcare, all of the cafeteria work at all three sites—the Charlton site, the Mountain site and the ambulatory health services site—has been contracted out already to a private organization, Morrison Food Services. Since then, the level of service has diminished significantly. Although we still have our unionized kitchen staff, a chain-link fence literally runs down the centre of the dietary facility and separates them and the Morrison staff.

St. Joseph's Healthcare Hamilton recently completed the construction of a 10-storey tower at the Charlton Avenue site. The unionized cleaning staff at the site were informed that they would not be doing the cleaning work in the tower, as it is now contracted out. The same issues of dietary and cleaning apply to the CAHS site. The cleaning and dietary staffs were transferred and contract workers came in and took over the work. The same will soon apply to the Mountain site, as the employer has signed a P3, public-private partnership, agreement—or should I say it's an alternative financing procurement initiative? It has also been indicated to the unionized staff that the materials management department is to be contracted out.

As representatives of these affected workers, the appropriate avenue of third party process has been initiated. According to the implications of Bill 36, the minister or the LHIN will very soon be able to order the existing dietary and cleaning services to this private contractor who is already on site. If true, the effect is that the third party process will probably be rendered mute and therefore abandoned. All this is if the minister declares this private contractor a health service provider. If the minister does this, does that mean that a restaurant owner can perform cafeteria or kitchen work in a hospital? Does that mean that Molly Maid cleaners can bid to clean and sterilize patient rooms in hospitals? Cutting back on support services is dangerous, as is evidenced by the numerous deaths of patients in Quebec and across Canada caused by hospital-acquired infections.

#### 1200

The minister called for the centralization of hospital surgeries, suggesting that not all hospitals need to do knee surgeries. The government has also begun to move surgeries out of hospitals and into clinics, an example being the Kensington eye clinic. The creation of new surgical clinics only further fragments the health care

system and promotes more privatization. Most definitely, a better solution would be to create surgical clinics in hospitals, where the infrastructure to support clinics already exists. More importantly, hospitals have the resources to deal with emergencies that might occur during procedures. Medical and surgical procedures must remain in the public domain.

St. Joseph's Healthcare in Hamilton and its entire staff have successfully weathered the health reform storms over the years, from the complete closure of St. Joe's to the drastic budget cuts in more recent years. Labour relations over these years have been at a level of cooperation that has been envied by other organizations. We were a well-oiled machine, but new initiatives dealing with collaborations, amalgamations, accreditations, the Health Services Restructuring Commission and budget cuts have left us as a lean, mean machine, but we are at least cost-effective. Now we will have to enter the arena of competitive bidding and integration that will end in the dismantling of a proven, well-established organization. I'm quite sure now that the situation of contracting out support services at St. Joseph's Healthcare is an indication of impending budget cuts being prepared for, without consultation, in order to maintain a balanced budget.

Unfortunately, the LHIN reform does not deal directly with the real culprits of rising health care costs, which are the trans-national corporations and their atrocious pricing of drugs and medical equipment, which leaves health care workers and the patients they care for to bear the burden of those costs.

Because the IHSP integration will remove jobs and services from the public domain and local communities, the following initiatives should be considered: Provide in the bill that nothing in the legislation authorizes cabinet, the minister or the LHINs to override the terms and conditions of employment contained in freely negotiated or freely arbitrated collective agreements; and remove from the bill the power of the LHINs, the minister and the cabinet to transform the health care system unilaterally.

Bill 36 will give the LHINs, minister and cabinet the legal authority to privatize large parts of our publicly delivered health care system. The LHINs will purchase services and hospitals, homes, community agencies and for-profit corporations will attempt to provide them. This is where a competitive bidding model becomes a very real threat to the providers of health care in the community. The LHINs would have the power to allocate funding or services to hospitals that underbid for knee and hip replacements, cataract surgeries etc. and, depending on the location of the successful bidder, patients would be required to travel even further to access health care services. The reality of an unsuccessful bid would be the layoff of health care workers in order to achieve and maintain a balanced budget according to the funding that's allocated. I would therefore suggest adoption of the following: that competitive-bidding models should be specifically excluded in this legislation, considering the negative impact it has already had on social services and CCACs.

The change in health care delivery contemplated by these reforms opens up possibilities for enormous changes in bargaining units, collective agreements and collective bargaining. The bill would extend the coverage of the Public Sector Labour Relations Transition Act to many of the potential changes in employment that could result.

**The Chair:** Can you conclude, sir, please?

**Mr. Tracey:** Okay. Most of my suggested initiatives and recommendations, which you have in detail in your written submission, are the same, if not similar, in wording to CUPE. Believe me when I say that I had thought of them before they did, but I used their more concise wording.

The minister states that the LHINs would be required to engage the community on an ongoing basis to develop an IHSP that would include a vision. The minister also states that it must be consistent with the provincial strategic plan. When a vision appears to a person—and history tells us that many individuals, ranging from the geniuses of this world to the lunatics, have been inspired by such vision—that person wishing to realize that vision must share that vision with those entities who can enable such a vision. The entities are identified in the preamble of the bill: “The people of Ontario and their government.” When will the people of Ontario get to see this vision? After it's totally completed? Thank you very much.

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

We will break for lunch. We'll be back here at 1 o'clock. I thank all of you.

*The committee recessed from 1207 to 1305.*

#### COUNCIL OF ACADEMIC HOSPITALS OF ONTARIO

**The Chair:** Good afternoon. We can start our first presentation for the afternoon. It's from the Council of Academic Hospitals of Ontario. We have Dr. Jack Kitts and Mary Catherine Lindberg. You can start your presentation whenever you're ready. There is a maximum time of 15 minutes allowed.

**Dr. Jack Kitts:** Thank you very much. As introduced, my name is Jack Kitts. I am the president and CEO of the Ottawa Hospital, but I'm here today in my capacity as chair of the Council of Academic Hospitals of Ontario, which I'll refer to as CAHO. Joining me, as introduced, is Mary Catherine Lindberg, who is our executive director at CAHO.

On behalf of all of the members at CAHO, I want to thank you for the opportunity to table our comments and observations with respect to Bill 36. The Council of Academic Hospitals of Ontario is a not-for-profit organization. We represent 22 academic hospitals in Ontario with annual operating budgets ranging from \$25 million to \$1 billion per annum. This investment is close to \$6 billion and accounts for 45% of the resources spent on hospitals in Ontario.

Academic hospitals are large and complex organizations that provide a broad and complex set of services.

Our mission or our mandate is really threefold: First, we provide care for the most complex patients; second, we train future physicians and all other types of health care providers; and third, we provide a focal point for world-class research that contributes to improved patient care, new innovations and best practices.

We also serve as an important economic driver in society, creating new knowledge, new innovations and new jobs. These economic spinoffs contribute to Ontario's quality of life, our international competitiveness and economic prosperity. We also provide leadership to assist in the transformation and sustainability of our health care system. Collectively, these roles result in a complex set of current local, provincial and national working relationships with other hospitals, other health service providers, universities and colleges, specialized provincial health networks and a variety of government bodies that contribute to the various aspects of the academic mandate.

Bill 36 is an important and defining piece of legislation. The impact of the bill on the role and reach of the academic hospitals will be significant and requires careful consideration. I would ask you to consider the following:

First, Ontario teaching hospitals and their hospital-based research institutes conduct over 70% of the health research in the province. This represents 40% to 50% of Ontario's entire research enterprise. The money spent on hospital-based research provides a major impetus that leads to better patient care, improved population health and greater efficiencies. Much of the research relating to health care will inform the strategies and decisions made by our LHIN boards.

Second, academic hospitals are intimately involved in educating the full range of future health professionals, in collaboration with many different academic institutions. Ensuring the right number and mix of appropriately prepared health care providers will be a key challenge shared by all of us. If LHINs are to become fully engaged in meeting this challenge, Bill 36 will need to acknowledge their role.

Third, based on the current LHIN boundaries, the 22 academic hospitals in this province are located in seven of the 14 LHINs; 40% of them are located within a single LHIN in Toronto. Significant movement of patients across LHIN borders will be a reality. If the mandate of the LHINs is to be realized, all 14 LHINs will be significantly dependent on academic hospitals to plan services and achieve a continuum of care for the population they serve. Given these facts alone, it is clear that Bill 36 must acknowledge the importance of research, innovation and teaching in improving the health of Ontarians.

Given the time allotted for the presentation today, we will focus on three key areas of concern with respect to the bill: first, omissions from the purpose of the bill and LHIN objects; second, the power of the minister to require hospital foundations to provide financial reports to LHINs; and third, the implications arising from the

minister's ability to assign contractual rights and obligations to LHINs.

Details with respect to the amendments we are proposing will be found appended to our brief.

Issue 1: We believe that the purpose statement described in section 1 is under-inclusive and that the list of objects included in section 5 is incomplete. The purpose statement in Bill 36 is missing two critical points: first, it lacks reference to the need to improve the health of Ontarians through better access to high-quality health services; and second, it lacks reference to the need to ensure coordination of health services not only at the local health system level but across local health systems and across the province.

CAHO recommends that section 1 be amended to include reference to both of these points.

### 1310

Another key shortcoming of the bill relates to the lack of reference made to education, research and knowledge transfer in the list of LHIN objects of the bill. Each of these activities is vital for ensuring quality, efficiency, effectiveness and sustainability across the full continuum of the health care system.

As already mentioned, we believe that Bill 36 must acknowledge the importance of research and innovation for improving the health of Ontarians and give LHINs a role with respect to health research, innovation and best practices, and quality of care. We have developed specific amendments to section 5 to address this.

Finally, with respect to section 5, we propose that a new clause be added, referencing the need for LHINs to support the training of future health care professionals, as well as health human resources planning and education.

Issue 2: With respect to the power of the minister to require hospital foundations to provide financial reports to LHINs, we believe the amendment proposed to the Public Hospitals Act in section 50 of the bill is unnecessary and inconsistent with other provisions in the bill. We support the concerns raised by the Ontario Hospital Association in its brief yesterday regarding the proposed amendment to the Public Hospitals Act that could result in hospital foundations having to provide financial records and reports to the LHINs.

Because foundations are not within LHIN jurisdiction under Bill 36, and because Bill 36 already contains a section relating to LHINs' ability to require reports from entities that are not within their jurisdiction, we ask that consideration be given to deleting the proposed amendment.

Finally, we are concerned about the broad scope of the minister's power to assign contracts under subsection 19(3). This subsection is overly inclusive. The broad nature of the assignment of contract provisions in the bill has the potential to seriously jeopardize and undermine the progress that has been made in negotiating key contracts, particularly with academic physicians, in terms of alternate funding plans, alternate funding arrangements, and hospital on-call committee agreements.

Currently, these agreements involve the minister, health service providers and third parties, and are derived

from centrally bargained and negotiated agreements. Accordingly, we believe that the minister should continue to administer these on a provincial basis. At a minimum, the agreements should be administered by an entity with a provincial mandate relating to research, education and, where appropriate, physician matters, in addition to funding responsibility concerning physicians, hospitals and other health service providers.

Because of the importance of the alternate funding arrangements and AFP initiatives, and the complexity of the issues involved in agreements relating to alternate funding arrangements, including issues that transcend LHIN boundaries and are of provincial scope and concern, CAHO recommends that subsection 19(3) be amended to require the minister to make a regulation where there is an assignment of an agreement which includes an entity that is not a health service provider. Appended to our written brief is specific wording for revising this section accordingly.

In conclusion, I want to emphasize CAHO's strong support for local health integration networks in Ontario. We must strengthen planning, coordination and integration of health services at the local level to improve access and timeliness of patient care. In doing so, however, we need to make sure that the legislation will facilitate effective working relationships between academic hospitals and LHINs, and acknowledge collective roles and responsibilities with respect to clinical care, teaching requirements and the promotion of research and best practices.

Thank you for this opportunity.

**The Chair:** Thank you. There are about three minutes. I'll start with Mr. Arnott, please.

**Mr. Arnott:** Thank you very much for your presentation. I want to ask you a question about the second issue that you raised in the course of your presentation. You said, "With respect to the power of the minister to require hospital foundations to provide financial reports to the LHINs, we believe the amendment proposed to the Public Hospitals Act ... is unnecessary and inconsistent with other provisions in the bill." Could you tell us again why you feel that way and why you suppose the government included that provision in Bill 36?

**Dr. Kitts:** I'm not sure why the provision was included, because under the Public Hospitals Act there is that provision. The concern, I guess, is that anything that might be detrimental to fundraising activities for hospitals, and particularly for teaching hospitals, where research is funded almost exclusively by fundraising, any cutback in fundraising and research dollars will negatively impact our future. So that's why I think we're particularly concerned about that.

**Mr. Arnott:** But it certainly raises the spectre, I guess you'd say, of the Minister of Health sticking his nose into the private business of hospital foundations. One would question, why is that happening? Certainly, you might conclude that he's trying to get his hands on some of this money. This is the concern that we're hearing from a number of people. I would hope that that's not the case,

but I think the government has to respond in a way that reassures people that that is not what's planned.

**Dr. Kitts:** I don't know the reasons, but my concern and CAHO's concern is anything that might negatively impact on our ability to fundraise for research will negatively impact on the future of our health system.

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

**Ms. Martel:** Thank you for your presentation today. I wanted to focus on how you might see your participation in the planning that goes on being assured by the LHINs. You were right, there's not a reference now, despite the very important role that's played by academic health centres. So what suggestions do you have? I appreciate the concerns you've related, but I'm more interested in some of the concerns that you might have about how you ensure your voice, your role, is heard and played in this—

**Dr. Kitts:** That's a very good question. I can look at the health system from my perspective both as a physician and as chief of an academic department in an academic hospital and now, more recently, as a CEO. There's no question, whether it's an academic hospital or any hospital, that the debate between medical leadership and administration and boards, when resources are short, turns to, "Well, if we're a hospital, we should be focusing more resources on patient care, because that's what hospitals do, and let the universities handle the education and the research institutes worry about the research." But the fact of the matter is, in an academic health science centre those three are completely intertwined and must be. So we would like to have provisions in there to let the leadership of the LHINs—the boards and the CEOs—know that the academic mandate is absolutely essential, not only for current health care but particularly for our children and our grandchildren for years to come. We would like to see explicitly stated that while LHINs is health care, the academic mission must be protected.

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

**Mr. Dave Levac (Brant):** First of all, thanks very much for your presentation and well-thought-out concerns and recommendations. You, along with a few other deputations, have indicated a concern about the foundations issue. We've heard it quite clearly. Quite contrary to my colleague across the way, there was never a mention of anyone getting their greedy little hands on the money, and I don't want to have you characterized as asking that question either. It's unfortunate it was characterized that way. I would suggest that those concerns that have been brought up are definitely heard and we'll be working on those.

The second question that I do have for you, though, is a relationship between hospitals, academic hospitals and the LHINs. In my LHIN, for example, the 14 hospitals have gotten together and they're going to coordinate all of their IT so that the communications process—what are the academic hospitals doing or are they doing something that would help us benefit the LHINs and the patient at the end of the road?

**Dr. Kitts:** In many cases, the most complex patients end up on the continuum at an academic hospital because

that's where the tertiary care is concentrated, the latest technology and equipment. What the academic hospitals offer as part of the LHIN is that we work with—the 14 hospitals in your area plus the community partners sit down and plan the clinical services distribution, who is going to do what. That has never been done before. Everybody has continued to plan in silos. So the academic hospitals can then reach out to the partners in the LHIN and say the continuum is this: Maybe a small community hospital does this primary care, it moves on to a larger, more regional hospital and then ultimately to the academic centre. So basically we just want to work in partnership with them.

What the other hospitals don't have, though, is a mandate to educate future health professionals and do research. That is really the key to a sustainable system. We'd like to have that recognized, that we'll all do that together. Studies have shown that where doctors train, they often stay. I think it would be remiss of us if we didn't send them out into the other partners in the LHIN for their educational experiences, and that's why I'd like to have it in the LHIN that that's a protected—

**Mr. Levac:** A great rationale.

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

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#### ONTARIO COLLEGE OF FAMILY PHYSICIANS

**The Chair:** We'll get the next presentation, from the Ontario College of Family Physicians. It's Dr. Levitt and Jan Kasperski. Good afternoon. You can start any time you are ready, Doctor.

**Dr. Cheryl Levitt:** Hello, everyone. My name is Cheryl Levitt, and I'm president of the Ontario College of Family Physicians, the OCFP. With me today is our executive director and CEO, Jan Kasperski. Thanks for the opportunity to present the Ontario College of Family Physicians' reaction and concerns regarding the LHIN legislation to the standing committee on social policy.

The OCFP is the voice of family medicine in Ontario and represents more than 7,300 family physicians. Our purpose is to build and maintain the highest standards of practice, maintain competence through continuing professional development of our members and advocate for improved access to high-quality family medicine services for all residents of Ontario. We live in communities throughout the province and provide family medicine care for all Ontarians. By listening to the voices of family doctors, you will hear the concerns of all our citizens about our health care. Moreover, we feel that family doctors are the canaries in the health care mineshaft. We are able to inform you in an early, expert and dispassionate manner about what works in the system and what doesn't.

Family medicine is the cornerstone of the health care system. The evidence is clear: An enhanced primary care system in which every person has a family physician will

save Ontario millions of dollars; provide more equitable care for socially deprived populations, especially children; lower the all-cause mortality, all-cause premature mortality and cause-specific mortality from asthma and bronchitis, emphysema and pneumonia, cardiovascular disease and heart disease, and numerous other maladies; and contribute to Ontario communities, small and large, as facilitators of social and economic well-being and growth. Yet more than 1.4 million Ontarians do not have access to a family doctor.

I wish to state at the outset that while we participate in Ontario society as family physicians, and specifically are intervening here, we always do so not primarily to serve our own interests as family physicians, but rather to serve the public interest as a whole. Our profession is unparalleled in its dispassionate dedication to the broader public interest. Even when we might be perceived as speaking for ourselves, we do so because of the central role our discipline plays in our patients'—that is, all Ontarians'—lives. We strongly believe that in order to continue to do so, we must ensure the strength, numbers, sustainability and viability of our discipline.

The OCFP is concerned about the new LHIN legislation. We believe that regionalization, if it is to be undertaken, should be occurring because it's a mechanism that will improve the state of health care for all Ontarians. We are open to this being the case, but are not yet convinced that this is so. In any case, most fundamentally, we believe this should be attained through improved family medicine-based primary care services and whole-population access to family physicians. Unless this is made an explicit goal of the legislation, we believe the exercise may simply be one that deflects discussion and action from the central concern of most Ontarians about their health care, namely, continuous and proper access to family physicians.

Please do not mistake our intervention as an effort on the part of family physicians in Ontario to protect or further our own interests as a group or to perpetuate a perceived status quo. Family physicians are not frightened of social change. On the contrary, we are advocates of constructive, evidence-based efforts to do away with impediments to the effective provision of optimal medical care to all Ontarians and to put in place major innovations that will ensure this critical goal. Our discussion paper, *Starting with Primary Care: Patient/Family Centred Organizational Transformation*, based on our consultations with health care leaders throughout the province, documents the needed changes that we envisage. However, we feel that this must not be undertaken on the basis of this season's ideology or change for change's sake. It must rather be undertaken on a foundation of evidence-based approaches and open, transparent and rational considerations of whether or not what's being proposed meets the test of being in the public interest.

We wish to make the following recommendations with respect to the LHIN legislation:

There are many competing interests for resources in health care. If, as we believe the evidence shows, family



medicine and family medicine-based primary care are the single most important investments that will guarantee a healthier society, then this should be made explicit in the legislation.

The preamble and part III of the bill should explicitly state and ensure that family medicine and family medicine-based primary care is a central priority, including in the provincial strategic plan and in the integrated health services plan of each LHIN, as key to ensuring better access to high-quality, cost-effective health services in Ontario.

Bill 36 calls for the development of a provincial strategic plan and the engagement of the community in the development of an integrated health services plan for each LHIN. Family doctors need to be involved in the development of the PSP and seen as key members of the community in the development of each IHSP.

Subsection 16(1) needs to provide the definition of the term “community,” and community-based family doctors need to be included in that consultation process.

We also support the amendment to the bill as proposed by the Ontario Hospital Association in regard to part II, section 5, “objects”; and part V, subsections 25(2) and 28(2).

The OCFP actively participated in a multi-stakeholder consultation process led by our colleagues at the Ontario Hospital Association to develop the principles which should underpin the functioning of the LHINs. The OCFP used this work to demonstrate how the LHIN principles could drive decision-making in Ontario. Our discussion paper, *Local Health Integration Networks: A Means Not an End*, provides an overview of key recommendations that we hope would influence the spirit of the legislation and any policy decisions that flow from the legislation. We would like to submit the paper to you as a backgrounder to our input on the legislation.

Subsection 16(2) calls for the health professionals advisory committee. The OCFP does not believe that this broad-based group can or will adequately ensure that family doctors are properly consulted. LHINs will fundamentally change the way many health care services are delivered in this province. Physician involvement in general and family physician involvement in particular is vital in the management and organization of local health care. The Ontario Medical Association has proposed that each LHIN should support the development of a physician advisory body composed of specialists from the hospital sector and physicians from the community representing doctors who deliver care in family practices, long-term care, home care and public health. The OCFP supports the development of a physician advisory committee.

The LHIN legislation or regulations must ensure that physicians are properly consulted and formally included in LHIN structures through a physician advisory committee.

In addition, the LHIN legislation or regulations must ensure that family physicians are properly consulted and included in LHIN structures through a family medicine

advisory committee, as proposed in our report, *Linking Family Physicians with Local Health Integration Networks (LHINs) in Ontario*, which we have provided here.

The FMAC is specifically aimed at addressing the issues facing family medicine and improving the interface between primary care and the rest of the system.

The province is investing significantly in increasing the number of family doctors and in developing better access to family medicine through the support of group practices, including family health teams. Our research indicates that the LHINs must invest in supportive organizational structures to hear the voice of family physicians and to foster integration at the point of care in family practices and throughout the system. Family physicians need the same structure to support them to identify patient care issues, to problem-solve and to undertake quality improvement activities.

In our report, *Linking Family Physicians with LHINs*, which we submit, we propose a 10-point approach to the structure and function of the family medicine advisory committee, FMAC.

The LHIN legislation is virtually silent on improving the quality of care rather than cost saving and cost-cutting. In reviewing the development of regional health authorities across Canada, we are acutely aware of the fact that the drive for savings in the system led to the consolidation of services in larger centres and closure of small hospitals. Inequitable distribution of resources, travelling long distances for care and lack of a holistic approach to care—i.e., care that treats people as a series of body parts to be distributed throughout a city—is not, in our minds, a quality approach to system planning. The legislation should establish parameters for protection of small communities through fire walls.

The LHIN legislation, through the provincial strategic plan and the IHSPs, should protect the erosion of resources from small communities by establishing fire walls.

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The LHINs cannot only be about building regional structures and devolving responsibility. They must be about continuously improving quality, making sure that we get the very best value for money and using the new regional structure to build a truly better service. Section 1, the purpose of the act, needs to be changed to reference access to high-quality health service, coordinated locally and across the province. The legislation should require that the LHIN demonstrate improved quality of care for Ontarians. The IHSPs should include detailed plans for continuous quality improvement and ongoing evaluation.

The legislation is also silent on the role of the LHINs in protecting, promoting and supporting the education and continued professional development of health care professionals, clinical research, and health services research and evaluation. Quality practices in health care do not occur in a vacuum. Universities and colleges preparing future health care providers must plan in partner-

ship with their regions. The LHINs must ensure that providers are encouraged to practise high-quality care and to continually maintain and enhance their competence. Clinical research is needed to develop new knowledge and evidence, and the legislation must ensure LHINs undertake evaluative research.

The legislation should stipulate the role of LHINs in protecting, promoting and supporting education, continuing professional development of practitioners, clinical research, and health systems research and evaluation. Their link with the colleges and universities should be made explicit in the legislation. Amendments to sections 25 and 28, as per OHA's recommendations, should be added to the bill.

In closing, we would like to thank you for this opportunity to present our views. We would welcome any opportunity to work with you on these points as this important legislation is carried forward.

**The Chair:** Thank you. You've used the 15 minutes. There is no time for questioning, but we thank you for your presentation.

#### CHIEFS OF ONTARIO

**The Chair:** The next presentation is from the Chiefs of Ontario. We have Angus Toulouse, Ontario regional chief, Chiefs of Ontario; Randall Phillips; and Paul Capon. Meegwetch to you, gentlemen. Please proceed whenever you are ready. It's your floor, sir.

**Regional Chief Angus Toulouse:** First of all, I'd like to acknowledge the Mississaugas of New Credit, whose territory we are sitting in today. I am the Ontario regional chief, elected by the 134 First Nations in Ontario. The status Indian population of these First Nations is the largest of any province in Canada.

In June 2005, Ontario shared its newly developed aboriginal policy titled Ontario's New Approach to Aboriginal Affairs. To quote from the document, "Ontario recognizes that First Nations have existing governments and is committed to dealing with First Nations' governments in a co-operative and respectful manner that is consistent with their status as governments.... Aboriginal peoples will have greater involvement in matters that directly affect their communities, including where applicable in programs and service delivery."

In relation to First Nations health services and programs, Ontario's new approach has yet to be implemented.

The already established LHIN boards and the LHIN legislation will have significant impacts on First Nation health services. The First Nation task force identified seven areas that raised concerns and issues.

Number one, governance and accountability: The establishment of a forum on financial services would require the involvement of the federal crown, which has the primary fiduciary relationship with First Nations, particularly in the health field. Another possibility would be the implementation of a bilateral intergovernmental forum with First Nation leadership for the purpose of

establishing a new organizational entity or institution dedicated to First Nations health in Ontario. Such an entity could be designed to reflect the government-to-government relationship and serve to ensure transparency, accountability, and efficient use of federal and provincial funds in meeting the health and healing needs of First Nation citizens, regardless of residency.

The new health organization could develop joint First Nation ministerial protocols, standards, research, health criteria, and could conduct performance management and evaluation of the LHINs, as well as ancillary and related services of the ministry and the Aboriginal Healing and Wellness secretariat.

**Health system planning and evaluation:** For the LHINs to be accountable to First Nation citizens on and off reserve, First Nations are concerned that LHINs may undermine our jurisdiction. First Nations have the right to decide our own health criteria, and we need to maintain ownership of this information. This may result in a First Nation performance management and evaluation process being established to ensure that our citizens' health needs are met according to the treaty and fiduciary obligations of the Crown.

**Service delivery coordination and integration:** Service delivery on and off reserve must be maintained and enhanced for the protection of First Nation programs and planning within mainstream institutions and in First Nation communities. Services and programs must be developed by First Nation governments for citizens both on and off reserve, which include planning, implementation and evaluation. This could be accomplished through a First Nations health organization with authority to make recommendations and implement change at the provincial and individual local LHIN levels.

**Human resources and staffing:** There is a lack of capacity in First Nation communities, both on and off reserve, in terms of professional support. Health staff in the mainstream health care systems are often not equipped with the proper skills and knowledge to deal with First Nation communities, particularly cultural knowledge. To ensure First Nation health needs are understood and met, there must be cultural training of provincial and LHIN staff, including provisions for translators. This would also involve First Nation leadership being involved in the selection of staff and reviewing qualifications before a person is sent to a First Nation community, particularly a remote northern community.

**Northern issues:** Northern First Nation communities have unique circumstances that must be considered. Even basic services are a priority for the North. To ensure these circumstances are considered, the provincial government and the LHINs must factor in remoteness. If these communities are ignored, the service gap in the north will only get worse. The significance of these issues calls for a government-to-government relationship.

**Roles of Health Canada:** The task force has advised that Health Canada must maintain its fiduciary responsibility and that the federal government must be accountable to First Nations in the provision of services, regardless of collaboration with the provincial govern-

ment. The best option is to use the intergovernmental process to bring the federal government to the table to negotiate with First Nations, the province and the LHINs. This must be a flexible, collaborative and coordinated effort.

**Community engagement:** There must be engagement of individual First Nation communities and citizens residing on and off reserve, given the fact that each First Nation's rights and interests are unique. Joint decision-making processes must be developed and implemented to ensure communications continue on an ongoing basis.

The legislation affects First Nation rights and interests. The LHINs boards have a direct impact on the 134 First Nations communities across Ontario. Despite the lack of appropriate notification, First Nations participated with the minister and ministry in good faith to attempt to determine the impact of the LHINs. First Nation participation in the process did not receive the respect it is entitled to: the special relationship First Nations have with the crown. The LHINs legislation was pushed forward despite First Nation efforts. The minister had not yet responded formally to the final recommendations and report of the First Nations task force. Despite First Nations' efforts, our legal rights and interests have not been accommodated. This is not consistent with the honour of the crown. Based on this, legislative exemption is what First Nations are seeking.

The draft legislation should be delayed to permit a full government-to-government dialogue with First Nations. In that context, First Nation representatives would be prepared to discuss and develop positive alternatives and options. It should be possible to develop a model that respects First Nation rights and interests, as well as the provincial imperative with financial resources and administrative efficiency.

This is pretty much the end of the presentation. As noted, a more formal written presentation will be submitted in short order. If there is any time, I would be glad to answer any of the questions you may have.

1340

**The Chair:** We've got plenty of time. A couple of minutes, Ms. Martel.

**Ms. Martel:** Meegwetch. Welcome, Chiefs and support staff. I'm not sure of your appropriate titles.

The top of the presentation, which you didn't read, clearly outlines the lack of real consultation that went on with First Nations with respect to this bill. This is an issue that we have heard before, in other communities that we have visited, but I'm glad that you put it in writing to clearly show what your expectations were and how your expectations were not met—not just your expectations, but your treaty and other rights with respect to consultation have not been met, as well.

At the end of the presentation, then, you make it very clear that you are seeking a legislative exemption. Are we going to receive the actual copy of that? Do you have that with you? Because I don't think it's attached to my copy of the presentation. Would this be a non-derogation clause essentially, or something else?

**Chief Randall Phillips:** Perhaps, if I could make that distinction, we are looking at an exemption with respect to the complexity of our services in the service delivery process right now. That's what we're looking at in terms of that type of thing. I know that the minister had talked about those types of things.

But with regard to the non-derogation clause, we are talking about two separate issues: One, the non-derogation clause firmly recognizes our aboriginal treaty rights and that whatever is in that legislation must have a mechanism to deal with that. That's the distinction that we make in there. With respect to the exemption, our concern, of course, is the governance ability of LHINs to override any of the decisions that we make or that will impact on our current service delivery and our jurisdiction within that whole area of health. I hope that helps.

**Ms. Martel:** Yes, it does, but can I be clear? You're looking for two things then, not one: You want a legislation exemption, but you also want a non-derogation clause?

**Chief Phillips:** We've taken a traditional stance, not only in Ontario but across Canada, that with respect to any legislation, a non-derogation clause be included in there. That provides the federal and the provincial governments with a mechanism to deal with those treaty and aboriginal rights that are addressed within legislation. So it is a non-derogation clause. We've asked for that consistently with regard to any legislation; this one is no different.

**The Chair:** Mr. Levac.

**Mr. Levac:** Meegwetch, Angus. I have a question basically about the end story. The end story, if I'm not mistaken, is to better the health care system for the First Nations people. Is there any value that you see in your evaluation of the LHINs as they presently stand that would provide some of that assistance, given some of the circumstances that need to be overcome, obviously? And I would suggest that, respectfully, we have to get through that, and then at the end story, which is the health care provision, are there ways in which LHINs can show, after your evaluation, that there would be some good end story to this issue?

**Regional Chief Toulouse:** Chief Phillips will address that again, as chair of our task force.

**Mr. Levac:** Just before you do that, I understand you've met and will be meeting shortly with the minister to outline some of the specific concerns that you have regarding the process?

**Chief Phillips:** Yes, to both of those.

Your question is very good. Unfortunately, I'm not in a position to see exactly how the LHINs will respond to our issues and concerns, so this notion of whether or not they're going to actually advance or address our health concerns—I just want to make it clear to committee members that within this whole Ontario health transition, First Nations are included in that, so if the goal here is to improve health status, then we need to focus on First Nations communities and there needs to be some specific direction either given to the LHINs or a separate process

that deals with these issues. That's why we're looking at this not only as a separate process—enhance and confirm that we're still following along this notion of treaty and aboriginal rights—but the minister has also mentioned the fact that he is looking at, the best way to say it, implementation at the ground level.

Those were the concerns that we addressed right from the get-go when we found out about LHINs, so there seems to be some movement towards trying to at least accept that notion and put that into some kind of legislative framework or comment or whatever else.

I don't know whether these processes will work and enhance and direct and address our health concerns, but we're certainly hopeful that once we get down to that engagement level at the community level it's going to move towards that. That is our goal, of course: to enhance our own health services.

**Mr. Arnott:** It was approximately seven months ago that the government released Ontario's New Approach to Aboriginal Affairs, June 2005, and it was only a few months later that the government made an internal decision to move forward with health services restructuring, regionalization of health services, creating these new authorities that they call local health integration networks. Did the Minister of Health not know about the new approach to aboriginal affairs? How would you account for the fact that the government completely ignored that policy or completely overlooked their obligation to consult with First Nations? How can you account for that?

**Regional Chief Toulouse:** It's unfortunate that not only this government but many governments overlook their duty to consult First Nations. We are constitutionally recognized people. It's unfortunate that a lot of times this is what happens when there's a new announcement. Even a lot of the new approach is done in isolation, with not much consultation. But we did speak to the minister, and I think there's some willingness to recognize that we are nations and we need to have a government-to-government relationship and we need to have discussions in building a relationship along those same lines. That has certainly been communicated to the Premier and to various other ministers within this particular cabinet that that's what we're talking about when we're talking about a new approach to dealing with First Nations people and communities in Ontario. That's something that we want to continue to build upon. I agree that there wasn't much consultation when that was drafted, where it's understood as to what's meant by "new approach" and a consultation with First Nations leadership and communities.

**Chief Phillips:** If I could just add to that, prior to this whole exercise, the First Nations were involved with a first ministers meeting, and one of the issues they talked about was health. The Minister of Health for Ontario led that process, so I'm assuming that he would know of the requirement to deal with First Nations. I'll just leave it at that.

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

KRISTY DAVIDSON

DOUG ALLAN

**The Chair:** The next presentation is from Kristy Davidson. There will be 15 minutes for your presentation, and if there is any time left, there might be questions or statements from the members. Just start whenever you're ready.

**Ms. Kristy Davidson:** Good afternoon, everyone. My name is Kristy Davidson. I live and work in Toronto. Having reviewed Bill 36, I have a number of concerns that I want to bring to your attention. I am particularly concerned about how local the structure truly is. I'm also very worried that what Bill 36 creates is actually not better for Ontarians in terms of the health care services we have and how we access them. I also am really concerned that it doesn't truly integrate services. Also, around the issue of networks, I believe they may actually not be true networks, that they may be some false networks, and I'm going into that specifically now.

Getting back to my point about how they may not be truly local, I'm concerned about representation and the fact that the boards are appointed and that the minister has the ability to pass the minister's power on to those boards. The boards are driven by the minister's strategic plan, which members of the public also don't have access to. I believe, all in all, that removes the responsibility, the accountability, from the elected MPPs. I also don't see in here any representation of workers, of equity groups and of communities as they presently exist, and that causes me great concern. My answer to those concerns is that the boards, if we are going to have them, should be elected, like our school trustees are.

Around the issue of community involvement, I don't see any minimum level of community engagement or access to meetings for members of the public, and I believe that a lack of local input into services will create instability locally. My answer to this is that we have legislated protection of democratic and meaningful community input.

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My last point on the issue of whether or not LHINs are actually local is around the fact that I don't believe LHINs reflect the way that communities are presently organized. If we look at municipalities and the provinces and the federal ridings, they're getting their boundaries together, but the LHINs come along and create an additional boundary. I'll give you a personal example. I live in Toronto. I access one hospital for specialist services. My partner accesses another. Those two hospitals, in the plan as I understand it, will be in two different LHINs. Now, that's not to say that I need to have my services in one LHIN, but my point is that the LHINs maintain that they reflect the referral patterns and the existing patterns of services, but I really don't think they do in that they don't reflect the existing boundaries. For example, for Toronto, one city, to have five LHINs, I don't see how that is a reflection of local structures.

Moving on to the next part of the acronym—getting off of "local" and looking at "health"—I'm concerned

about the existing health care services and that this is simply an attempt to spread the strategy of competitive bidding. I'm on the executive board of a local social service provider in a community, and I see what competitive bidding does to the services that this agency is able to provide. They spend more time and money worrying about what to apply for and how to apply for it and who to hire to do the application than they do on planning the services that are needed and delivering those services. Section 33 specifically calls for privatization of non-clinical services, and that is of deep concern to me. Public health care is what we have paid our taxes for and what we have believed in the principles of the Canada Health Act, and they're what we should continue to support. So my answer to this concern is that we include protection of all existing health care systems in the legislation and specifically that we exclude competitive bidding as well.

Moving on to the next part of the acronym, under "integration," I don't see how it is actually true integration. It seems to be a selective integration. There are critical parts of the system that are not aligned: no major providers, like family doctors, dentists, optometrists, labs, provincial drug programs. Again, my answer for this would be true integration of all health care providers, and when and if other services are to be integrated into the LHINs, we need to have further consultation if we're looking at having public health and ambulance become part of LHIN structures.

I really do believe that integration, as I see it here, is a misnomer. The networks cover large areas, and yet they sharpen regional inequalities. I'd like to give another personal example. I'm originally from Sault Ste. Marie, and I have a grandparent there. To get her surgery she had to come to Toronto and stay for four months to recover. The initial guess at how long the recovery would take was two months; it actually took her twice as long, because she was outside her regular circle of family and friends. Depression sets in and it increases the time it takes to recover. These costs are not factored in here, the costs of someone to travel through a LHIN to get to a service, from Toronto to Parry Sound or vice versa, or the travel for families who then have to go to a completely other part of their region to support a relative who has had to travel there to get the surgery. These are not factored in. Again, my answer to that is that the LHINs need to reflect the existing boundaries.

My last point, about the network issue of LHINs, is that the word "network" suggests strength, stability, togetherness, but I do believe that the networks as suggested here actually interrupt and separate the existing patterns of service delivery. The services have developed over time in response to community needs, and yet the powers given to LHINs can ignore all of that work and all of that history in communities. Boards can order closures for not-for-profits. They can merge services from provider to provider. They can order transfers of property from provider to provider. These services that have developed over time based on community need can

completely disappear. We come back to the issue of, who do you go to with your concerns about that: a board that you haven't elected and that you have no connection to? My answer to that is that we add protections into the legislation for existing local services, including and particularly in the not-for-profit area.

I have one sheet, and I think copies have been distributed. It is basically the summary of the points I have made here today. I don't believe that LHINs really live up to their name. I don't believe that they are truly local or that they are truly good for public health, and I am concerned that, at best, this attempt to integrate health care is premature and, at worst, it's harmful. It's harmful to me as a resident, it's harmful to workers, and it's harmful to our whole public health care system in Ontario.

I urge the government to act on the suggestions that have been made here, and I thank you very much for your time.

**The Chair:** Thank you for your presentation. We have a minute and a half each.

**Mr. Khalil Ramal (London-Fanshawe):** I listened carefully to all the points you mentioned. Hopefully, after we implement the LHINs, when the law passes, you'll change your belief and you will be convinced that LHINs are a good invention for the health care of Ontario.

First, you mentioned "local." I don't understand how you don't see that it's more local than the present situation with health care since we have right now, almost, one LHIN covering the whole province, and we have 14 with this bill. It will be divided into many different sections to help the smaller communities have better input, a better say, in health care delivery. The minister yesterday, in the Timmins Daily Press, mentioned that with the implementation of LHINs, the smaller communities will have more to say, especially when it comes to health care decision-making.

About the service: You mentioned your partner goes to one hospital and you go a second hospital. Implementation of LHINs is not going to change the service. You'll go wherever you want, you'll choose whatever hospital you want to be treated in, and it's not going to affect you at all. The LHINs can only work on the limitation of the administration level and also work to consolidate the service. It's not going to affect the people or the clients if they decide to go to this hospital or another hospital.

The present situation is not going to—you said the LHIN has more authority now than before to close and to open. The minister will still have the same authority over the LHIN as in the past and it will continue in the future. Also, he said in his opening remarks, when he opened this session for the committee, that he is against any hospital closures and he is working toward maintaining health care in the public domain.

**Ms. Davidson:** In response to your comments about the issue of whether they're local or not, my point is really about local access and accountability, and if your local connection to the LHINs is a board that you have

had no input into how they operate and you have no future chance of that, whereas with the existing system now, as you described it, there is that connection through your MPP and there is certainly a local connection. There's my example in Sault Ste. Marie, and I've seen how the health care system has developed there with the group health centre and then the addition of the women's health centre and the addition of a west end health centre. That all came from community input and from direct community pressure. There is no connection here. I don't see the connection here—

**Mr. Ramal:** It's perfectly clear about the community involvement.

**Ms. Davidson:** —between the community and a board that is not elected and that can have the minister's duties passed on to it. So the one elected person who maybe would be there can pass on their responsibilities to the board.

**Mr. Doug Allan:** If I could just add one point, I think part of the concern that many presenters have raised is that the powers that have been given to cabinet, to the minister and to their agents, the LHINs, are so extensive that the vitality of existing boards is seriously threatened. The way community health care has been preserved and expanded when other parties and other governments have been in power has been because communities have organized, largely through their community board organizations, to preserve and enhance those services. The power that has been given to the government is so great that that threatens the vitality of the ongoing organizations.

I'm sorry. I didn't want to interrupt you.

**Ms. Davidson:** No. Thank you.

1400

**The Chair:** Mr. Arnott.

**Mr. Arnott:** Thank you very much for your presentation. It was excellent, and I appreciate your thoughtful comments.

You were talking about accountability and the need for the minister to be accountable to the public, the need for MPPs to be accountable to their constituents when there's a health care issue. Like you, I think the political motivation behind Bill 36 is so as to create a political buffer between the minister and any problem that might exist in the health care system, whether it be a difficult decision that's been made to perhaps close a hospital or to integrate two services together or whatever it might be. And if an issue is raised in the House, if an opposition member raises these questions in the House, I would anticipate that the minister is going to say, "Oh, I had nothing to do with it. Talk to the local LHIN. They're the people who made that decision. I had nothing to do with that." Is that your concern?

**Ms. Davidson:** That's absolutely my concern, yes. You probably said it better. Absolutely, yes.

**The Chair:** Madam Martel.

**Ms. Martel:** Thank you for your presentation. I want to focus on the aspect of competitive bidding, because the minister in his opening comments tried to say that

essentially people who said this was going to be competitive bidding were providing misinformation and a few other adjectives that I won't get into right now. If you look in the bill, there isn't anything to say that they can't. So if the government meant that, you would have thought it would be in the bill.

Because you specifically referenced, because you had a personal example, I wonder if you can just comment on the concerns that you had watching competitive bidding operate in the agency that you were attached to and then what your concern would be if that was magnified to the other health care services that now fall under this bill.

**Ms. Davidson:** Absolutely. I did comment on the fact that the competitive bidding process was like it pulled away hours and time of workers who should be delivering services, but it also changed the focus of the organization. For example—I don't want to jeopardize anyone with what I'm saying here—the organization I'm talking about actually went after some money so that they could do something that they thought would make them look better to a provider of funds. So instead of focusing on their community, which they do in a fantastic way—and they still find a way to do that—they get sidetracked into trying to create something that will be attractive to someone they're doing a bid for. That's kind of what I'm trying to say. It does sidetrack the energies and the focus of the agencies that have done such an excellent job so far in focusing on communities and community needs and developing appropriate programs.

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

#### ONTARIO PHYSIOTHERAPY ASSOCIATION

**The Chair:** We will have the next presentation, the Ontario Physiotherapy Association; Dorianne Sauvé, please. You can start whenever you're ready.

**Ms. Dorianne Sauvé:** Thank you, Mr. Chairman, and thank you for the opportunity to appear before this committee. My name is Dorianne Sauvé, and I am the chief executive officer of the Ontario Physiotherapy Association. With me is Don Gracey.

I'm not sure whether it's an advantage or a disadvantage to appear this late in the committee hearings. I fear that you have probably heard everything there is to say about Bill 36, from every possible perspective.

We have given copies of my prepared remarks to the clerk, and I don't mind if you flip through them while I'm speaking. We will also be making a written submission. But rather than follow my prepared remarks, I think I'll make just a few points that are of particular interest or concern to the physiotherapy profession and thereby leave as much time for questions and dialogue as possible, because, as I said, I suspect you've heard it all before.

We have the same concerns as many others as to what is beyond the scope of Bill 36. By this I mean the exclusions in subsection 2(3) and the fact that inde-

pendent health facilities, medical laboratories, public health, in fact pretty much all of primary health care delivery, is not explicitly part of the LHINs jurisdiction. We don't see how the LHINs can do what they are supposed to do in terms of health service integration when so much is beyond their reach.

Community-based physiotherapy is in a no-man's land. We are neither excluded by subsection 2(3) nor included under subsection 2(2). We have asked the ministry for clarification as to where we sit and why, but we have had no response.

It is the OPA's position is that all physiotherapists in the public sector should be covered within Bill 36, regardless of the venue in which they practise. In fact, we believe that every significant component of the public health care delivery system should fall within the ambit of Bill 36. There should be no exclusions.

You have also heard many concerns that Bill 36 creates an unlevel playing field between the for-profit and not-for-profit providers. We agree with those concerns, particularly as they relate to section 28. The OPA has no objection to the operation of for-profit providers in the publicly funded health care system, but we see no valid public policy rationale for giving them special status. If for-profit providers choose to play within the publicly funded system, they should play by the same rules as everyone else.

We also support those who are concerned that Bill 36 is really about centralization of control over the health care delivery system rather than the regionalization and local decision-making that we were told to expect. Bill 36 looks to us like the Minister and the Ministry of Health want it both ways: the apparent devolution of responsibility while retaining real control of the ministry.

This committee has asked previous presenters what powers the government should or should not have in LHINs. We believe the discretionary funding power provided by the ministry pursuant to subsection 17(1), the requirement for an audit by the Auditor General, the ability of the minister to require reports, coupled with accountability agreements and the requirement that the LHINs' integrated health service plans be consistent with the provincial strategic plan, provide the government with adequate control and direction over the LHINs. Beyond that, we respectfully suggest that this committee take the minister and ministry officials through the long list of additional powers the government would have under Bill 36 and ask them to justify their necessity.

As written, regionalization and local decision-making is an illusion. LHINs will have very little in the way of real independence. We think this will have negative implications for the governance of LHINs and for their relationships with individual community-based health service providers.

We have spoken to ministry officials about our concerns with the expansive governmental powers and how they might be used. We have been given assurances that they will be used carefully and in such a way that local decision-making is respected. That might be well for this

ministry and this government, but the health care sector and I'm sure other sectors are replete with examples of how legislation has been put in place with certain understandings as to how discretionary powers are to be used or how statutory provisions will be interpreted in practice. We have frequently been given assurances, "Oh, we'd never do that," or "That's how we intend to interpret that," only to find that a subsequent minister or government does exactly that or applies an unexpected interpretation. The fact is that the authorities provided to the government in Bill 36 could be used by this or any subsequent government to enforce completely centralized control over Ontario's health care system.

I would like to close my abridged remarks by talking a little bit about consultation. When the minister appeared before this committee, he was quite emphatic that there had been extensive consultations about the LHINs. Let me make two points in response. First, the consultation that our members attended amounted to the ministry telling the attendees what it was going to do. The ministry may feel this is consultation. We don't. Most of our members who attended came away very disappointed that they were unable to put forward ideas or to influence the direction the ministry was going in. Second, there has been no opportunity for groups like ours to consult with the ministry on Bill 36 per se. We have been invited to attend technical briefings, but there has been no opportunity to raise or address issues that we have with Bill 36. This is particularly important given what I said earlier, namely, that Bill 36, particularly in its centralization of control, is not what we were expecting from the ministry's consultations.

Mr. Chairman, that concludes my remarks. Don and I would be happy to hear any comments or any questions.

**The Vice-Chair:** Thank you for your presentation. We have almost seven minutes. We'll divide it equally between the three parties. We'll start with Ms. Martel.

**1410**

**Ms. Martel:** Thank you for the presentation. Let me phrase my questions this way: You're very critical of this bill and critical of the lack of consultation, and it's not because you have a vested interest, because you don't. Physiotherapists aren't going to lose their jobs or their employment one way or the other if this bill goes through. When you look at this, particularly your concerns with respect to the increased concentration, I can tell you that government members have tried to say that this isn't an increase in powers, that it's the same kind of powers the minister already has, that it's not an expansion. You were pretty clear that that's not the case. Maybe you want to expand a little bit further on the differences you see with respect to this bill and what might have come before.

**Mr. Don Gracey:** Let me make two comments about that. If you look at the long list of powers that the minister, the cabinet and various other ministers may exercise over LHINs, it's at least as much and in some cases more than the powers the government can exercise over one of its crown corporations, over its agencies,

boards and commissions. To say that LHINs have the capacity for local decision-making or whatever simply doesn't work when compared with the long list of powers. The other thing you've got to look at, I think, is from the bottom up: Look at the control the LHINs have over the health service providers: the accountability agreements, the funding arrangements, that they can transfer services back and forth. That power does not exist today. So I think it is a tremendous expansion of the ability of the government at Queen's Park to control the health care system; it's much more than what we have today. It may not be more than the controls the government currently exercises over hospitals, but it's more than they can exercise over long-term-care facilities now, it's more than they can exercise over health service providers now.

**Ms. Martel:** Secondly, you talked to the ministry, and the government said, "Oh, don't worry. We're not going to exercise these powers." You don't find a lot of comfort in that. Why is that?

**Mr. Gracey:** Let me give you an example. When your government passed the Long-Term Care Act in 1995 and it talked about the multi-service agencies, the MSAs, could anyone have believed at that time that that legislation would have been used to introduce community care access centres and managed competition? That's the kind of thing. I mean, if a power is there—when I was in government, we used to refer to it as Trojan Horse legislation. Once it's there, it can be used for whatever you like. If those extensive powers are there, they can be used by this government or any subsequent government however they choose. Whatever verbal undertakings may be given today really don't mean anything later on. If you look, for example, at some of the undertakings that were given when the Regulated Health Professions Act was going through committee in 1991-92, a lot of those went out the window immediately after it was proclaimed in 1993.

**Ms. Sauvé:** I'd like to comment too from the physiotherapy perspective. I think that those kinds of extensive powers—we have currently one of the few professions that work fairly extensively in almost every aspect of the health system that will be under the control of the LHINs, whether that be long-term-care homes, CCACs, in some cases community-based clinics, and hospitals, obviously, so any decisions that are made to those areas have a tremendous impact on our front-line providers. I think that is where our concern comes in in terms of these extensive powers.

**Ms. Martel:** Because you are attached to those agencies.

**Ms. Sauvé:** We're attached to those agencies.

**The Vice-Chair:** Mr. Arnott.

**Mr. Arnott:** During the election campaign in 2003, the Liberal Party promised not to create two-tier health care, but of course in the first budget there were a number of provisions, one of which was that the Minister of Finance announced the delisting of physiotherapy services, optometry services and chiropractic services.

What has happened in your sphere of activity since that delisting? If you could inform the committee of that, it would be most appreciated.

**Ms. Sauvé:** We were delisted, then we were partially relisted with an announcement that, effective April 1, 2005, we would have services for those under 18, over 65, and those under social assistance programs. Through the current system of designated physiotherapy clinics, what has occurred since April 1, 2005, has been a limited rollout of services to specific long-term-care homes that did not have services, and currently a limited rollout, at this point, to those who have a small amount of services. That's under way. There has been no improvement in community-based physiotherapy services for Ontario because there are only 95 designated physiotherapy clinics and they are still mostly located in metropolitan areas, the Golden Horseshoe, a couple out east in Ottawa and Kingston—nothing north of Sault Ste. Marie. So there has been nothing done in terms of community-based services since that announcement.

In actual fact, we're in a worse situation now because there's so little horizontal planning around physiotherapy services or any rehabilitation service in Ontario. There is a misconception out there that those services are available because of that announcement, so some hospitals have been reducing or cutting their outpatient services based on the fact that they think it's available in the community, but it's not. So in actual fact we're in a worse situation now than we were with the initial delisting announcement, because then everybody would have known there were no services. We're even worse off now with a partial relisting, because there's still a misconception that those services are available, and they're not.

**The Vice-Chair:** Ms. Wynne.

**Ms. Wynne:** I apologize. I came in just at the end of your presentation, but I have looked it over while the other folks were talking. The issue of the exclusions in the bill: Part of what we're trying to do by mandating the local health integration networks to engage the community, and particularly the health community in each of the areas, is that we're trying to get all of those voices into the planning process. Can you comment on that, firstly? Then secondly, this issue of centralization as opposed to decentralization: I understand the Trojan Horse analogy, but I also believe and know that what this minister wants to do is put into the hands of someone other than ministry officials at Queen's Park some control over budget and over the organization of the health care system. That's what we're trying to do. Could you comment on those two pieces, the community engagement and the need for there to be local input, which you seemed to agree with at the beginning of your presentation.

**Ms. Sauvé:** I'm not really sure how the exclusion component would achieve greater integration or community involvement.

**Ms. Wynne:** I'm saying, though, that the mandate—in section 16, the bill mandates each LHIN to engage the community, so that would be a way of having those



voices at the table. Can you comment on that piece? Maybe it's completely separate from the exclusion discussion, but can you comment on that community engagement clause?

**Mr. Gracey:** I think the exclusion issue is somewhat different from the community engagement issue. We have difficulty understanding that if there's going to be, through the health professionals advisory committee—if, for example, physicians and podiatrists are going to be on that, why should the services that they provide be excluded? It's the old joke that if you're not going to play the game, why should you be involved in setting the rules? There seems to be a dichotomy there. The government says, "We'll bring physicians and podiatrists into the planning process, but of course the LHINs can't have anything to do with the services they provide." With specific reference to physiotherapy, the question about the exclusion is, why? In terms of the community-based physiotherapy that Dorianne was talking about before, they are funded through OHIP in exactly the same way as physicians, podiatrists, optometrists etc., so why aren't they excluded? It's what Dorianne referred to as a never-never land.

In terms of the community-based decision-making, as I said earlier, if it works, that's fine. I can tell you, from a personal point of view, I now serve and have served for a long time on the board of a long-term-care facility in Markham. I will resign when this legislation is passed, because I do not see how my duties, responsibilities and liabilities as a director of that long-term-care facility can be reconciled with the role of the LHIN and the role of the minister.

**Ms. Wynne:** Thanks.

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

1420

#### CANADIAN PENSIONERS CONCERNED INC., ONTARIO DIVISION

**The Vice-Chair:** Now we have Canadian Pensioners Concerned, Ontario division. I don't know how many we have with us here; we have listed about five people. Are all of them here? Okay. There are two people. They'll mention their names when they come to the table. You can start whenever you want. You have 15 minutes; you can use it all, or you can use part of it and the other part for questions. I think she was here yesterday; she knows the game.

**Ms. Gerda Kaegi:** Yes.

**Dr. Don Bellamy:** Thank you very much. Ladies and gentlemen, I represent Canadian Pensioners Concerned. At the moment, I'm the president. My colleague here is also on the board.

**The Vice-Chair:** Sir, could you please provide your names? I have five names here.

**Dr. Bellamy:** I'm Donald Bellamy, and my colleague is Gerda Kaegi. We're both members of Canadian Pensioners Concerned, which was founded in 1969. It's is a

national, voluntary, membership-based, non-partisan organization of mature Canadians committed to preserving and enhancing a humanitarian vision of life for all citizens of all ages.

We have distributed for your reading our brief. I'm going to take the short way out, perhaps, and read the summary of recommendations, if you will allow me to.

With respect to the preamble, we would like to see the preamble to Bill 36 amended to include the following statements:

"The foundation of the integrated system is based on the following principles:

"(a) the five principles of the Canada Health Act," which are not there.

**The Vice-Chair:** Sir, if you could back up from the mike, it would be a lot better.

**Dr. Bellamy:** Am I too close? I usually am lectured for—

**The Vice-Chair:** This is a very sensitive microphone.

**Dr. Bellamy:** It's an excellent one; I would like to take it away with me.

Second, "community-based boards, responsible and accountable to the community and the government."

Third, "The local community has the legislated right to meaningful consultation/participation and determination of the services it needs in its local LHIN."

Fourth, "The primacy of non-profit provision of services over for-profit."

On the issue of the definitions in the legislation, our second group of recommendations is to amend Bill 36 to include the following under the section on definitions:

First, the term "entities" must be defined—a woolly word.

Second, under section 2.3, the order to integrate applies to for-profit entities as well as non-profit.

Third, non-profit service providers must not be required to integrate with for-profit entities unless there is no other option available.

Fourth, all providers of health services provided and funded by the LHINs and the Ministry of Health and Long-Term Care must be covered by the legislation. The minister must have identical powers to make orders with respect to not-for-profit and for-profit providers.

Next, on performance standards, accountability, community engagement, we would like to see Bill 36 amended to ensure the following:

First, evidence-based criteria founded on evidence-based performance standards must be used to evaluate the performance of each LHIN. The evaluation results must be public.

Second, each LHIN must be held publicly accountable to the community it serves as well as to the minister.

Third, LHINs' funding is based on the actual needs of the population and includes a number of variables such as socio-economic status of the population, health status, age distribution, the number of recent immigrants, ethnocultural diversity and so forth.

Fourth, each community must be consulted and participate in planning and setting the priorities of its LHIN.

The procedures for consultation must be part of the regulations. The ministry's strategic plan should be informed by the local LHINs plans.

Fifth, clarification is needed on the relationship between the public health departments and the relevant LHINs.

Finally, health promotion should be one of the critical priorities for each LHIN.

With regard to the composition and practices of the LHINs, we would like to see Bill 36 amended to ensure that, first, the board of directors must number not less than 21 nor more than 25, and should reflect the nature and complexity of the community being served.

Second, a seniors advisory committee will be one of the committees required under the regulations for each LHIN.

Next, the aboriginal community has representation on those LHINs serving a significant proportion of their population.

Fourth, the board of directors must be required to meet for a minimum of 10 meetings a year, and these meetings must be open to the public.

Fifth, the Auditor General should be required to perform a comprehensive value-for-money audit on all of the LHINs on a periodic basis or upon request from the Legislature.

**Funding and accountability:** We urge amendment of Bill 36 to ensure that the government is required to provide to the relevant standing committee of the Legislature detailed comparisons between the current level of funding for health services in each region of the province and the funding apportioned out to the LHINs.

Second, funding and accountability agreements be set for a minimum of three years.

Third, ageism is prohibited in all forms of planning and service delivery.

Fourth, each LHIN should have an independent ombudsperson's office that reports to the Legislature.

**Integration and devolution:**

We urge that Bill 36 be amended to ensure that, first, effective and responsive service delivery is the primary focus of the LHINs.

Second, the public has the right to appeal an arbitrary delisting of services. If a decision on delisting services is made, it must come after extensive public consultation.

Third, the public and non-profit service providers have the right to appeal a decision to transfer services to another provider.

Fourth, the use of competitive bidding to select appropriate service providers for each LHIN is not used for the funding of service providers. The selection criteria must include a proven record of the quality and continuity of care provided to care recipients.

Far from meeting the resonant words of the preamble, this draft legislation leaves much to be desired. We do not see it as the government fulfilling our vision of an integrated health system that delivers the health services that people need, now and in the future, as in the preamble. Our vision sees an integrated system focusing on

wellness and health promotion while ensuring the real care needs are being met. We believe that such a vision can be achieved if we listen to those being served and develop a responsive and responsible system.

Thank you very much, Mr. Chairman.

**The Vice-Chair:** Thank you for your presentation. We have three minutes left. We can start with Mrs. Van Bommel.

**Mrs. Van Bommel:** Thank you for your presentation. It was certainly very well thought out and gives us a lot to think about.

One of the things that I notice in recommendation 5 is that you feel that the board of directors should be between 21 and 25 members, and currently it is set at about nine. Can you tell me why you feel that it needs to be that large?

**1430**

**Ms. Kaegi:** Yes. I think it's quite straightforward. The LHINs areas are very large and some of them encompass a very large, diverse population. We do not see how a board of nine can possibly represent and truly hear from the community with that size of a board. If I could explain, I sat on the district health council in Toronto. We had a board of 25, and even we struggled to meet the representation needs of the population of this city. Some of the LHINs are over a million people, so we felt very, very strongly that the boards have to be bigger. Nine is far too small.

**Mrs. Van Bommel:** You mentioned things such as seniors advisory committees and the aboriginal community. Do you feel that there should be guidelines as to who should be members, to be sure that we cover all the groups that have an interest and should be represented there?

**Dr. Bellamy:** Yes, we do.

**Ms. Kaegi:** Seniors are the major consumers of health care dollars and they are the ones who tend to be marginalized, and we can document that if somebody wants. But "first bed available" is being done now to seniors; hospitals throw them out. Even though the rules say they can't do that, they're kicked out to the nearest available bed. What we need to have is some watchdog, if you like, and some voice for the population that is, we believe, quite vulnerable. That, of course, is our role as Canadian Pensioners Concerned.

**The Vice-Chair:** Mr. Arnott.

**Mr. Arnott:** Thank you very much for your thoughtful presentation this afternoon. It's very interesting, and you've put a lot of effort into it. Your organization deserves a lot of credit for bringing this advice forward to us.

I had a similar question to the one Mrs. Van Bommel asked about the size of the board and the number of people, but you've already addressed that and answered it. I did have another question. I'm just looking for the recommendation here.

**The value-for-money audit:** There have been a number of presenters who have come forward and said, "If this is just another level of health care bureaucracy, we don't

need it. There's enough bureaucracy in health care already." Is that part of your concern, as well? Is that why you are asking that provision be made for the Auditor General to order a value-for-money audit at any time? Is that what you're getting at here?

**Ms. Kaegi:** CPC, in the past—if I may speak, Don—has found that the reports from the Auditor General have been extremely thoughtful and very useful. We believe, especially when a new structure, a new organization, has been set up, it would be very useful for the Legislature and the public to see that kind of critical outside review of what has happened. That's one of the reasons behind that recommendation. We have in fact asked for that kind of review of a particular service in the past, and his report achieved what we had hoped to achieve: It was stopped.

**The Vice-Chair:** Ms. Martel.

**Ms. Martel:** Thank you for your presentation. I wanted to focus on your recommendation 7(c), "The public and non-profit service providers have the right to appeal a decision to transfer services to another provider." The legislation is silent on any form of public response to an integration decision or order at this point, and the service provider's right is only for reconsideration to essentially the same body that made the negative decision in the first place. What were your thoughts around this section? Did you have in mind a structure or a process that you think would be better?

**Ms. Kaegi:** In the brief, we refer to a process that we suggest could ultimately come to a standing committee of the Legislature. In fact, if there can't be resolution, we think there has to be a right of appeal. It has to be long enough, not quickly done within 30 days so that nothing really can be achieved. We believe there must be enough time to launch a formal appeal. Ultimately, coming to a standing committee of the Legislature might be the final avenue, but we feel there's got to be a process external to those who have already made the decision. I know you are busy people, but it's one way to get outside the system to be able to hear a dispassionate presentation on an appeal. I don't know if that was a clear enough answer.

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

CANADIAN UNION  
OF PUBLIC EMPLOYEES,  
LOCALS 4308 AND 3896

**The Vice-Chair:** Now we'll move on to our second person, Kelly O'Sullivan. Kelly, you have 15 minutes. You can use them all or you can divide them between speaking and answering questions.

**Ms. Kelly O'Sullivan:** I thank the committee for the opportunity to speak to you about Bill 36 and the local health integration networks. My name is Kelly O'Sullivan and I'm a president of two CUPE locals here in Toronto, CUPE 4308 and 3896. I represent workers at three community-based, not-for-profit agencies here in Toronto: Central Neighbourhood House, Senior Peoples'

Resources in North Toronto and Toronto Homemaking Service.

In total, close to 300 workers provide services at these agencies each and every day out in our community. The majority of our workers are personal support workers and community workers who are responsible for supporting seniors and people with disabilities or mental health issues to live with independence and dignity in their own homes. The range of services we provide includes personal care, adult day programs, supportive housing, meals on wheels, social work, community dining programs, transportation, advocacy and support. Our work, our agencies and the very communities in which we live and work will be directly impacted by Bill 36 and LHINs.

As a front-line worker in the community, I have seen first hand the devastating impact of the competitive bidding model in home care. This is the first area I wanted to focus on for the community. When it was introduced in 1997 by the government, the impact on our workers and clients was immediate. During bargaining for us, one of our employers tabled concessions and cutbacks to already low-waged personal support workers because they had to be able to compete. They wanted to do more, but the bottom line for them was being able to compete in the sector against the for-profit companies.

Another employer stated that any wage increase that we might try to bargain with them for would mean that they would not win a contract with the community care access centre. They issued us a gag order, because to publicly speak out about that fear would be perceived as labour unrest and, once again, it would damage their attempts to secure a contract.

The focus for our employers became a contract at any cost, and the cost was borne by the personal support workers who had to carry out this work in the sector. They have seen their wages flatlined for over 10 years, with the majority—even though they are health care workers who provide 70% of the care in the homes—not having access to health benefits. I'm talking about basic benefits here, a benefit plan. Our workers, for the first time in 30 years, after we were forced out on strike, were able to access a basic benefit plan. The majority of workers in this sector do not have that access. There is inadequate sick leave, a health care worker receiving sometimes only 40 hours of sick leave a year, and that's those who are fortunate to have that in the not-for-profit sector. Almost none of these workers has a pension plan. Competitive bidding has resulted in wages being driven down even further, work conditions deteriorating and workers expected to do more for less.

Those we provide the services to have also felt the impact. Reduction in service, cutbacks to hours of care, waiting lists and lack of support have meant that many seniors and people with disabilities are struggling to be able to maintain a home and are entering institutions prematurely. In addition, families and informal caregivers are left with an increased burden of care that it is not reasonable to expect them to meet.

In 2006, the not-for-profit, community-based agencies and clients we serve are still being negatively impacted by this model. Since 2004 alone, 22,000 clients have been affected by the loss of contracts through competitive bidding, and over 1,000 workers have been laid off or have lost their jobs completely. At least 24 not-for-profit service providers, many with 50 to 100 years of standing in local communities, have closed their doors. Once again, personal support workers in the community who were already working for low wages lost those jobs, lost benefits, seniority and guarantee of hours they may have been able to gain after years of service for an agency.

In one loss of a contract, a worker was at an agency and had been at that agency for seven years. A month later, she was serving the same client, but at a lower wage, with a loss of her benefits and having to work for another for-profit employer. That was a fortunate client who was able to maintain their worker. In fact, many clients who had had the same worker for years—I represent workers who have been in this sector for 15 years, some of them. For clients, that personal care that they receive from the same worker consistently, week after week, year after year, is important, and they're now forced to accept care through strangers. I have to say, from my perspective and that of the workers I represent, the only gain that has come from competitive bidding has been the opportunity for private companies to make money off the vulnerable, ill and frail seniors and people who require support in their home.

**1440**

I ask that the committee ensure that Bill 36 is amended to include a provision that would eliminate existing models of competitive bidding and not allow for the expansion of competitive bidding models to be introduced in any health or community support service.

Another concern I wanted to bring to the attention of this committee is the role of the community care access centres. Currently, CCACs are responsible for coordinating and referring to service providers in a number of areas of health, including nursing, personal care and occupational therapy. This is not an exhaustive list. It is my understanding that Bill 36 will not only maintain the CCAC structure but also possibly expand the services it contracts out and coordinates. The issue here is another layer of bureaucracy for service providers, workers and those who receive service to deal with. Let's think about this: Money from the Ministry of Health will go to the LHINs, the LHINs will then take that money and give it to the CCAC, and the CCAC will allocate that money to various service providers. At the end of the day, what's left over for workers and clients? It's just the crumbs, that's what's left for us. I ask that the committee review the role, responsibility and mandate of the CCACs and not allow another layer of bureaucracy to encroach on already limited funding for the home and community care sector.

The final area of Bill 36 I wanted to focus on today is the issue of community engagement and control. I put

forward a challenge here today to every committee member: Before you make any final decisions on this bill, connect with your own communities. At random—and I mean at random, not loyal people who show up in your constituency office every day—speak to at least five of your constituents and ask them if they have ever heard about the local health integrated networks. I think you'll find the majority of them have not heard anything about it. Then ask yourself if you believe, as an elected official, if Bill 36, LHINs, and the restructuring of health care has been done publicly and with community engagement. I can guess what the answer is.

I also ask that the committee ensure that Bill 36 includes the democratic election of LHINs directors by all residents in the LHIN geographic area and that all meetings of the board be open and accountable to the public.

I wish to thank the committee for listening to the concerns and suggestions I've put forward on behalf of the personal support and community workers I represent. All of us strongly urge the committee to recommend to the Minister of Health and the government that the bill in its current form needs to be set aside and that a real and significant consultation process with local communities, health care workers, not-for-profit service providers and the public take place to assess how health care should and could be transformed to all of our benefits. It is with an inclusive, democratic, open and accountable process that change should happen. Thank you.

**The Vice-Chair:** Thank you kindly for your presentation. We have about four minutes, divided equally between the three parties. We'll start with Mr. Arnott.

**Mr. Arnott:** Thank you very much for your presentation. You mentioned, in the context of your talk, that you feel that a lot of people don't know this bill is before the House, they don't know what a LHIN is, they don't know what a local health integration network is, and I would concur with that. From the discussions that I've had with people in my constituency when I tell them—first of all, when the House isn't sitting, they don't think we're doing anything, which isn't the case; we're down here doing public hearings, in this case. When you talk to them about what this bill is all about, there is a great deal of interest when you start engaging them about it, but until you explain what's happening, they aren't aware. I think the government has a real obligation to communicate that. Do you have any suggestions as to how we might do a better job of getting word out that this bill is before the legislature and what the implications may be?

**Ms. O'Sullivan:** By getting the word out, I think it's more important to stop this before it gets steamrolled through and actually engage in a full consultation process with our communities. I would argue that all members here, as elected representatives, have that responsibility, regardless of the party they are sitting with. That would be the practical way to do it.

**The Vice-Chair:** Ms. Martel.

**Ms. Martel:** Thank you for your presentation today. I want to focus on competitive bidding, as I have many

times already in the public hearings. While the minister says this is not in the legislation, of course there's nothing in the legislation that says it won't be used. I have encouraged the government to bring forward an amendment to make it absolutely clear that competitive bidding will not be used as a model for acquisition, obtaining of health care services that the LHINs are responsible for.

You gave us a very clear description of how devastating competitive bidding has been in the sector and related a very personal experience with respect to the members you represent and, frankly, the clients, the patients they are dealing with. Over and above that, I guess it's also the issue of, where does the money go in home care when you have competitive bidding? Because there certainly has been extensive analysis on how much money has been taken up in the system by every agency putting in requests for proposals, having the consultants do that, and then how much money doesn't go to patients when you have a for-profit provider that's in the picture. Some of that money that should go to patient care ends up being diverted to that for-profit provider.

What are your concerns, having seen it first hand in home care, about a potential broader application to other areas of the health care sector?

**Ms. O'Sullivan:** I think the direct effect which I focus on as a front-line worker is for those who are most vulnerable. What we saw in our sector when the for-profit players became more prominent was their inability and/or refusal to work with hard-to-serve individuals. If it was basically costing them too much money to work with an individual who might have a mental health or complex situation, it ended up being the not-for-profits that went in and were able to do the work, because we're not there to make money. We're there because we have a philosophy, we have a mission and we have a mandate to provide services to clients. It's not about the bottom line. It's about finding a way to provide service to meet the needs and to support that individual. The for-profit providers would just walk away. They literally would walk away and say, "We're not dealing with it. We can't do it. Sorry. No, thanks." For that to happen, what happens when we're no longer around? When you continue to have a model that pushes not-for-profits into closure, who is going to work with those individuals in our community who are most at risk?

**The Vice-Chair:** We will move to Ms. Wynne.

**Ms. Wynne:** Thanks for coming today, Kelly. I appreciate it.

I just wanted to talk about that interesting point you made about people not knowing what a local health integration network is. Starting in the spring and fall of 2004, the ministry and the minister started to have consultations on this bill—430 submissions on LHINs so far; 4,000 people registered for workshops and attended those workshops. The ministry also established a provincial action group to provide advice on the design and implementation of LHINs, and in that group were provincial associations representing home care, community

support service providers, community mental health service providers, hospitals, public health agencies and a number of others. Then, between December 2005 and just this last month, January 2006, there were 48 community and union groups who were part of a technical briefing on the bill in order to allow them to give their feedback.

It's not that I'm challenging your contention that people don't know what LHINs are yet, because that's probably for the most part true, but after that amount of consultation—we've had six days of hearings and we're going to have seven in total after tomorrow—I think the knowledge level of what a LHIN is is going to have increased. I think that until LHINs are set up and start functioning, the general public won't know what they are. To me, given the efforts that have been made at public consultation so far and given that section 16 in the bill gives LHINs the mandate to continue to have community engagement, given all of that, I think people know what LHINs are, and that will be a good thing in terms of their ability to connect with the health care system. I don't know if you want to comment on that, but I just wanted to outline the kind of consultation that has been done up until now.

**1450**

**Ms. O'Sullivan:** Thank you for referring to that. I guess for me it's kind of like the horse before the cart. We're going to have the LHINs, we're going to have Bill 36, and then we'll let the community tell us and make sure that the community has a full understanding. When you talk about 4,000, how many millions of people actually live in Ontario, and who were those 4,000 people? Were they selected and solicited? In your own constituency, did you have a community forum?

**Ms. Wynne:** Actually, I did have a community forum. I let people know that the consultations were happening, and I made sure that anybody who wanted to take part was connected, so in fact—

**Ms. O'Sullivan:** And how many other MPPs did that?

**Ms. Wynne:** I don't know the answer to that.

*Interjection.*

**Ms. Wynne:** Khalil did it. I think it happened pretty much across the province. And not everybody is interested in having this conversation. But, Kelly, I wasn't saying that the bill passes and then people get informed. I was trying to say that there has been an upfront consultation, and the very nature of the LHINs is that that consultation will be ongoing. That was the point I was trying to make.

**Ms. O'Sullivan:** I would disagree with your perception about an upfront consultation, because I'm active in my community, I'm active as a union member—you know, I was not aware of your meeting with 4,000 people, and I certainly didn't receive any information about being involved. I'm one community member and I actually live in the minister's riding.

**Ms. Wynne:** I'm glad that you've had the chance today to put your voice on the record, and that discussion will continue as the LHINs get set up.

**The Vice-Chair:** Thank you, Kelly.

I wonder if the Ontario Health Coalition, Lindsay chapter, is here. Is anybody here from Lindsay chapter? No.

SERVICE EMPLOYEES INTERNATIONAL  
UNION, LOCAL 1.0N

**The Vice-Chair:** We'll move to the second one, Roseann Clarke. Would you mind mentioning your name and your friends' names for the record?

**Ms. Roseann Clarke:** My name is Roseann Clarke. On my left is Pat O'Brien and on my right is John Van Beek.

Good afternoon. I am a clerical health care worker at North York General Hospital and the designated certified worker co-chair of the joint health and safety committee. I am also a union steward for the Service Employees International Union, Local 1. With me is Patrick O'Brien, the steward for the service unit at the hospital.

As a union steward, I represent approximately 1,400 health care workers. As the certified designated worker co-chair of the joint health and safety committee, I represent a total of 3,000 workers at the same institution.

Bill 36 will remove any local control over health care and place that control solely within the power of the Minister of Health and Long-Term Care and the Ontario cabinet, who in turn have placed the power to integrate, amalgamate and privatize health services in the hands of unelected political appointees, many of whom have no background in health care. It is they who will decide our future.

My job is important and, might I say, essential. As a unit secretary, my job is of the utmost importance as it provides the clerical support that allows physicians and nurses to focus their attention on the patient at the bedside. The unit secretaries transcribe the physician's orders and communicate them to the nursing staff, to other health care professionals and to every other department in the hospital. We are trained, dedicated health care workers whose jobs are on the chopping block if this legislation is enacted.

The only thing that's saving us right now is the non-contracting-out language in our union's collective agreement. Because of this language, the hospital cannot contract out our work if the result is a layoff. Hospitals, including North York General Hospital, have become very creative in their human resources strategies to get around this clause in our collective agreements. The hospital will reassign employees of the department it wants to contract out to other duties in the hospital or offer employees incentive packages to leave. The hospital will then contract out those functions, particularly dietary and housekeeping services, to foreign-controlled, private, for-profit enterprises such as Compass Morrison, Sodexo or Aramark. Employees for profit operators earn less than \$10 per hour, have no benefits and no pensions.

The Minister of Health, George Smitherman, has been quoted as saying his mission is to reduce the health cost

curve. Sadly, he is going to do so, as Bill 36 demonstrates, on the backs of workers like me. George Smitherman does not consider clerical or service workers to be vital, front-line components of Ontario's health care system. The most vulnerable workers in the health care system are being targeted by this government to sacrifice the most so this government can contain health care spending.

I object to my—

**The Vice-Chair:** Excuse me, can you back off a little bit from the mike?

**Ms. Clarke:** Okay.

I object to my public health care dollars going to foreign, private, for-profit companies to enhance their profits. It is undemocratic to allow nine LHIN board members to decide what community gets what health care services and which health care workers have a job and which do not.

I do not see how this legislation will provide better health care to Ontarians. The long wait times in the emergency rooms are not caused by health care workers; patient referral patterns are set by doctors. The previous government integrated and amalgamated local hospitals. When the hospitals were amalgamated the bureaucrats, in their infinite wisdom, closed beds and decreased the availability of care to everyone. The result was increased wait times in the emergency rooms, and health care workers had to do more with less.

Health care worker jobs are the most risky of all occupations. Not only are they subject to infectious diseases, but they also have a greater amount of back and repetitive strain injuries from lifting patients. The speed-up of workplace duties has led to exhaustion, stress and burnout.

Let's not forget SARS. I would like to take you back to the spring and summer of 2003, when we had the SARS outbreak. At North York General Hospital, 42 health care workers were struck down by SARS. This virus was non-discriminatory in whom it attacked. Every discipline at the hospital was affected: doctors, nurses, environmental services, central stores, dietary, portering and clerical staff.

I was newly appointed by my union to the joint health and safety committee. The JHSC was given the daunting task of investigating this outbreak. One of the hospital's staff died as a result of having contracted the disease. It became apparent that there was no effective infection prevention and control program in place and that the funding for this kind of program was being severely skimped. There was only one IPAC practitioner for all three sites of North York General Hospital: the seniors' health centre, the general site and the Branson site. Since then, extensive training has taken place to ensure that all staff are knowledgeable and diligent in their IPAC procedures.

What we learned from SARS was that it is imperative to have well-trained, dedicated and adequately compensated workers at all levels so that the public is confident that they are protected from infectious diseases. If our

jobs are contracted out to for-profit companies whose only mandate is to cut costs and make a profit, then quality standards in our health care institutions will be sacrificed. Do you think that minimum-wage workers would risk their lives to come to work every day in a SARS environment as we did?

What SARS taught us is that an enormous amount of planning is required to run an efficient health care system. The type of planning and accountability measures that Bill 36 envisages only relate to the bottom-line financial outcomes, and not quality-of-care standards.

North York General Hospital is currently in negotiations with Compass Morrison, a foreign-based, private, for-profit company. The proposal is for a 10-year contract with North York General Hospital to manage our in-patient food services and retail food services departments. The workers in the dietary department, many of whom have worked at North York General Hospital all their lives, are to be displaced in order for Compass Morrison to bring in their own, non-health-care employees. Compass Morrison employees are not health care workers. Therefore, there can be no accountability from these workers to the hospital.

#### 1500

The Guardian newspaper, in a late 2004 survey, found that the Compass group paid employees in Britain—a group of 412,500 employees—an average of 9,406 pounds per year. The vast majority of Compass employees earned minimum wage and well below the average salary in Britain of 24,600 pounds per year.

In British Columbia, the Vancouver Island Health Authority let go 1,000 health care workers and contracted out their housekeeping and food service jobs to Compass Group Canada. This deal was worth about \$25 million a year, and the Vancouver Island Health Authority says it will save \$10 million over the next five years as a result. How will it save? By cutting wages in half. Workers, having earned \$19 per hour, are now being paid \$9 to \$10 per hour. They have no benefits and no pensions.

The Compass disease is fast spreading into Ontario. North York General is just one example. Contracted-out cleaning services in the National Health system in Great Britain found companies not paying overtime or sick pay, no pensions and only 12 days of vacation per year. Food was transported from more than 200 miles and then reheated for hospital patients by contracted dietary service providers. This practice is also creeping into Ontario's hospital sector.

Several hospital cleaning contracts were axed by hospitals for failing to come up to regulated hospital cleaning standards. In September 2002, porters at the Kingston Hospital National Health Service Trust were told they must bring their own cleaning materials to work with them because the firm significantly underpriced its bid for support services at that hospital.

In July 2002, the South Glasgow University Hospital National Health Service Trust terminated a cleaning contract Sodexo had with the hospital and brought the cleaning service back in house, after three deaths at the

hospital. An investigation confirmed an outbreak of salmonella caused the deaths, and the hospital blamed Sodexo as an inadequate contractor.

Reports of inadequate standards continue to pile up against these for-profit hospital service providers. I ask again, do you really want to transfer our public health care dollars to for-profit firms offering inferior services?

At the end of the day, as with public-private partnerships—or alternate financing initiatives, as this government prefers to call them—it always costs taxpayers more in the end. With the contracting out of hospital non-clinical services, not only will taxpayers be ripped off, but hospital service workers too will pay the price.

We already pay up to \$900 per year in the Liberal health tax. Every hour we work, 50 cents goes to this government's health tax. Now you expect us to pay even more, by sacrificing our jobs.

I would like to go forward to item 7.

**Mr. Patrick O'Brien:** Maybe Roseann can rest her voice a minute. I would like to address number 7 here, and I would really do it in very layman terms.

I have been a hospital employee since 1973. I've worked at North York General Hospital all of that time. In my own observations, I know the community takes pride in its hospitals, but at the same time, the "H" above hospitals stands for "hospital," not "hotel." In my own observations over the years, I've seen enormous amounts of money actually being spent on luxurious trappings for hospitals: enormous main lobbies that cannot be heated properly in the wintertime, and in the summertime it's way too hot. I see all the furniture being brought into the hospital, the luxurious boardrooms and all of these things. So my question really is, where are the priorities? Where is money actually being spent?

I understand very well that health care is one of the largest budgets, next to education, and there have to be ways to reduce that cost, but it should not be on the backs of the ordinary workers who are delivering a very important service for the patients, because my question really is, what does all of this have to do with direct patient care? And it needs to be noted. Thank you.

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

#### ONTARIO HEALTH COALITION, LINDSAY CHAPTER

**The Chair:** The next presentation is from the Ontario Health Coalition, Lindsay chapter. James Mulhern, please have a seat. There is 15 minutes for your presentation, and if there is any time left, we'll be happy to ask some questions or make comments. Please start whenever you're ready.

**Mr. James Mulhern:** I just wanted to thank you for allowing me to be here and make a presentation. I'm from Lindsay local health integration network, region 9.

I want to begin by saying that the Ministry of Health and Long-Term Care has developed an act entitled the local health integration act. "Local" itself, if you want to

look at the word, the dictionary defines “local” as “of a limited area or place; local governments.” If the minister went a little further and used the word “localized,” Webster’s dictionary defines “localized” as “to restrict or be restricted to a particular area or part.”

The Ministry of Health and Long-Term Care has divided the province of Ontario into 14 regions, with five of the regions serving a population larger than five Canadian provinces. A sample travelling distance within the same local health integration network is, for example, from Haliburton to Scarborough with a distance of 203 kilometres, with a travelling time of two and a half hours; or Parry Sound to Timmins, with a distance of 468 kilometres, with a travel time of six hours; or Kenora to Thunder Bay, with a distance of 491 kilometres, with a travel time of six and a half hours. This all depends on the driver, the road conditions and the weather.

I fail to see where the definition of “local” or “localized” really applies to the local health integration act, Bill 36. My chapter of the Ontario Health Coalition submits that the local health integration act has nothing to do with local or the community, but more to do with centralization. The local health integration act gives the Ministry of Health and Long-Term Care the power to restructure the health care system in Ontario and to contract out.

If we go a little further, the word “integration” is defined in Webster’s dictionary as “1. to make into a whole; unify; 2. to join with something else, unite; 3. to open to all ethnic groups.” This would be a great idea if this is what the Ministry of Health and Long-Term Care was planning, but the local health integration act, Bill 36, fails to integrate all aspects of Ontario’s health care system. The act includes both clinical and non-clinical services, hospital—including labs—long-term-care facilities—for- and non-profit—community care access centres, community support services, community health centres, mental health and addiction services, and the University of Ottawa Heart Institute, but fails to include physicians, ambulances, laboratories, specimen collection outside of the hospitals, independent health facilities, homes for special care, public health, provincial drug programs, psych hospitals and defined specialists like podiatrists and optometrists. The Ministry of Health and Long-Term Care has excluded a major portion of Ontario’s health care system. How can you have an integrated network system when you exclude a major portion that could give the—okay, where did I go here?

1510

**The Chair:** Just tell us what is on your mind, because we have it in writing here.

**Mr. Mulhern:** The major portion is submitted—the health system, doctors and all that. They can give the greatest input, and they also give us the service. So you’ve excluded a major portion of our health care system. They should be put in. They should be part of the system if you’re going to continue with this act.

Community care access centres, with this act, are going to be amalgamated, merged and eliminated. We

have 42 of them and they’re going to be merged to align with the 14. What’s going to happen with the board members on those community care access centres? There’s going to be more chaos with home care. With the community care access centres and a lot of the decisions with health care made further from the communities, it is diminished. Like I said, it’s not local anymore.

The networks themselves fail to address the real drivers of the health care system, which really create the major expense. The ability of the community to influence which services are offered locally is diminished. It doesn’t say anywhere in the act that the community and the agencies have any input, especially in hospitals, into what’s going to be cut or given or what services are going to be offered. Even in the strategic plan for the health care system, according to the legislation, “The minister shall develop a provincial strategic plan for the health system that includes a vision, priorities and strategic directions for the health system.” There is no provision for any public consultation or process for this plan.

In my area, we had one public meeting and it was to find directors and to give out the information, and that’s it. There hasn’t been any information about public consultation or even any meetings at all about the strategic plan and where he’s going with this.

The legislation itself defines “integration” in the way that we would define “restructuring,” as the following: create partnerships; transfer, merge and amalgamate; order providers to start or cease provision of services; order providers to dissolve or wind up operations. It’s the same thing in housekeeping in the hospitals or any agencies. There’s no say that we have as to whether or not they should be closed or continue.

We have a few concerns:

(1) The provisions for democratic input and community control are weak or non-existent. The legislation supersedes a lot of democratic safeguards that were set out in other of legislation. The Minister of Health is not held to any democratic process for his strategic plan or his restructuring decisions. The provisions for community input are vague and left to regulations.

(2) The legislation facilitates privatization. Cabinet is expressly given new powers to order wholesale privatization of non-clinical services. In the act there is no protection or promotion of non-profit or public delivery of services. In fact, the legislation empowers the minister to order these services to be closed down but does not give him the power to do the same with for-profits. The local health integration networks may move funding, services, employees and some property from non-profits to for-profits. There is no definition in any Ontario legislation of what constitutes “non-clinical” services. Even under this legislation, cabinet is given the power to define these services as broadly or as narrowly as they wish.

(3) The principles governing the direction of health restructuring and accountability for the government are inadequate. Although all health providers covered are made accountable through service accountability agree-



ments to be backed by court orders, the ministry itself is held only to the undefined principle of acting in the public interest in the preamble to the legislation, and it's not legally binding.

The Canada Health Act principles of comprehensiveness, universality, accessibility, portability and public administration are not included at all. In our opinion, they should be. If you're going to continue with this act, they should be. There is also a deep concern for the public interest when the health minister indicates that his strategic direction is to centralize and consolidate hospital services and community mental agencies.

Under the provincial wait time strategy, the ministry is implementing a competitive bidding system for hospital services such as cataract surgery or hip and knee replacements. When competitive bidding was introduced into the home care sector by the previous government, it created a lot of chaos. A lot of non-profit agencies like VON could not compete, so they had to close up shop in that part of the sector, home care, and a lot of the for-profit providers continued on. The results of competitive bidding also includes constant turnover of employees, lack of continuity of care, low wages, shortages of skilled workers, high cost and a downward pressure on wages and benefits.

I work at a college, but the company that I work for is getting into some of the hospitals, like Sodexo. Like the previous presenter said, workers there may have been earning maybe \$17 or \$18 an hour or more, yes, but this company, Sodexo, comes in and knocks everybody's wages down, either in half or even less, close to minimum wage. I can barely live on what I'm making now because of that, and I don't think they can.

(4) The legislation itself sets up an extra, expensive administrative tier for no clear benefit. The 14 local health integration networks' boards will operate like regional ministries with awesome powers, with heavy administrative requirements and little public accountability for improving the health care system.

**The Chair:** Conclusion, please.

**Mr. Mulhern:** Under the legislation, the local health integration networks are not accountable to their communities but to cabinet. The board members are appointed by cabinet. There is a very high cost of administrating just the board itself and not giving out money at all to the various agencies and the hospitals. The board members themselves, the CEOs and directors are creating a high cost just for them doing their work.

**The Chair:** Thank you, sir. Thanks very much for your presentation. As I said, we have your written material, but there's no time for question because you went over the time. Thanks again.

The next presentation is from the Ontario Public Service Employees Union, Local 269, Hamilton Victorian Order of Nurses, Lois Boggs. Is Ms. Boggs here? No.

We'll go to the next one. Is Aubrey Gonsalves present? No. Ukrainian Women's Association of Canada, is anyone here? Could I ask, are any of you here to speak to us today? No.

We are ahead about 15 minutes, so maybe what we can do is take either 15 minutes to go back to our offices and work, or five. Madame Martel, what would you recommend?

**Ms. Martel:** Ten at least.

**The Chair:** You have the right to tell us what to do for the next 15 minutes.

**Ms. Martel:** My office is close and I can get back there, but everybody else's probably is not.

**The Chair:** Let's take 10 minutes. Okay? So we'll be back here a few minutes before. Thanks.

*The committee recessed from 1520 to 1549.*

#### AUBREY GONSALVES

**The Chair:** Our next presentation is from Mr. Gonsalves. Would you please have a seat. You have 15 minutes to make a presentation. If there is any time left, we will be able to ask some questions and/or make some comments. You may start any time you are ready.

**Mr. Aubrey Gonsalves:** My name is Aubrey Gonsalves. I'd like to thank you for paying attention and listening to me.

I'd like to focus on four aspects of the LHINs: first, the governance structure; second, the LHINs' boundaries; third, the need for consultation; and fourth, concerns about privatization and contracting out.

My understanding is that the local health integration networks, or LHINs, board members will be appointed. This is not a democratic process. Further, there is no clear definition of who sits on these boards. What would the makeup of the boards look like? Would there be doctors, business people, service providers, or individual citizens like myself? Who? I don't know. What would their primary concerns be? Would they focus on the health services provided, or would they focus on saving money? In the past, looking at government appointments to boards, it is clear that it is not what you know but whom you know.

Further, the LHIN boards are not accountable to the population and the people whom they represent, but rather to the Minister of Health. We have seen through the community care access centres that complete ministerial control over local health authorities does not work. In fact, the cost of providing home care has gone up, not down. The citizens of Ontario believe that Ministry of Health money is better spent on improving our health services and not on unnecessary administration costs or salaries.

I make a recommendation to this committee that democratic selections of LHIN directors be made and that there be legislative requirements that each LHIN establish a health sector employee advisory committee made up of union representatives and representatives of non-union employees.

The second issue I'd like to discuss today is geographic boundaries. These proposed structures are not local, they're not based on communities and they do not represent community interests. There is no legislative

guarantee that all services will be provided in every LHIN area. Also, these boundaries would negatively impact rural areas, specifically the elderly and people on social assistance. These low-income earners would have great difficulty affording transportation to travel to receive medical services.

I make a recommendation to this committee that LHIN boundaries must reflect real communities, that there be a requirement in the legislation for extensive public consultation on the existing boundaries and that there be a requirement in the legislation that guarantees that all regions have the same health services with the same access to them.

Community health centres that are run by community boards elected by community residents and consumers of the health services are responsive to the needs of local communities. These will be integrated under the LHINs. These are the only real form of community health care that will disappear under this legislation.

The third area I'd like to talk about is the need for meaningful consultations. Over the past couple of days, I have spent time watching channel 70, and I have heard a lot of deputations to this committee from individuals, agencies, unions and the like. There has been a strong message: People want to be involved and consulted in this process. This process for introducing and moving toward making the bill into law has been very fast, with little consultation but with large amounts of change to our health care system contained in the bill. The people of Ontario have a right to be knowledgeable about their health care services and about any proposed changes the government wants to bring about under LHIN restructuring.

But most people in Ontario have never even heard of LHINs, let alone understand the potential outcomes of these massive changes. It is clear that the public does not want any decrease in our health services or longer waiting lists for services. Public consultation is the cornerstone of good policy. Without true, meaningful and thorough public consultation, any restructuring of the health care system will bring about significant backlash from the public.

I'd like to make a recommendation that there must be a commitment from the current government, like the commitment they provided during the last provincial election, to strengthen and support health care in Ontario.

The final area I'd like to talk about is my concern over the privatization and contracting out of our health care services. The vast majority of the citizens of Ontario do not want privatization of their health care system. The LHINs structure creates a split between the purchasers of service and the providers of service.

Competitive bidding has been a disaster no matter what sector has been subjected to it, since its main objective is to drive down costs through awarding the contract to those providers with the lowest bids. While the minister has been clear over and over that Bill 36 does not contain a requirement of competitive bidding, it is clear that the legislation is meant to achieve cost

savings by contracting out services, and does not guarantee or support in any way the public, not-for-profit foundation of our health care system.

I make the recommendation to this committee that amendments be made to the bill to ensure that privatization is not assisted by this legislation. I also question why this legislation merges not-for-profit health services and does not touch for-profit services.

Finally, as citizens of Ontario we all know that privatization does not save money in our health care system. All it does is put public money in the pockets of wealthy corporations that generate profits for their shareholders. I ask that this government do what is best for all citizens.

**The Chair:** Thank you. There are about six minutes left; two minutes each. We'll start with Mr. Arnott.

**Mr. Arnott:** Thank you for your presentation. I want you to know that over the last number of days this committee has heard from quite a number of people on Bill 36, and some of the best presentations have come from people like you. I want to congratulate you for coming forward and expressing your views today.

**Mr. Gonsalves:** Thank you.

**The Chair:** Ms. Martel.

**Ms. Martel:** Thank you for coming today. You didn't tell us where you work; maybe we should get that information from you. I'm assuming it's somewhere in health care.

**Mr. Gonsalves:** I'm actually a social worker, a family service worker for the Children's Aid Society of Toronto. I also work as chief steward for our union, CUPE Local 2316, at the Children's Aid Society of Toronto and am an active member of, and one of three representatives on, the CUPE Ontario social service workers' coordinating committee, and represent CASs around the province.

**The Chair:** Mr. Ramal.

**Mr. Ramal:** Thank you for your presentation. I listened to it carefully. I know you have some concerns, but hopefully when we implement the LHINs, if the bill passes, all the concerns will be eliminated when you see the positives about them.

You said many different things in your presentation: You are concerned about their not being local; you are concerned about privatization. You are concerned about many different things. On what assumptions did you build your analysis to build this idea?

**Mr. Gonsalves:** Where did I get the information on the bill?

**Mr. Ramal:** Yes.

**Mr. Gonsalves:** Like I said, I've been spending time listening to the deputations, I have read the newspapers, and I have skimmed through the bill myself and checked the websites of unions and the media.

**Mr. Ramal:** When you talk about the lack of consultation, I don't know if you know or not—probably you heard us talking at many different times, since you watch the channel. You heard us on this side say many different times that before the preamble of that bill we consulted with more than 4,000 groups across Ontario to create ideas and create the bill. After that, we went on com-

mittee for—today is our sixth day—travelling the province, listening to many different people, listening to you, to many unions, to many individuals through teleconferences. We tried all avenues to engage the people of Ontario—all the stakeholders of Ontario, all the communities—to give us input. Don't you consider that consultation?

**Mr. Gonsalves:** I do, but sometimes it's important to consult groups of people before presenting the bill. My knowledge is that no groups were consulted prior to developing—

**Mr. Ramal:** We consulted with 4,000 before, and we're still in the consultation process. That's why we're listening to you. We're taking your input and the input of hundreds of other people who came before this committee to present to us.

1600

**Mr. Gonsalves:** I understand that. I understand that this is the process of the way bills are made into law. But what I'm saying is that you're informing me that prior to the bill coming out you consulted 4,000. Thank you for that information.

**The Chair:** Unless there are other questions, we thank you for your presentation.

#### NORTH BAY HEALTH COALITION

**The Chair:** I believe we are going to go to the 4:30 meeting, which is a teleconference. I believe that we already have on the line the North Bay Health Coalition: Mickey King, the chair, and Tony Morabito, the chair of the mental health division. Good afternoon. You can start your presentation any time. You have 15 minutes for the presentation and for potential questions and answers.

**Mr. Tony Morabito:** First of all, let me congratulate you on pronouncing my name right. My name is Tony Morabito and I'm grateful for being given this opportunity to speak to the committee today. I have many roles in health care in Ontario: as a family member, an advocate for health services and a union representative. All of these roles bring me here today.

I am the president of OPSEU Local 636. We are the workers of the former North Bay Psychiatric Hospital, now the Northeast Mental Health Centre. There are approximately 600 members in our local and we provide an array of health care services. I am also the chair of the mental health division of OPSEU. This division of OPSEU is unique, as we have members and locals both from the broader public service, where you find most hospitals and community agencies, and the Ontario public service, where the two remaining provincial psychiatric hospitals remain. At the Northeast Mental Health Centre, I work as a leisure life skills instructor. I work on a forensic unit, where I support the patients or clients of the program in meeting their work and leisure goals. I have many concerns on how the proposed legislation, Bill 36, will impact on the members of my local, on the health care providers in general and on my clients, my family and me.

When we calculate overall health care spending, Canada ranks second to the United States, due to large parts of the system that are presently being privately delivered. When private health care is calculated, Canada spends 10.7% of GDP on health, still well below the 16% the United States is forecast to spend in 2006. However, it is a cautionary statistic, particularly when we consider that the LHINs legislation opens the door to further private, for-profit delivery of health care. The fastest-growing expenditures in health care are actually outside the medicare system altogether. If we want to make health care more sustainable, the logical conclusion would be to bring more of it into the publicly funded, not-for-profit domain.

The local health integration networks are being presented as the solution to many of the difficulties Ontario is experiencing within its health care system. In fact, Ontario's health system may not be so broken as to require such a massive and costly reorganization. The real cost drivers in the system are not addressed by this reorganization. For example, pharmaceutical costs made up 16.7% of the health expenditures in 2004. Drug costs are the fastest-growing expenditure in health care, yet pharmaceuticals are left out of this structure.

Ironically, the sector repeatedly targeted by the Minister of Health is the hospital sector. It is ironic because the hospital sector has been the star performer in Ontario's health care system. They have the shortest stays in Canada, an average of 6.6 days, down from eight days in the 1990s. Ontario hospitals treat more patients on an ambulatory basis than any others in Canada and they are the most cost-efficient. Ontario also has fewer hospital beds per capita than any other province. While funding for hospitals has exceeded the inflation rate, much of that funding has been targeted to specific initiatives. When core funding is distilled, in 2004-05, most hospitals received increases of 1% to 1.8%. According to an independent March 2004 report by the Hay Group, Ontario's hospitals are more efficient than others in Canada. The Hay Group report shows that Ontario hospitals have a lower potential for finding additional savings, a reminder of the efficiency measures already taken by Ontario hospitals.

**Ms. Mickey King:** Hello. I'm Mickey King. I'm also an employee of the Northeast Mental Health Care, formerly the North Bay Psych. I'm a vocational specialist, and I'm also chair of the North Bay Health Coalition. I'm here today for many reasons, but the main reason is that I'm one of the people who actually works in the system that we already have. I see the results of the cuts and I fear for what you're doing. If you could walk a mile in the shoes of the people we work with, maybe you'd understand that this isn't such a good idea.

While the local health integration networks have been touted as a solution to the integration problems within the system, key parts of the system remain outside the model. Physicians are left outside the system, despite their role as gatekeepers. Ambulance is left out, despite problems interfacing with hospitals. Public health is left out,

despite the lessons learned from SARS. Hospital labs are in; private labs are out. Psychiatric hospitals run directly by the ministry will be out; divested ones will be in.

The cleaving of the health care system in fact creates more disconnects with certain sectors, like mental health, than presently exist. I count myself fortunate that I have a family physician, but for how long? My clients are not so fortunate. Those who do not have a family doctor use the walk-in clinics, emergency rooms and, when all else fails, a physician contracted by the mental health services for in-patients. They have no chart, no consistency, no preventive health care. By leaving physicians out of the LHINs, the needs of a very vulnerable group of users of the health care system are not being met.

Commercial interests reduce sharing of best practices. By going to a purchase provider model, like the CCACs, there will be incentive not to share best practices given to facilities within a sector that may face competition. My fear is that the integrated services that are common in mental health will be carved off.

Outpatient support teams, such as ACTTs, case managements and intensive community treatments, will no longer be able to provide the range of services that they now do. Will the interests of cost-efficiency mean that these teams will not have dedicated rec specialists, voc specialists, trained professionals who support, educate, mentor and hand-hold when necessary? That's what I do every day, my job.

The emphasis on making the system more sustainable suggests the public are about to pay a price for this so-called sustainability. The often cited example is of a number of hospitals transferring cataract surgeries to a single factory-style clinic, yet when it is suggested that other services could follow the same route, the government surprisingly calls its critics fearmongers.

Under fiscal pressure from the government, the LHINs could very well rationalize many health services under the integration plans, forcing patients to travel hundreds of kilometres for services they presently receive in their local communities. While this may be efficient from a delivery standpoint, it is not efficient from a user standpoint. Who pays for flights, hotels, time off work, to assist patients to travel to distant cities for treatment? For those who cannot afford these substantial expenses, are we creating a two-tier system? What is the difference between charging user fees and creating conditions whereby access to health care is dependent on sustainable personal expense.

The clients that I support cannot afford to travel outside of their home community for treatment. Just because they have a serious and persistent mental illness, that doesn't exclude them from suffering from other health issues. Actually, they are more likely to suffer from other health issues. The medications often lead to weight gain, increase in type 2 diabetes, high cholesterol, heart conditions and other health concerns related to obesity. Many of the medications that are used to control the active symptoms of their mental illness need to have kidney and liver functions closely monitored monthly. They will need access to specialists in their lives, and if that access

is not in their home community, who will get them to and from appointments? Who will provide the after-procedure support? The family physician? Don't forget, they don't have one, because you can't get them one. Over a number of years, the former North Bay Psychiatric Hospital has been actively recruiting psychiatrists and many more professional disciplines, but with little or no success.

Permanent instability: Across Ontario health care, users are likely to experience more and more service transfers under the LHINs. The LHINs are not a one-time restructuring, but rather, a process for continued amalgamations, transfers and even the winding up of certain services. This is permanent instability within our system. While there is some limited protection for workers under the Public Sector Labour Relations Transition Act, which Bill 36 proposes to amend, it is cold comfort to those who will be forced to choose between their community and their job. Workers are not always as portable as the government would like to believe. Two-income families are often faced with a dilemma when the workplace for one is suddenly shifted to a location hundreds of kilometres away. In mental health we have been down this road, and having lived it, we can tell you it's not pleasant.

#### 1610

North Bay Psychiatric Hospital was divested in 2005, with another tier-2 divestment coming in 2006—maybe even tier-3, we've heard from our management. Yes, we had a choice when we were divested, but if we didn't accept the employment with the receiving hospital, then we were unemployed. Some choice. It doesn't take a rocket scientist.

With the recent media attention on the divestment of ACTT teams in southwestern Ontario from St. Joe's regional mental health centre, the former London Psych and St. Thomas Psych, to the community agencies in the Windsor area, our members are scared. Do they have to do this again: accept job offers from employers they never wanted to work for or face unemployment? With this legislation they don't even have the rights they did the first time they were sold off, or, in a polite way to say it, divested.

The impact on the client has never been fully explored. Fortunately, most of them kept the same providers. However, the providers who did their jobs changed and some of the supports and services that were previously available to our clients and their families changed. There is no more patient counsel or family resources on the site of the centre.

I'm aware that the hospital is facing challenges in recruiting all the professionals it would like. I fail to see how this legislation would be of assistance with this challenge. Who wants to come and work in health care in Ontario when you have no guarantee of employment or working conditions?

We cannot understand why non-clinical services are being targeted by the government. Under section 33 of the bill, dietary and building maintenance are inherent parts of the health care system. Other health systems

have made these services the focus of privatization and restraint, creating more hospital-borne infections and increasing the likelihood of the transmission of viruses in the health care environment. It is another case where the government's idea of integration is contrary to the good functioning of the health system.

In the hospital I work in, the non-clinical staff are just as important as the clinical staff. Our non-clinical staff are highly trained and absolutely necessary. The clients rely on them to assist in keeping them safe. I rely on them to keep me safe. They interact with patients on the floor in a way that is difficult for clinical staff to really see what is going on. I'm seeking a definition of non-clinical services. Is it dietary, maintenance and house-keeping? Is it the staff educational department? Is it the secretarial pool that types notes and letters, clinical notes and psychiatric notes? Is it the practice leaders who support our work or the managers who don't directly look after clients? All of these services are essential to the client's care team and to the health care workers who provide care to the client.

If the McGuinty government truly wants to devolve decision-making to the community, why would it not set up elected boards like school boards?

Lacking in the LHINs legislation is any real HR strategy. While the PSLRTA rules do provide a forum for unions to battle out representation issues, the whole process is going to create retention and recruitment problems. Human resources plans need to be negotiated and include layoff as a last resort, measures to avoid layoff, voluntary exit options, early retirement options, pension bridging and retaining options. A transitional fund should be put into place and a health service training and adjustment panel should be convened.

I do have suggestions on what is needed for a health care system, and they are:

Front-line workers and unions need to be consulted in the development of LHINs.

Health care needs to be fully portable and equitable so that everyone in Ontario has access to the same minimal level of services, no matter where they live.

LHINs must comply with the Canada Health Act and the Romanow commission and their role should be to provide planning advice to the Ministry of Health.

The health care sector must not be compromised for for-profit services.

No competitive bidding on health care should be permitted in any LHIN.

No further fragmentation of services but consolidation to improve services.

**The Chair:** Ms. King, can you conclude, please?

**Ms. King:** Okay. The LHINs must be accountable to the citizens and the minister.

Successor rights need to be restored to all members who work in this field, especially the Ontario public service.

Front-line staff, their bargaining agent and collective agreements must follow the work in any restructuring, transfer or sale of business.

Employment stability: No layoffs and a mandatory, comparable job offer.

Seniority needs to be recognized, seniority needs to be dovetailed and voluntary exit options are necessary.

Employees' rights under the Ontario Labour Relations Act, the Employment Standards Act and pay equity will remain intact.

Human resources plans for affected workers must be negotiated with health care unions.

You need to think about what you're doing to the people who work in your community, in your province, and the people who receive the services.

**The Chair:** Thank you very much for both your presentations. There is no time for questions. We thank you very much for your presentation. Bye-bye.

There is only one other presentation left; that's the 4:45. We called them. I'm told that they are on their way, but they're not here yet. It should be any moment. That's the Association for Healthcare Philanthropy. My suggestion is that we hang around here. The moment they come, we'll hear them and that will be all. There have been a few cancellations today, as you can see from your list. Do we all agree? Thank you.

*The committee recessed from 1616 to 1630.*

#### ASSOCIATION FOR HEALTHCARE PHILANTHROPY

**The Chair:** We will start the next presentation; I believe it's Pearl Veenema. Would you please have a seat? You can start whenever you're ready. Your presentation is the last one for the day. We are happy that you're here. Thank you for coming half an hour earlier to assist us.

**Ms. Pearl Veenema:** It was fortuitous that I was just down the street and able to do so.

First, I'd like to introduce myself as the chair-elect of the Association for Healthcare Philanthropy, or AHP. I would also like to introduce Alex Maltas. Alex is with Fraser Milner Casgrain. Being an international organization, and given the context of the bill, we wanted to be properly informed and therefore have been working with Mr. Maltas.

AHP Canada is part of an international organization of health care fundraising executives and health care institutions that is dedicated solely to the advancement of health care through philanthropy. Our association represents 390 health care charities nationwide—that's in Canada—the majority of which are in Ontario. We very much appreciate the opportunity to make some remarks and to share some of the issues with respect to this bill, and we thank you for that opportunity.

There are specifically two aspects of the bill that we would like to address. One relates to section 30, which allows the minister or a local health integration network, or LHIN, to order a health service provider to transfer charitable property it holds. The second relates to subsection 50(11), which amends a subsection of the Public Hospitals Act to allow the minister, by regulation, to

require hospital foundations to provide financial reports and returns to the LHINs.

As mentioned earlier, section 30 allows the minister or LHIN to make an order directing a health service provider to transfer charitable property that it holds to a transferee. We believe that donors play an important role in health care today, and that charitable gifts are most vital to our organizations. Donors do make their contributions, and today are choosing very carefully, given the number and growth of charities across the country, the areas they would like to support.

AHP Canada is deeply concerned that giving the minister or LHINs the power to transfer charitable gifts donated from one organization to another directly contradicts the fundamental right of donors to determine where their donations are directed. We are concerned that the provisions of the bill do not allow donors or health care providers to have input to, or perhaps be privy to, consultations regarding transfers of charitable property. We believe that this function is perhaps best left to the courts. The courts currently have jurisdiction to transfer charitable property in circumstances where it is no longer possible for the terms of the original donation to be fully discharged. We also believe that the courts are well placed to perform this function, because they do so from an impartial point of view, have expertise in making such decisions and, importantly, allow stakeholders to offer input as to when or how charitable property may be transferred.

We're very much concerned that this section may discourage donations to health care providers and organizations. Gifts, as you know, are often based on a desire to make a difference at the hospital of a donor's choice. If donors feel that the minister or the LHIN could perhaps set aside their original charitable intention and move their philanthropic gift to another facility or program, donors may choose to direct their charitable contributions to non-health-care-related organizations, a decision that will not benefit but perhaps hurt our health care system by removing an important source of funding that institutions rely on.

AHP Canada proposes that section 30 be deleted from the bill and that decisions regarding the transfer of charitable property be left to the courts.

Subsection 50(11) amends subsection 32(4) of the Public Hospitals Act, allowing the minister, by regulation, to require hospital subsidiaries and foundations to provide financial reports and returns to LHINs. We understand that the minister previously enacted regulations under this section in 1996. AHP's understanding is that at that time hospital foundations and other health care organizations expressed concern over the legal validity of these regulations. Concerns were also expressed regarding the possibility that financial information obtained from hospital foundations might be used to reduce the operational funding the institutions receive from the government, and perhaps that there would be an expectation that hospital foundations cover the shortfall.

We understand that in 1998, after discussions and negotiations with all parties involved, the minister

decided it was best to revoke the regulations. We also understand that the minister agreed not to enact any further regulations. So it leaves us uncertain today as to why Bill 36 purports to broaden the scope of a provision that has really not been in use for the past eight years and that it was previously agreed not be used, and we are actually seeking clarification on the purpose and intent of these amendments.

I'd also like to say that this is not a concern from an accountability point of view. Foundations do file their public financial statements, and these are widely available through the T3010s we are all required to file. So this isn't about accountability or the lack of it, but really to address why and to ask for clarification on this, concerned that at this particular time, as our institutions depend so much on philanthropy, there may be some negative consequences.

Lastly, we share the concerns that were expressed in 1996 regarding the requirement of financial disclosure. Particularly, at this time, AHP is concerned that our hospital foundations are being called on to provide significant support for research programs and capital projects, and clearly don't wish—and we know you share that concern—that at any time that source of additional and generous public funding not be available for these key projects.

AHP proposes that the reference to “hospital foundation” be removed from Bill 36 and from subsection 32(4) of the Public Hospitals Act.

We believe that a flourishing philanthropic community is in the best interests of our country. We want to continue to foster an environment where donors are encouraged to give to the health care organization of their choice. We want to ensure, as we know you do too, donors' comfort in knowing that their gifts will be directed to the purposes for which they gave them originally.

We certainly feel that charitable support is more and more critical to health care institutions. We know that, in particular, it is very critical to the research agenda for our province. In closing, on behalf of the Association of Healthcare Philanthropy, we know that you support and encourage charitable activity, and we are hoping that you would consider amendments deleting section 30 from Bill 36 and deleting the reference to “hospital foundations” from subsection 50(11) of Bill 36 and subsection 32(4) of the Public Hospitals Act.

**The Chair:** Thank you, Madame Veenema. There's about five minutes left. Ms. Wynne?

**Ms. Wynne:** Thank you very much for coming today. A couple of things: First, we have heard your second recommendation from a couple of organizations, so it's in the works in terms of a recommendation that has come to us. Have you been in conversation with the ministry about it? Have you been in any dialogue with the ministry or the minister's office about this?

**Ms. Veenema:** With respect specifically to the requirement on the filing?

**Ms. Wynne:** Yes, subsection 50(11).

**Ms. Veenema:** In fact, one of the things we did try to do first—it was just from a scheduling point of view—was meet with the Deputy Minister of Health who was involved back in the late 1990s for that clarification. Regrettably, scheduling did not permit, and we felt we could not lose the opportunity to make our concerns known to this committee on behalf of health care charities.

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**Ms. Wynne:** That's good to know. Thank you.

The second thing is, in section 30, this subsection (2)—I'm just going to read it. You've expressed a concern about the specified purpose that a donation may have been intended for. Subsection (2) says, "If a will, deed or other document by which a gift, trust, bequest, devise or grant mentioned in subsection (1) is made indicates that the property being transferred is to be used for a specified purpose, the transferee shall use it for the specified purpose." Can you comment on that section? Because that seems to put some of the protection that you're looking for in place.

**Ms. Veenema:** I guess there are two things. One that I briefly mentioned is how that happens. Having been part of a hospital and foundation merger most recently—Sunnybrook, Women's College and the Orthopaedic and Arthritic—and having had conversations with donors in particular—and I'll speak from the experience that I had the closest, the Orthopaedic and Arthritic: Although the musculoskeletal program continues as a priority program within Sunnybrook and Women's, the concern that the donors had as we approached them about the amalgamation and so on was what kind of guarantee they would have with respect to the use of and the original purpose of the gift that they gave. They wanted to be part of that dialogue. As it turns out, that certainly helped to facilitate donor comfort, but it took a substantial amount of time and process to be able to engage the donor community to feel a comfort level.

I won't go into other experiences related to that particular merger, but I will share another that may be familiar to members around this table, and that is related to the time that the Wellesley Hospital closed and programs and services were transferred to St. Michael's Hospital. A donor whose family had invested very significantly in the maternal program and built a brand new birthing facility—and then, of course, the institution over time was slated for decommissioning. That conversation became a real challenge for fundraisers, or that feeling that the donor has: that there isn't enough protection or respect for what was the original purpose of the gift.

**Ms. Wynne:** Can I ask one more question on that?

**The Chair:** Yes, of course.

**Ms. Wynne:** Do you think the bill should be silent, then, on that—because you're saying to delete that section altogether—or should we be amending it to set in place a process or a framework that would be more respectful?

**Ms. Veenema:** The key thought that we had was that there is due process for that; in the event that there is integration, it is not required to be in this particular bill.

**Ms. Wynne:** So that just puts everything into the courts, is what you're saying.

**Mr. Alexandre Maltas:** I think a sensible compromise on this specific issue is that perhaps the minister or a LHIN could seek judicial approval before property was transferred. I think that our association, along with other stakeholders, would probably be interested in developing criteria or guidelines that would govern the acceptable conditions under which property could be transferred from one charity to another.

We understand the minister's concern here, the government's concern why this provision is in the legislation. But at the same time, we feel that by providing this judicial review of the minister's decision, or simply having the minister seek judicial approval, provides a greater level of comfort to donors that there is some judicial accountability, that there is a review of the decision. We think, going forward, that that could be a possible compromise between leaving everything to the courts and leaving things to the minister. We think that could be a possible compromise.

**Ms. Wynne:** Thank you.

**The Chair:** Before I recognize Mr. Arnott, did I understand you correctly that you feel comfortable with the courts making the decision? Because the courts in the past have ruled in favour of the donors. Is that a fair conclusion?

**Ms. Veenema:** The impartial view, in our opinion, looks at what the original intent of the gift is and can act as a trust on behalf of the donor as there is consideration for the organizations that would perhaps be beneficiaries or recipients of those gifts.

**The Chair:** I was involved in a case, and that's exactly what happened: the court ruled in favour of the donors because they felt that their intent should stay the same. As long as the intent is still the same, even if there is a change, it cannot change significantly to affect the original intent of the donations. The court ruled in favour of the donor in a public situation.

**Ms. Veenema:** My experience has been, having been through a foundation merger, that with conversation and consultation there is the opportunity to talk; that, in the event that you couldn't 100% follow the intent or the original intent, it's done in the spirit of the gift.

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

**Mr. Arnott:** Thank you very much for your presentation. When these hearings commenced this afternoon at 1 o'clock, we heard from the Council of Academic Hospitals of Ontario. They expressed concern about this provision in Bill 36 which gives the minister the power to require hospital foundations to provide financial reports to LHINs and asking for clarification and amendment.

I expressed my reservations about that particular section of the bill and suggested my explanation as to why the minister was seeking this power and my concern about it. In response, the chief government whip, the

member for Brant, said I was completely out to lunch, essentially, and was overstating the case dramatically.

Unfortunately he's not here at the moment to hear your presentation, because I think you've again expressed the concern very clearly. The government has acknowledged they're aware of the concern. Now the litmus test is what's going to happen with the amendments. There's an opportunity for us to amend this bill, as you well know. I can't commit our party to an amendment at this point in time, but certainly my own position is that this needs to be clarified. On behalf of the Progressive Conservative Party, we understand the concern. I hope that we will see the government members, when the bill finally does come back for clause-by-clause, support the kinds of amendments you need to clarify this issue to your satisfaction, in the interests of all the hospitals in Ontario and all the hospital foundations and their supporters.

**Ms. Veenema:** We very much appreciate that. Also, we're very much looking forward to the upcoming budget and the elimination of capital gains. We know our donors are going to be looking for that, and those who

are waiting to see, to make a very significant investment in health.

**The Chair:** That's another topic, Ms. Veenema. I understand from the government whip that she will try to arrange—

**Ms. Wynne:** Yes. If you're still interested in meeting with ministry officials, we can try to make that happen.

**Ms. Veenema:** Thank you.

**The Chair:** The clause-by-clause will take place on the 15th, so there is that space. The 15th of this month, right?

*Interjection.*

**The Chair:** February 13. I'm sorry. If you can meet prior to that date, February 13, I think there will be plenty of opportunity to look into what you're raising and try to deal with it, if possible.

We thank you for your presentation. We thank all of you for being here today.

We'll resume tomorrow at 9 o'clock, same place. Have a nice day.

*The committee adjourned at 1648.*







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