ISSN 1710-9477

Legislative Assembly
of Ontario

Second Session, 38th Parliament

Assemblée législative
de l'Ontario

Deuxième session, 38e législature

Official Report of Debates (Hansard)

Wednesday 8 February 2006

Journal des débats (Hansard)

Mercredi 8 février 2006

Standing committee on social policy

Comité permanent de la politique sociale

Local Health System Integration Act, 2006

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

Chair: Mario G. Racco
Clerk: Anne Stokes

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Hansard Reporting and Interpretation Services
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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

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

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Wednesday 8 February 2006

Mercredi 8 février 2006

The committee met at 0902 in committee room 151.

LOCAL HEALTH SYSTEM INTEGRATION ACT, 2006

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

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

The Chair (Mr. Mario G. Racco): Good morning and welcome to our final deputation day on Bill 36.

ENVIRONMENTAL HEALTH CLINIC, SUNNYBROOK AND WOMEN'S COLLEGE HEALTH SCIENCES CENTRE

The Chair: The first deputation for the morning is from the Environmental Health Clinic; Dr. Alison Bested. There are 15 minutes for your deputation and potential questions.

Dr. Alison Bested: Good morning, Mr. Chair and committee members. My name is Dr. Alison Bested. I'm one of the physicians working part-time with the Environmental Health Clinic at the Women's College Ambulatory Care Centre, which I will refer to as Women's College in the future. I am here at the request of the clinic's patient consumer advisers Ms. Eleanor Johnston, representing the Environmental Hypersensitivity Association of Ontario to my right, and also Ms. Audrey MacKenzie, representing the Myalgic Encephalomyelitis Association of Ontario. She sends her regrets; she's ill today.

Thank you for allowing us the opportunity to voice concerns about how the introduction of Bill 36 will negatively impact upon the Environmental Health Clinic and other innovative provincial ministry programs since they are left out of the LHIN model.

We represent the 1.5% of the people of Ontario who suffer from chronic fatigue syndrome or myalgic encephalomyelitis, multiple chemical sensitivities and fibromyalgia. How many of the committee members had heard about these very common illnesses before the presentation today?

The Chair: At least two—three.

Dr. Bested: Very good. Enclosed is background information about the Environmental Health Clinic, since this innovative provincial clinic is probably unknown to you. Following the presentation I will answer any questions the committee may have.

I hope to make clear to you today how the Environmental Health Clinic is left out of the LHIN model, why it is vitally important for the patients in Ontario to be included in the new model of health care for the province, and how this may be accomplished.

In response to emerging patient needs in the 1980s and the recommendations of the 1985 Thomson Report on Environmental Hypersensitivity Disorders, the Ministry of Health pioneered the creation of the Environmental Health Clinic in 1996. It is currently located in the Women's College Ambulatory Care Centre of Sunnybrook and Women's College Health Sciences Centre. The Environmental Health Clinic and Environmental Hypersensitivity Research Unit, which is the research arm of the clinic, resulted from the vision of the Ministry of Health as examples of unique, successful incubator programs in the province. They have been pioneers in developing ground-breaking research, diagnostic criteria, education, health promotion, clinical coping tools and strategies to help patients cope with these emerging, complex, chronic, environmentally linked illnesses.

The Environmental Health Clinic is the only government-funded, academically affiliated, provincially mandated clinic in the province providing limited services for the adults with myalgic encephalomyelitis or chronic fatigue syndrome, multiple chemical sensitivity, fibromyalgia and other environmentally linked illnesses. These are newly recognized chronic, complex medical conditions that can result in patients becoming severely disabled and unable to sustain any permanent employment. These conditions are extremely common, and early treatment can prevent worsening of symptoms and avoid huge costs to the Ontario health care system and to medical disabilities programs such as ODSP as a result of patients becoming severely disabled. The prevalence of ME, MCS, and FM equals diabetes at approximately 1% to 2% of the people of Ontario, according to the 2000-01 Canadian Community Health Survey.

The impact of the environment on health from ongoing low-grade environmental exposures such as second-hand smoke or indoor air pollution is just now being appreciated. Yet the Environmental Health Clinic, the only provincial program, has less than one full-time

doctor-equivalent on staff for the entire province of Ontario. The clinic has an eight-month waiting list, and is only funded for one comprehensive assessment and one follow-up visit, for adults only.

The Environmental Health Clinic provides a limited patient-centred consultation service for a vulnerable group of patients, mostly women, many of whom have a high burden of ill health and high use of the health care system, including CCAC or home care, because of their high degree of functional impairment and disability. They have considerable difficulty accessing appropriate health care, social systems and accommodation in housing, schools and workplaces if they can still continue to work.

The EHC needs to respond to patients' needs in Ontario, and become an ongoing treatment clinic that provides ongoing care for both adults and children in an academic research setting.

These illnesses are called the orphaned illnesses. These patients are so complex and time-consuming that they often can't get a family doctor in Ontario. Nobody wants these patients in the current 10-minute booking schedule model; they simply take up too much time. As a result, these patients are denied access to health care in Ontario on an ongoing basis due to having newly, poorly understood illnesses that are very complex and take up a lot of physicians' time.

The clinic's integrative model is very different from the usual hospital or primary health care model. A part-time team of physicians, family physicians and medical specialists, myself, a psychologist, nurse educator-coordinator, a program manager and community outreach coordinator together, in a team approach, try to help support this community of patients in the rapidly emerging area of environmental health.

The Environmental Health Clinic also does population health and health promotion in collaboration with community partners, extensive networking, educational seminars, plus educating medical students, nursing students and physicians in the community, both family physicians and specialists.

Currently, the clinic is a provincially funded clinic with base funding that has not been increased, even with the cost of living, since 1998. As a result, the clinic has had more to do as it has become established, and has had less money to do its work, as the hospital employees have had raises with no mechanism to increase its budget.

Women's College, contending with other pressing local priorities and budget pressures, decided that the clinic was not a priority program and did not ask the ministry for additional funding, despite the need for the expansion to meet the needs of patients in Ontario.

In the spring of 2004, in response to ongoing budget problems in health care, and after doing a strategic focusing, Women's College decided that the Environmental Health Clinic did not fit Women's College's strategic plan and the Environmental Health Clinic should find a new home.

The Environmental Health Clinic is a provincially mandated clinic that is overseen by a hospital that is mandated to deal with local health issues. Does this sound familiar? This creates an obvious conflict in outlook of patient care.

The ministry stated to patient stakeholders that the Environmental Health Clinic must continue and be transferred with its base funding to follow the program wherever it relocates. Searching for a new home has been difficult and worrisome to staff, patients and community partners.

At this point, we are guardedly hopeful that when Women's College is de-linked from Sunnybrook at the beginning of April, the incoming board will review its decision and agree to help keep the Environmental Health Clinic as part of their new focus. We will still need to address the need for increased funding for the Environmental Health Clinic and the need for at least one in-patient hospital bed in Ontario for patients who are critically ill and need to be hospitalized. There are currently no hospital beds for these patients with special needs.

The LHIN process, which is dividing the province into 14 LHINs, has a number of potential benefits, including opportunities to improve local co-operation, networking and possible integration of services in some areas. The LHINs will be expected to set priorities based on local needs and opportunities, and to stretch limited resources to best meet those pressing local needs and local priorities. Competition for priority status and funding will be quite intense.

Provincially mandated and funded programs such as the Environmental Health Clinic are totally left out in this LHIN model currently. There's no mechanism to expand the clinic to all 14 LHINs, and it is impossible to stretch one physician-equivalent and supportive staff into 14 different locations. In the LHIN model, there is no mechanism to fund the Environmental Health Clinic on an ongoing basis or to review the funding on a periodic basis. The Environmental Health Clinic budget is overseen by a hospital with a local mandate, which to date has viewed the clinic, with its provincial mandate, as a low priority.

0910

The new health care system needs to include provisions so that innovative ideas can be incubated, even if they are not local priorities or priorities within a hospital's strategic plan. The system cannot leave to chance that one of the 14 LHINs would do all necessary pioneering work in such areas. Equity requires that information about such innovative ideas and access to promising treatments are available to all patients throughout the province.

The idea that tobacco smoke could cause cancer in cigarette smokers and also that second-hand smoke could cause cancer took many years to gain acceptance. Had the innovative idea that smoking was related to cancer been studied earlier and appropriate action taken, the health and quality of life of many people would have been greatly improved, lives could have been saved and thousands and millions of health care dollars saved.

In a LHIN that includes an innovative program such as the Environmental Health Clinic that serves the whole province, local, financial or other pressures could result in a decision to eliminate the program and its benefits for the entire province. Such a decision would leave a major gap in services to patients province-wide, without the rest of the province having any input. Clearly, this would not be in the best public interest: Scarce expertise and years of pioneering work would be lost.

In our opinion, Bill 36 should include some explicit provisions that the ministry retain the responsibility and powers, duties or functions to supervise and support work in some innovative areas such as the Environmental Health Clinic. This would still be in keeping with the ministry's wanting to devolve many powers to the LHINs while asserting itself at a more strategic level.

Our experiences illustrate why such provisions would be important to the survival of some innovative programs. When the joint clinical and research program was being established, a ministry-appointed clinical research advisory board or CRAB provided advice to the program and recommendations to the ministry, including funding. It was this board that recommended that Women's College hospital be asked to be this provincially mandated clinic's host hospital. Later, when the advisory board was discontinued, all contact with the ministry was through Women's College. The clinic has a six- to eight-month waiting list. The program urgently needs to be expanded to provide ongoing treatment to adults and to offer services to children with these complex and often disabling illnesses. It needs funding for an in-patient hospital care setting.

The Environmental Health Clinic's provincially mandated focus on these emerging illnesses, its unusual integration of both patient-centred and population health activities, and its collapsing budget that has effectively decreased since 1998 are reasons for the minister to re-establish a ministry-appointed clinical research advisory board or CRAB to provide advice to the program and recommendations on issues, including funding, to the ministry. This type of mechanism would ensure that innovative programs such as the Environmental Health Clinic will continue in the Ontario health care system as it is reformed and modernized.

Innovation is important to this government. As Premier McGuinty, who is Minister of Research and Innovation, has said, "If you want a culture of innovation, we need to support the risk-takers, the dreamers and the doers," such as the Environmental Health Clinic. The ministry needs to have mechanisms to ensure that innovative or incubator programs such as the Environmental Health Clinic can develop and not be inadvertently squeezed out by processes being used to modernize the Ontario health care system.

We urge you to include in Bill 36 new, specific provisions to support innovative programs such as the Environmental Health Clinic.

The Chair: Thank you for your presentation. There is about a minute left; 30 seconds each.

Mr. Ted Arnott (Waterloo–Wellington): Thanks very much for your presentation. We really appreciate your advice and suggestions. We have heard from a number of what I would characterize as highly specialized health service organizations like yours over the past few days. I think there is a sense of anxiety out there as to whether these services will continue after the passage of Bill 36 and its implementation. Are you confident that the important services to patients, and to your broader clientele in the medical field too, will continue after the passage of Bill 36 and its implementation?

Dr. Bested: We have been reassured that the clinic's current budget will be continued. The concern is that in its current state, it's inadequate: Children are not being treated, and there is no in-patient hospital care for this patient population, which represents 1% to 2% of people in Ontario.

Mr. Arnott: There's a lot more to do, and you've made a good case.

The Chair: Ms. Wynne.

Ms. Kathleen O. Wynne (Don Valley West): Thank you very much for being here; I've met with Ms. Johnston.

In the conversation you're having right now with Women's College, have you also talked to them about the women's health institute and the possibilities of a linkage there?

Secondly, you're saying that you wouldn't like to see the Environmental Health Clinic's mandate included in the accountability agreement of one LHIN but you'd rather see the ministry retain control. Is that accurate? It could be that an accountability agreement for the area that Women's College is in could have as part of its mandate to encourage and make sure that this work continues to be done, but that's not what you're looking for.

Dr. Bested: I think there is currently nothing specific in Bill 36, so this needs to be addressed. Because this is a new, emerging area, it would be preferable, until there is enough available support that it be present in each LHIN, that it be part of a global, overall perspective of the ministry. I think that would be the preferable position, because there's only one physician equivalent for all of Ontario.

Ms. Wynne: Right. So when patients come to the clinic, they see a practitioner.

Dr. Bested: Right. They have a one-time assessment and a one-time follow-up. There's no ongoing treatment.

Ms. Wynne: Okay. Thank you very much.

The Chair: Thank you for your presentation.

UNION OF ONTARIO INDIANS
ANISHINABEK HEALTH COMMISSION

The Chair: The next presentation is from the Union of Ontario Indians: John Beaucage, grand council chief of the Anishinabek Nation. Good morning.

Grand Council Chief John Beaucage: I'd like to say good morning to everybody and then just make a special

acknowledgement to Norm Miller, the MPP for my riding, and also to Peter Fonseca, who is on the Smoke-Free Ontario committee, on which I sit as well.

I'd like to begin this joint presentation of the Union of Ontario Indians and the Anishinabek Health Commission with my co-presenter, Elder Merle Assance-Beedie of the Beausoleil First Nation. Elder Assance-Beedie will open our discussion with a teaching of the Anishinabek mno-maadzowin, or living a good way of life. That's what we as Anishinabe people are acknowledging: the responsibilities and obligations of health and healing. Is that okay with the committee members?

Ms. Merle Assance-Beedie: Good morning. I'm going to begin by doing what we do as a tradition, and that is to give you my spirit name, which is Waas No De Kwe, which means "northern lights woman." I'm of the Otter Clan, and Christian Island is my home community.

It's a pleasure to be here and to address such an important gathering. I would like to give you a very brief history of the mno-maadzowin, which translates to "a good life," that our people enjoyed prior to contact. In fact, one of the famous research institutions in Canada acknowledges that the First Nations enjoyed an ideal way of life prior to contact. As a teaching, I'm going to give you a short history of what mno-maadzowin is.

From zero to six, a child is given what is called the good life. From the time he's zero to six or seven, he's given a tremendous amount of nurturing and love and care, which prepares him for the rest of his life. We haven't enjoyed that kind of experience for some time, and that is what we would like back for our children.

The next stage of life is the fast life stage, where the children can't do anything fast enough. Those of you who have children and grandchildren will recognize that from the time a child is seven until they're 14, they can't move fast enough. We're always chasing after them, and everything they do is so fast.

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The seven-stages-of-life teaching takes an entire seven days to recall and to pass on to our students and our people. So I'll just leave it at that. I'll just give you the two stages of life briefly, because it takes an entire day to go through each stage. The seven-stages-of-life teaching was part of our ongoing, day-by-day way of doing things prior to contact, and we knew no other way of life than the one we were born into, which was a good life. Everything that we did was with respect, with truth, with humility, with love, with kindness—-all of those seven grandfather teachings that each and every one of us hear about daily from First Nations people. We live that way of life.

Any word in our language that has the word "win" at the end of it translates to "a way of life." Mndenamowin is "respect," so we had a respectful way of life. Sahgidiwin, "love" in our lives; devwayowin, "truth," came from the heart, and that was a way of life prior to contact.

Mno-maadzowin means a returning to that kind of life for us. That is what we are working towards. I wish I could explain all of this in our own language to you so you could understand, because in our language those teachings are so powerful, and they are so good. I will leave it at that. I thank you very much for listening.

The Chair: Thank you.

Grand Council Chief Beaucage: Chi meegwetch, Elder Merle.

My name is John Beaucage. I'm the Grand Council Chief of the Anishinabek Nation. I have been entrusted to serve the 43 chiefs of the Ojibway, Pottawatomi, Odawa, Delaware, Chippewa, Algonquin and Mississauga First Nations that comprise the Anishinabek Nation.

The Anishinabek Nation incorporated the Union of Ontario Indians as its secretariat in 1949. The UOI is a political advocate for 43 member First Nations across Ontario. The Union of Ontario Indians is the oldest political organization in Ontario and can trace its roots back to the Confederacy of Three Fires, which existed long before European contact. The peoples of the Anishinabek Nation have governed themselves in this manner as a confederacy since pre-contact times. Today, the Union of Ontario Indians receives its political mandate from the 43 chiefs at regular and special assemblies of the Anishinabek Grand Council.

The Anishinabek territory encompasses the entire Great Lakes area from the eastern watershed of Lake Huron, near present-day Ottawa and Peterborough, westward to the northwest shores of Lake Superior and through the south-central part of Ontario to the base of Lake Huron at Sarnia and London. The Anishinabek Nation territory is the traditional homeland of 35% of the total First Nation population in Ontario today. I would like to acknowledge the Mississaugas of New Credit, on whose territory we stand before you today.

We have a number of significant concerns with regard to Bill 36, the Local Health Systems Integration Act. Certainly, on the surface, the integration and reorganization of health services is a positive and sensible approach for Ontario. It will place significant decision-making power for health at the community level and ensure that local service delivery remains in local hands. It will go a long way to ensure that health resources and funding meet community priorities. However, there are some very real concerns that First Nation programs and services and the unique needs of First Nations communities will be lost in this process.

Yesterday, we met with the Minister of Health and Long-Term Care, and he proposed some amendments to Bill 36 that will speak to the engagement of First Nation communities at the LHINs level. Further, he spoke to a new government-to-government process with First Nations in Ontario. The minister and the legislation speak of community engagement, but will that engagement truly meet the needs of our people? Will these amendments meet the minimum standards for consultation and accommodation of First Nations' interests that have been brought down by the Supreme Court of Canada? Do these amendments respect the aboriginal, treaty and inherent rights of First Nations people in Ontario?

The Supreme Court of Canada has consistently upheld First Nations' right to be consulted and accommodated on issues involving aboriginal rights in the following case law:

—R. v. Sparrow, 1990;

—Delgamuukw v. British Columbia, 1997;

—Haida Nation v. British Columbia, 2004;

—Taku River Tlingit First Nation v. British Columbia, 2004; and

—Mikisew Cree First Nation v. Canada, 2005.

The Supreme Court has decisively confirmed the duty to consult and even accommodate aboriginal communities even where aboriginal rights and title are not yet proven.

The government of Ontario has yet to adequately respond to the Supreme Court decisions, nor has it developed a position on consultation and accommodation in dealing with aboriginal people in Ontario. The Supreme Court advocates a jointly developed process of consultation in dealing with aboriginal issues. To proceed with implementation of the Local Health Systems Integration Act without adherence to Supreme Court requirements could leave this legislation open to a constitutional challenge based on Haida Nation-Taku River.

We recommend the following: that the committee on social policy recommend that a comprehensive review occur to study the legal duty to consult First Nations, including requirements under the Supreme Court and how they may affect the Local Health Systems Integration Act; that the government of Ontario and Ontario First Nations jointly develop policies and guidelines to meet the minimum requirement for consultation and accommodation of First Nations' interests.

It is our hope that the provincial government will work with First Nations in a truly collaborative manner to fulfill their constitutional duties to consult with and accommodate First Nations, in order to improve the health status of First Nations members residing both on and away from their reserves.

Here are a few more questions:

—Will the 14 LHINs across Ontario understand our First Nation communities and health concerns?

—Will they understand traditional healing or the healing value of the sweat lodge or naturopathic remedies?

—Do they understand why the suicide rate is almost six times higher in First Nation communities than in mainstream society?

—Do they understand the concept of intergenerational impacts of residential school abuse?

—Have they lived in an overcrowded home, infested with mould and undrinkable water?

These are questions that cannot be answered by the Legislature or by this committee. Only First Nations have the answers to these questions, and First Nations need to be a significant part of the solution to improve First Nations' health in Ontario. After all, that is the goal of this bill: to put decision-making power for health at the community level. First Nations expect nothing less.

I'm here to urge you to protect First Nations' interests in the Ontario health care system. We need to ensure that our priorities continue to be decided upon by our governments, not a board of non-native people who cannot possibly understand our people, our health concerns or our way of life.

In recommending a legislative exemption and non-derogation clause, our intent is to provide the Ontario Legislative Assembly with an opportunity to maintain the status quo for First Nations health programs and services and prevent a further decline in the health status of First Nations. The acceptance of the First Nations' amendments to the legislation—exemption and non-derogation—provides the standing committee on social policy with an opportunity to make a significant first step in addressing the constitutional requirements of the Supreme Court.

The Union of Ontario Indians recommends that the committee on social policy and the Minister of Health and Long-Term Care adopt the amendments and proposed language set out in our written submission as a means to address First Nation concerns, protect First Nation programs and services and First Nation governments' right to constitutionally protected duty and process. This includes a new definition for First Nation programs and services and a substantive provision that these First Nation programs and services shall not be transferred to LHINs.

The health services integration act and other unilaterally developed legislation do little to respect First Nations' constitutionally protected aboriginal and treaty rights and the inherent right to self-government. A process needs to be developed in Ontario that respects First Nations' rights and puts control of First Nations' health interests in the hands of First Nations people.

The Union of Ontario Indians is advocating for the establishment of an Ontario First Nations health accord. This will offer the Ministry of Health and Long-Term Care a single-window approach to dealing with First Nation governments in the area of health, and is consistent with the government's policy of a new approach to aboriginal affairs in Ontario.

0930

It is our submission that these amendments, coupled with the establishment of a First Nations-Ontario health accord, would provide for the orderly harmonization of First Nations, provincial and federal laws and policies, programs and services in the short- and long-term future.

We recommend that the Minister of Health and Long-Term Care, on behalf of the government of Ontario; the grand council chief, on behalf of the Anishinabek Nation; and the Ontario regional chief, on behalf of the Chiefs of Ontario, explore the development of a First Nations-Ontario health accord that will govern First Nations and province of Ontario relationships regarding health in Ontario.

The First Nations-Ontario health accord would establish a foundation of mutual respect and understanding to foster and facilitate a continued evolution of the naturally

evolving collaboration of First Nations and mainstream health systems. In this way, the individual LHINs would come to know some of the unique health needs and aspirations of First Nations members residing on and away from their reserves in a comprehensive and orderly manner with the assistance of, and in conjunction with, First Nations governments and health technicians.

With regard to a First Nations-Ontario health accord, our objectives include but are not limited to the following: to safeguard our aboriginal and treaty rights and the government's fiduciary obligations to provide health services to First Nations; to enhance the health status of our First Nations citizens residing on First Nations lands or away from First Nations lands; to implement the Kelowna accord and the aboriginal health blueprint in a mutually agreeable way that respects First Nation rights; to govern First Nations and province of Ontario relationships regarding health in Ontario, including health integration initiatives and the aboriginal healing and wellness strategy; and to develop mutually acceptable health integration models between provincial health providers, Health Canada initiatives and First Nations health providers.

I will forgo any questions until the conclusion of the Anishinabek Health Commission's oral presentation to this committee.

The Chair: Please go ahead. We still have 13 minutes.

Ms. Deb Pegahmagabow: Greetings and warmest hellos to our grand chief, to the chairperson and members of the standing committee on social policy, and to our elders and others present. I would like, as well, to acknowledge and thank the Mississaugas of New Credit. This is their historical land base on which we conduct business today. I say meegwetch.

My name is Deborah Pegahmagabow. My spirit name is Enaatigohkwe, which is Maple Tree Woman. As it was explained to me, I am someone who brings new ideas or reformats old ideas into newer ways of thinking. I think my role as a band member of the Wasauksing First Nation and currently the health director for the Union of Ontario Indians health program allows me a bit of latitude in sort of taking those ideas and reshaping and helping our communities to reformat health and integration in terms of how they see it.

I come today, as have our Grand Chief John Beaucage and our Elder Merle Assance-Beedie, to bring forth issues on behalf of the Anishinabek Health Commission, the technical and political steering committee of the Union of Ontario Indians, who on a very regular basis advise me and the political department of the Union of Ontario Indians on options that can be taken in the overall strategic direction of attainment of mno-maadzowin, the good way of life, for the collective interests of our 43 First Nations in our territory.

You may ask yourself, how does the Union of Ontario Indians and the Anishinabek Health Commission accomplish this task? To be honest, it is not easy. As noted by our grand council chief and our elder, we have 43 First Nations that stretch from Thunder Bay in the northwest to the Ottawa Valley in the east and across to Sarnia in the southwest. It is accomplished through the Anishinabek Health Commission, a body that meets on a regular basis to foster capacity building at the First Nation level, advocate on behalf of the Anishinabek Nation on health issues, facilitate co-operative planning and establish an effective and open communication process, all of which are dependent upon the Union of Ontario Indians health secretariat to organize and facilitate in addition to providing transfer payment processing of financial allocations to both the seven area health boards and the 43 First Nations' programming dollars via memorandums of agreement. The tasks are varied and concerns are raised on the application of another bureaucracy to oversee and attempt to enhance mno-maadzowin in a process where we were definitely not an active partner.

Both political and technical representatives through a network of seven area health boards meet to provide an effective process for the overall vision of mno-maadzowin for our people and our territory. A strategic planning process took place last fall that brought both the Union of Ontario Indians board of directors and the Anishinabek Health Commission together for the first time since the forming of the commission. Presentations by health staff on external and internal challenges to both organizations were discussed, and elaborations made on current activities of all the files were made available both verbally and in written format.

One of the files identified in December 2004 as needing attention by way of coupling both political and technical lobbying was local health integration networks. Preliminary issues brought to the attention to our leadership since December 2004 were the sweeping community consultations that did not offer a forum for First Nations to be consulted with, an item brought directly to the two system leads on the LHINs at one of the larger consultation forums in Toronto, where a short overview of the implications for such movement would result in many voiced concerns on the lack of consultation and follow-up on commitments made to renew and strengthen relations between all levels of government, inclusive of our First Nations government.

I have with me a listing of all our First Nations and where they may fall within the LHIN structure. It is unclear to me just how many LHINs our political office and the health program may have to intervene with on behalf of First Nations. We are looking at First Nations in LHINs 1, 2, 8, 9, 11, 12, 13 and 14; 12 and 8 are questionable. This a major concern. We have the political leadership; we have established programs and services within our territory. The Union of Ontario Indians health program serves as the secretariat to our 43 First Nations. The question still remains: Why wasn't our leadership engaged in government-to-government planning on legislation that is going to have major impacts on our people's current and future programs and services?

I meet with you today as the technical representative for all of our 43 First Nations. They are concerned and they are worried. As indicated by the Anishinabek Health

Commission, the commission supports the recommendations provided within the final report of the First Nations task force on LHINs and further provides support to the Anishinabek leadership in the establishment of a federal-provincial-First Nations health accord.

Meegwetch. Thank you for this opportunity to speak.

The Chair: We have a couple of minutes each. I'll start with Ms. Wynne.

Ms. Wynne: Thank you for being here. We have heard a number of times the concerns about previous consultation, but there has been an ongoing conversation with the minister. I don't know what amendments have been brought forward—we haven't seen all the amendments yet—but I'm encouraged that you were able to meet with the minister yesterday, Mr. Beaucage.

You asked about whether the amendments that have been brought forward will meet the needs of the First Nations. I guess I would put the question back to you: Without going into the details, are you optimistic that the recommendations that have come out of the consultations between you and the minister are going to go some way to address your concerns?

Grand Council Chief Beaucage: We haven't seen the amendments as well. There was a promise by the minister that they would go a long way to accommodating our concerns, but until we see them, we really don't know. I guess one of the big things is that we are concerned that we are going to be lost within the LHINs. There are special concerns that we have with regard to our health issues out there, and we have been asked if we can take a spot on the LHIN board, but then we have one person versus maybe 12 or 13 others. In the long and the short of it, we could be lost unless we have special performance indicators within the LHINs.

Ms. Wynne: Okay. One of my concerns is that up until now things haven't gone so well, from your telling of it, and my hope would be that as we try to push the organization and the planning for health care into more local areas, there would be more chance that the voices that need to be heard would be heard. I understand the government-to-government dialogue; I have heard that a number of times, and I understand that. If I thought that things had gone really well up until now, I might be more worried. But because they haven't—you haven't been satisfied that your needs have been met—my hope is that, moving forward, things will be better. So we'll wait and see the amendments. I appreciate your taking part and coming to talk to us today.

Grand Council Chief Beaucage: Thank you very much. I guess it's one of these things that can't get any worse. I'm hoping that it's not like that.

Ms. Wynne: It's going to get better.

Grand Council Chief Beaucage: I'm hoping it is going to get better, yes, and I'm hoping that the amendments will be more positive. As soon as we see them, we will be commenting directly to the minister about that.

0940

The Chair: Mr. Miller.

Mr. Norm Miller (Parry Sound–Muskoka): Thank you, and welcome to Queen's Park, Grand Chief, and Stephanie and Merle. Thank you for educating us about Mno-maadzowin, the good way of life. I did want to get on the record that you had requested a meeting; I think it was at Garden River First Nation. I did write to the Chair requesting that.

Grand Council Chief Beaucage: Thank you very much.

Mr. Miller: Obviously, the wish was not granted.

Grand Council Chief Beaucage: Correct.

Mr. Miller: You note in your presentation that the spirit of the new approach to aboriginal affairs has not been met and that the consultation has not been the sort of consultation that you would like to see in terms of government-to-government consultation. In a perfect world, what sort of process would you like to see in terms of consultation between First Nations and the government when the government is implementing a bill like Bill 36?

Grand Council Chief Beaucage: I guess, in a perfect world, there would be recognition that we have governments as well and, when there are new legislative initiatives being proposed, that there be a process to engage us, not as non-governmental organizations or interest groups but, because these affect our communities and our governments, that we get together on how the consultation will proceed and will ensure that that particular legislation, which affects us very strongly, is worked to make sure that our concerns are looked after in a good way; that it's not a top-down approach but it's a collaborative approach to make sure that the concerns are looked after. We've made the recommendation to a number of ministers that we would be prepared to be involved in it.

Mr. Miller: So more involved from the beginning, basically—

Grand Council Chief Beaucage: Yes.

Mr. Miller: —in setting out how the consultation—because from the government's perspective, this is consultation, basically; so planning the consultation as well.

Just one other quick question, because I probably don't have much time: What sort of representation would you like to see on the various LHIN boards from First Nations?

Grand Council Chief Beaucage: Well, our proposal of a First Nations health accord actually is keeping within the LHINs but separating our health issues just to one side of it. It's like a parallel approach. There would be indicators, performance standards, accountability measures and so on that would be parallel but somewhat separate, so that the dollars that flow specifically to aboriginal health are kept within the First Nations health accord and the parallel approach is kept all the way along. It's not separate from LHINs but it's adding to the LHINs.

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

Mr. Michael Prue (Beaches–East York): Thank you very much. Let me preface my question with an apology: I'm a late substitution. I got called: "You'd better get down here fast." I understand my colleague Ms. Martel is

not well today. I missed some of your deputation and for that I apologize.

I just want to get back to the government-to-government. This is something I hold very dear, and I think that for too many centuries politicians and general society have not dealt with the aboriginal peoples as a government. What can we do to strengthen that around the LHINs and everything else? What can we do to strengthen that so that politicians always know that they're dealing with another level of government? We know that with the mayors, we know that with the municipalities, we know that with the federal government, and I don't understand why we don't know that when it comes to aboriginal communities.

Grand Council Chief Beaucage: I think a great deal of it has to do with attitude on the part of all governments, federal and provincial.

I was at an official opening about a year ago where a very prominent member of the provincial government talked about the three levels of government in Ontario, and they were federal, provincial and municipal. If you went back to some of the high school courses, you'd know that municipal is not a level of government; it comes under the provincial government under a ministry. That third level of government is the First Nations. I think attitude and education would go a long way to making sure that that is there. I think that when the Constitution is reopened at some time in the future there will be a constitutional amendment that will make sure First Nation governments are the third level of government. It was proposed at Meech Lake, which didn't go, as we all know.

So I think it's attitude first and foremost, that we have to be involved early on in any process.

Mr. Prue: This year is also the 100th anniversary, I believe, of Treaty 9.

Grand Council Chief Beaucage: Yes.

Mr. Prue: That was a signature between the federal government, the provincial government and all of those people in northern Ontario. I don't believe that that treaty has ever really been enacted or upheld, in much the same way. It seems to have been ignored. Now I'm seeing the LHINs, and I'm seeing the same thing. Is that a pretty good parallel, or am I mistaken?

Grand Council Chief Beaucage: I think that's a fairly good parallel and, just to emphasize that point, our treaty Robinson-Huron/Robinson-Superior is 156 years old. Many of the provisions under that treaty, including resource-sharing, have yet to be met.

The Chair: I want to not only thank you for the presentation but to make sure that you appreciate that your request to Mr. Miller was evaluated, and a number of others, because Mr. Miller did send me the request.

Unfortunately, there were a number of requests and there was a perception within the subcommittee that we could address, as much as possible, issues through the process we went through. I'm happy to see you here today and to hear you in person. We also today and yesterday have been hearing people through teleconferencing, which is quite convenient. We can see each other. They can see us there and we can see them here, but the message is clear. That's why, unfortunately, we did not visit your location. But we thank you for coming today.

Grand Council Chief Beaucage: Thank you very much to everybody.

OLDER PERSONS' MENTAL HEALTH AND ADDICTIONS NETWORK OF ONTARIO

The Chair: The next presentation is from the Older Persons' Mental Health and Addictions Network of Ontario; Randi Fine, executive director. Good morning, Madam Fine. You can start any time you're ready, please.

Ms. Randi Fine: Thank you very much for allowing us to present. I'm really delighted to be here. Our presentation and our requests, in fact, are fairly simple, although the issues that we're concerned about are actually very complex. I'm going to try to talk fast and get a lot of information in fairly quickly. My passion often runs over. I represent the network, not only as the executive director but as a family member of someone who lived with bipolar disorder and manic depression for many years. So these are issues close to my heart and to those of many of the people of Ontario.

What you have been given is a detailed background package. I don't expect you to read the whole thing this minute, although I hope you will at some time take the time to do that. I won't read the whole thing to you either.

You also have a brochure in front of you. That's part of our depression and aging campaign. Just so you know, a display unit like this with those pamphlets in French and/or English is going to be distributed through every family doctor's office across Ontario, because we are very concerned about depression and aging, as we are about the other issues in mental health and addictions and aging. So that's part of our campaign.

First of all, what is the Older Persons' Mental Health and Addictions Network? We do call it by an acronym, which is almost as difficult: OPMHAN. OPMHAN was founded in 2000 provincially across the sectors of aging, mental health and addictions, bringing people together who work in the field, who live with the conditions, who are concerned about the growing numbers and the growing concerns of people living with those kinds of concerns.

We define "older" not by age but by the way people live their lives. As some of you may be aware, when you deal with chronic illness of any kind, certainly mental illness and with addiction issues, you may age as if you are chronologically older than you typically are. Someone who has dealt with any kind of life stress may have issues at an earlier age. We avoid the number, but we are talking about people growing older. We are talking about aging.

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In terms of mental health, to clarify, we're talking across the very broadest spectrum of mental health. We're talking about those people who are growing older with conditions like schizophrenia, manic-depressive disorder, bipolar disorder, but also those people who have conditions that are related to aging. Of course in mental health we also include the dementias, but frankly, because there has been a fair amount of attention given to dementia, we are focusing more on conditions like depression. You may be interested to know that depression—and we have very poor relevant Canadian statistics—affects at least 20% of older adults, and probably, unfortunately, much closer to 40%. We also know that much of that is preventable.

In terms of addictions, we are talking about substance use and substance misuse, drugs that are by prescription, alternatives, all of those kinds of things; also alcohol, smoking and problem gambling. We're very broad-ranging.

We are concerned about issues from the one end of prevention and health promotion right through to end-of-life issues. We're really kind of all-in-one.

We have been addressing huge unmet needs. Just trying to figure out what those needs are for the last five or six years has kept us extremely busy. Our membership now, which is free, open to all committed individuals—so people have to sign off—includes 60 provincial organizations, 300 individuals who have themselves experienced the mental health or addiction system and, through e-mail and quarterly meetings and a provincial conference etc., we reach 4,000 individuals on a regular basis.

Our funding, at this point, is project-based; we don't neatly fit any silos—I'm sure you've heard that word before. We are really crosscutting. We don't have any funding from theprovincial government, and we don't have any funding from the federal government either. What we do have, which I really do want to acknowledge, is support from the Ontario Seniors' Secretariat, which in fact is housing our office and providing clerical support and teleconferencing and frankly allowing us to survive. We recently received a major grant from the Ontario Trillium Foundation, which is funding us for three years and providing core support until we can find a way to sustain ourselves further.

What we do: We focus on raising awareness about older adults' mental health and addictions. We look at supports for family members and older adults themselves in terms of groups, counselling, physical activities, all of those issues. The only direct service, if you like, that we provide is training and education. We provide training across the province and have done numerous presentations. We do direct training for front-line staff, personal support workers, people in contact with older adults and public education almost where anybody will listen to us.

We have been involved, and I think this is really pertinent, in the development of regional affiliates. Because we are fairly new, because we came about at the time that the LHINs legislation was being discussed, we have been developing our regional affiliates in line with the 14 LHIN regions. We have six already developed, and hopefully we'll have all 14 in place within the next six months.

Part of our focus, of course, is giving voice to key messages. That's what we're here to do today.

Why are we here? Why do we care? Why do we hope that you care? Pretty simply, we know that people are living longer, that more older people in the community means that there will be more people at risk of and coping with mental illness and addictions, and more families in communities affected. I won't ask for a show of hands, but if I did, it's likely that most people in this room would know someone who has been affected by a mental illness or addiction. That means that most of us have been affected as well. Mental illness and addictions are devastating life conditions. People growing older with mental illness and addictions have all the problems that people do growing older anyway, as well as the additional issues. And so they face the stigma of the disease as well as ageism and the complexities of aging.

There is little relevant Canadian or provincial data available. In part because of the stigma, very little research has been done. For example, research on antidepressants has almost never been done using older people as the original research subjects. But we know that, for planning purposes, in Ontario we have very little data beyond the long-term-care sector, and that's a concern for us.

The good news is that prevention and early intervention can make a huge difference. Medical treatment, in combination with strong community and social supports, works. We know that we are at a crossroads here. There are more older people. There is more mental illness and addiction. Some of that could be prevented; much of it could be made easier to cope with. But we need to focus on these issues in a way that our network—and, to date, only our network—has really brought people across the sectors together to do. So we know there's a huge need to raise awareness and educate older adults, family members, service providers and the public, and that's our role.

If we can add to the LHINs discussion, we ask you to recognize that older adults' mental health and addictions are a prime example of the complex interactions between factors that contribute to health and impact on the broader community. We want to ensure that our unique population is represented, as everybody does. We want to point out that mental health and addictions themselves, as well as seniors' issues, as you probably are all aware, were listed among the top priority issues at the consultations for every LHIN across the province. We know that these need some attention.

We want to recognize the recommendations of the Elder Health Elder Care Coalition. Some of you heard their presentation, I believe, on Monday. OPMHAN is a steering committee member of that organization and was a signatory to those recommendations. But we want to

take them a little further. Out of concern that Bill 36 does not include clear provisions for community input—and I know we're not the only ones who have mentioned this—we want to recommend that a seniors' advisory committee be struck for each LHIN and for the ministry, but also that these committees include representation from those concerned about older adults' mental health and addictions. It's really important that within those committees, which we really hope will come about, there be special representation around these issues which affect so many older adults.

We want to make sure that Bill 36 is amended to include explicit parameters for public engagement in the development of the ministry's strategic plan. I heard my colleagues in previous presentations talking about a role for provincial organizations. Certainly, we're not the only ones concerned about this. We, as you've heard, are very concerned about making sure that there is regional representation, but we also know that there are cross-cutting issues across the province. We'd like to see a role for provincial organizations in these discussions, and that, as we say, our regional partners be included at the LHIN level.

I'm going to leave it there, asking you to remember that we are the only inclusive, cross-sectoral provincial network devoted uniquely to improving the system of care for older adults struggling with mental health and addiction issues, and to offer OPMHAN's assistance as the LHINs move forward to include this important population.

The Chair: Thank you. Less than 30 seconds each. Mr. Miller.

Mr. Miller: So your primary concern is that there aren't clear provisions for community input, and your main recommendation is that a seniors' advisory committee be struck?

Ms. Fine: Including some representation around older adults' mental health and addictions.

The Chair: Thank you. Mr. Prue.

Ms. Fine: Was that the question?

The Chair: It was 30 seconds.

Mr. Prue: Your organization is a fairly new one, and you said you have been able to develop it along the lines of what you anticipate the LHINs are going to be. I'm just worried that if you go too far and the LHINs are changed—because that's what I've been reading in the newspaper, anyway—how difficult will it be for you to change that at this time?

Ms. Fine: The truth is, we have representation and interest really throughout the province. To be politically astute, we have attempted to set up the regions within these 14 boundaries, but they are really local to their own communities and integral to those communities.

The Chair: Thank you. Mr. Fonseca.

Mr. Peter Fonseca (Mississauga East): Thank you, Randi. It's nice to see you again. It's great that you are already developing a model that mimics the LHINs. What you've done bringing so many organizations together is exactly what the LHINs want to do, to create that integration.

At many of our consultations where we've had—well, the numbers differ—between 4,000 and 6,000 people who have made presentations, many of them have been seniors groups around community support services, home care, and really bringing forward all the barriers and the lack of integration. Do you feel that the LHINs will be able to make patient care a lot easier for the patients so that they don't jump through hoops, especially seniors who find it difficult, at times, to navigate the system?

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Ms. Fine: We hope so. I have to say that I've been around since the days of one-stop shopping, which was a long time ago. So, yes, we hope so. I think there is a possibility that that can happen. I think it's going to be very important to make sure that the voices of people are heard, that seniors' voices themselves are heard, that the issues are crosscutting: recognition that seniors don't live in a box, that they live across all the boxes. So integration and collaboration can work, and we're hopeful.

The Chair: Mr. Miller, do you still have a question, a quick one?

Mr. Miller: Certainly, just in terms of the size of the LHINs. They're called local health integration networks, but the concern is that they're less local than what we currently have, especially if you get into the northeast and the northwest, where they're immense geographic areas. My own riding, Parry Sound, and James Bay are in the same LHIN, to give some idea of the size. How do you address that to make sure it is local?

Ms. Fine: It's as difficult for us as it is for—"us" I have to explain to you. We have a staff of one; you're looking at it. It's difficult for anybody to be anywhere. We use communication tools much as everybody else does. We use e-mail; we use telecommunication. We attempt to meet the needs and to find out what the needs are, recognizing that within one LHIN area or within one province or within one region there are going to be many, many differences and that each LHIN is going to have to address all kinds of differences, including those of geographic disparity.

Mr. Miller: So your advice is a committee for each LHIN—a seniors' advisory committee?

Ms. Fine: With the understanding of that particular LHIN's issues.

The Chair: Thank you very much for your presentation.

ONTARIO FEDERATION OF INDIAN FRIENDSHIP CENTRES

The Chair: The next presentation is from the Ontario Federation of Indian Friendship Centres; Sylvia Maracle, executive director, and a friend. Good morning.

Ms. Sylvia Maracle: Good morning.

The Chair: You can start any time you're ready, please.

Ms. Maracle: We did deliver a written submission to your clerk a day or so ago. I'm hoping they're going out.

Let me begin first with greetings. I'll be very interested in how you translate this in the minutes.

Remarks in Mohawk.

It means, "Greetings, and I hope great peace is with you."

The Chair: Thank you.

Ms. Maracle: I am Sylvia Maracle. I'm the executive director of the Ontario Federation of Indian Friendship Centres. On behalf of the federation, I'd like to thank the committee for the opportunity to make this submission today. I'd also like to thank the Mississaugas of New Credit, who are allies and who are our gracious hosts, in both the collective sense of the federation and this committee, and of course this building.

The Ontario Federation of Indian Friendship Centres is a provincial organization and umbrella group of 27 friendship centres, whose job it is to provide culturally relevant services in the areas of health, justice, employment, children's programming and youth, and we do that in what we refer to euphemistically as a status-blind process. It doesn't matter to us if you're a First Nations member, Metis, non-status or if you are indigenous from somewhere else. We've been doing that for 37 years in Ontario.

In our proposal, we detailed a number of health conditions. I think it's sufficient to say that the aboriginal community, irrespective of their residency in Ontario, suffers poor health, and all of the strategic approaches that are supposed to be tied up in Bill 36 have not resulted in improving those health situations. So I'm here today to voice a number of concerns on behalf of the federation.

You've already heard that there is rarely unanimity in the aboriginal community. It's very rare that First Nations, Metis women and men, on-territory and urban, agree. Oddly enough, Bill 36 has given us the opportunity to agree. We can rally around the notion that we have not been consulted, that we have not been recognized in terms of a rights-based agenda, that there are somehow amendments that are going to appease us that have never been shown to us; they're just promises. In fact, that's no different from the behaviour that has arrived with the tabling of this legislation that the committee is considering. We're going to be asked to be happy with an 11th-hour decision that someone has made in our best interests without talking to us, once again.

I brought for the committee—and we were perhaps bold, but we actually sent this to your committee clerk. This is the aboriginal health policy in Ontario. It was created in 1994. Perhaps you didn't personally sit in the Legislature, but all of the governments represented on this committee have had an opportunity to either concur, to amend or to get rid of it, and none of you have. So it existed and it exists today. The issues around representation, around engagement, around community involvement, around ownership, around the kind of health processes that have to be amended have been spelled out consistently since then. As far as I know, none of the organizations or governments who were involved in creating it have said, "We're withdrawing our support." It's still on the table.

We will also argue that the proposed bill that looks at integrating and improving health coordination issues will, in the end, create exactly the kind of competition that we've experienced so far: a competition over resources, in the broadest sense of money or human resources, and unfortunately around power and control: Who has the right to make what decision? Those competitions have failed us in every instance, not only in this province but across the country. But we're talking about this province.

We've also recognized that, over time, our experience has been that certain groups of health care professionals, social planning people and others will use aboriginal issues as a way to get resources: "Oh, we've got this many aboriginal people in our area; this many aboriginal people live in this city. They experience poor health, and we really need something." The fact of the matter is, the numbers play the game, but they don't result in services and programs for our communities. The very few that we've been able to develop over the last number of years are now subject to being sliced so small in this bill that it's potentially a further step by Ontario as a collective to—not only does it not acknowledge our rights, but it doesn't acknowledge and give credence to the organizations and the infrastructures that we've created to provide services; in this instance, health services.

We tried as a federation to participate in the consultations, as did other urban aboriginal people, and we found that we were relegated to diversity groups. It doesn't feel very good in the diversity area. Immigrants and refugees, visible minorities, the gay/lesbian/bisexual/transgendered community, sometimes francophones, sometimes women and certainly the disabled all get lumped into the diversity group, and somehow we're expected to rise to the top, when in fact we probably are representative of all of that. So we tried in consultations—and there were flip charts going around the room in Toronto, London, Ottawa and other places, and all of a sudden "aboriginal" would appear. Then the facilitator would go through the process of discussing LHINs, and eventually they needed to prioritize, to take all these down. They got boiled down and boiled down until we didn't get on a sheet.

We wrote to the minister on a number of occasions. He has not met with us; he hasn't even answered our letters. So when you talk about feeling that maybe there's some light at the end of the tunnel in terms of amendments, we don't know that to be true.

You have to understand that aboriginal health care needs are much more acute than the general public's, that there are all kinds of barriers. Sometimes, we don't like to talk about those barriers. We go through trends where we say the word "racist" and where we don't; we try to get along. The fact of the matter is, in urban areas, people do not feel compelled to go to mainstream services. They would rather just get sicker and let health situations that could be addressed become more chronic, because

they're not prepared. They're not prepared with what they see, what they feel, what they face when they arrive, so they avoid them.

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We have evolved over a period of time some community engagement, some community approaches. We're having conversations with the political leadership to try to create a better process. LHINs undermine that whole discussion, and they undermine it in a number of ways. We were party to a conference recently about the creation of aboriginal health care professionals and how we need doctors, physiotherapists, speech therapists, audiologists and all kinds of things. We participated in a conference with First Nations and our other colleagues called Vision 2020. We're talking about being able to start addressing that curve by 2020. LHINs will very much be driven by professionals who are recognized today, not in a future sense. They're not going to wait for us to catch up. The competition is going to continue, and the issues that were raised and the health policy around the lack of sensitivity of this other layer of bureaucracy now are simply going to be reinforced.

We've written and we've written and we've written. None of them has been answered. We haven't had a meeting. We haven't even been invited to a meeting with the minister. So certainly, as the Ontario Federation of Indian Friendship Centres, we don't feel consulted, and we are not sure there's a light at the end of the tunnel.

The new approach that the Ontario government created with respect to aboriginal affairs recognized the importance of programs delivered by aboriginal service providers in Ontario. That approach also recognized a greater involvement of aboriginal people in matters that directly affected their communities. The new approach said it was going to foster genuine understanding between the province and aboriginal people to help clarify shared priorities. It's very difficult for us to believe, in terms of this legislative development and the relationship of LHINs that will evolve, that any of that is going to be true, that any of it can be realized.

In our document, we made two specific recommendations. This government has the capacity to exempt aboriginal people. You've already done it in the Tobacco Control Act, in the midwifery legislation and in the regulated health professions. So you already have a precedent. It can be done. There has been a will in previous governments to do so.

Our primary approach would be exemption, that aboriginal people, our services, our programs and health issues would be exempted. Whether that exemption follows the notion of a formal health accord, as the grand chief who spoke just before me has suggested, or whether it's a secretariat that's created to address health, as the Chiefs of Ontario talked about, I think it's possible to be creative about how it can be addressed.

I think if you cannot and will not look at an exemption that allows us to preserve our culturally appropriate services and programs, that looks at not micromanagement but macro issues and real planning with respect to aboriginal health, then you might look at the creation of a 15th LHIN, an aboriginal-specific LHIN. Again, it could be a secretariat, it could be managed by an accord, it could be struck however. But for us, in terms of what we've experienced, the bill that you're proposing, that you're considering, is not going to meet our needs.

Bill 36 needs to be changed. It needs either an exemption or a different way to engage us.

The Chair: Thank you. There is 30 seconds each. Mr. Prue, you are first, please.

Mr. Prue: I don't think any member—I know that not one single member was here in 1994 who is around the table today. I was just having a read of this. I think number 11 says it all. Number 11 says, "First Nation/aboriginal communities' control of health needs assessment, planning, design, development and delivery of community-based health programs and services is essential to improving aboriginal health. Aboriginal people will define and negotiate the level of their participation in the governance of health programs and services available to and accessed by their communities."

That's really what you're asking for today: something that was set out in a paper in 1994 and that you have not seen, but if you did see, would resolve the difficulties you have.

Ms. Maracle: Absolutely. The document lives and it survived. As I said, all of your parties were involved in forming government at one point. I don't understand why something that has already been supported, that an all-party committee can support, you can't.

The Chair: Ms. Wynne.

Ms. Wynne: Thank you very much for being here today. I wanted to ask you about the contact with the minister. If you could get us the details of the letters, I'd like to track down where those are and get you a response.

Ms. Maracle: I'd be happy to do that.

Ms. Wynne: Our understanding is that the minister has attempted to meet with the First Nations groups and have this discussion leading to the amendments, albeit they are not here on the table for any of us to see yet. If we could track down those letters, that would be great. If you could let me know—

Ms. Maracle: Sure.

The Chair: Mr. Miller.

Mr. Miller: I was going to bring up the point that Ms. Wynne just did, that the minister has not responded to your letters. I'm surprised that he hasn't either met with you or responded to your letters.

In terms of representation, one possible ideal solution is the creation of a 15th LHIN specifically for First Nation concerns.

Ms. Maracle: As a second option. Our first option would be the acknowledgement that aboriginal health issues fall outside of the LHINs discussion and we would have a full exemption. We have demonstrated three other pieces of legislation where that has occurred already. If there has to be an engagement in this process, then it really needs to be aboriginally distinct.

The Chair: Thank you very much for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1999

The Chair: The next presentation is from the Canadian Union of Public Employees, Local 1999; Joanne Wilson and Lorrie Boake. Ladies, you can have a seat, please. Whenever you're ready, you can start your presentation.

Ms. Joanne Wilson: I'm Joanne Wilson. I'm president of CUPE Local 1999, Lakeridge Health hospital. I'll give you a little history. We are a five-site merged hospital: Uxbridge, Port Perry, Bowmanville, Oshawa and Whitby. That happened in 1998. Since then—and this was done through the restructuring committee—the Uxbridge site has been sheared off and realigned with the Markham-Stouffville site. So now I am president of one local, with a subsector in Uxbridge. I represent approximately 1,350 health care workers ranging from nursing staff to clerical staff to service staff within Lakeridge Health and Uxbridge.

Thank you for allowing us to come today and present. I'd like to thank CUPE for helping with research on this as well. We're here today about the centralization, consolidation and privatization that is proposed in Bill 36. Once again, the Ontario government wants to transform health care and certain social services, this time by creating local health integration networks. Fourteen LHINs have been established in the past year to plan, integrate and fund hospitals, nursing homes, homes for the aged, home care, addiction, child treatment, community support and mental health services. Ambulances and public services have been excluded initially, along with privatized labs and clinics. The government has allowed doctors to escape the LHINs. If passed, Bill 36 will give governments and the LHINs new and troubling powers to restructure public health care and social services.

I must make an admission here: I forgot to introduce Lorrie Boake. She's a vice-president of our local. I'm a little nervous, as people have probably seen already.

The Chair: You don't have to be; all friendly faces here.

Ms. Wilson: Okay, I'll continue on. I'm not going to read this document verbatim. There are certain issues in this document that Lorrie and myself are going to address that we feel very strongly about. One of them is centralization.

The LHINs are local in name only. We're LHIN 9. Our geographic area goes from Toronto up to Haliburton, Algonquin Park, Campbellford hospital—all those huge areas. If we look at the definition of "local" in the dictionary, that's not what LHINs are; they're not a local service at all. Our concern is that, with this huge geographic area, how will our local community have any say in the services that are provided within our community?

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I'll go into this. The LHINs are local in name only. The bill will grant little real power to local communities and providers to make decisions. Rather, it transfers control over local community-based providers to the ministry, the cabinet and to their agents, thereby centralizing, rather than localizing, control over health care in Ontario. The bill grants unprecedented authority to the Minister of Health and the cabinet to effectively control most public health care service providers and to completely restructure public health care delivery, including the power to turn delivery over to for-profit corporations.

The government describes the legislation as a made-in-Ontario solution that would give power to the local level. It distinguishes this reform from regionalization in other provinces, as LHINs will not directly deliver service. In fact, the government reform takes the worst aspects of health care regionalization in other provinces and combines them with the worst aspects of health care restructuring in England. It would create a new layer of bureaucracy that would be unaccountable to local communities, reduce provincial government accountability for the largest part of its budget and create a purchaser-provider split that will undermine health care and social services.

What follows is an outline of these problems. The LHIN covers vast and very diverse areas. The LHIN boundaries have been formed based on hospital referral patterns, overriding municipal, provincial and social boundaries. The proposed LHINs are not local; they are not based on communities and they do not represent community interests. As a result, they lack political coherence.

The definition of "local," like I said earlier, is "of or relating to a small city or town or district rather than a large area. Not broad or general. Not widespread." Our LHIN, LHIN 9, is the size of a small country, going from Toronto to the border of Algonquin Park. How can this be defined as local? It will be very difficult for people living in a LHIN to have a significant voice over the direction of that LHIN, even if the LHIN board wishes to listen.

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 the 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 the cabinet and may be removed at any time.

I have a huge concern about this. Where is our community's voice in who sits on our LHIN board for our local? This is our local community health care network. Where do we have a say in who is picked for these boards? These directors should be elected to these positions by the communities, not appointed by government. That's one of my huge concerns, because then there's no accountability to those who elect you. As you know, as representatives in Parliament, you're accountable to your constituents. How are these boards accountable to the community? That is a huge concern with me.

The 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. For example, hospital boards are not appointed by the provincial government. They have doggedly pointed out the need for better care in the communities, with significant success. The previous government attempted to cut hundreds of millions of dollars from local hospitals, but when local hospitals helped to point out to their communities the problems this created, the government reconsidered. The cuts were revised and the hospitals were allowed to continue to provide decent, if still underfunded, care.

This happened in my own community. Port Perry was one of our small, rural sites in this huge hospital setting. Port Perry was going to lose its maternity services in that hospital, and it was the community that got together, along with the doctors, and said, "This community needs those services." If not, they would have to drive to Oshawa to be provided with those services, because they've already lost those at our Bowmanville site, as well as at our Whitby site. The problem with this is that in the winter you're going through an area that, if it was like the other day with the snow, you might not get through to deliver your baby.

Again, in Ajax just a few weeks ago, there was a protest by 1,200 citizens about the closure of their pediatric and mother-baby care area, and that process has stopped there as well. These are community hospitals. They are based in the community, with the needs of the community in mind. When we do these huge local areas, that is lost.

Another point in the LHINs legislation with the LHIN boards being set up is that they are going to take all the flak for any decisions that are made, but in reality the decisions are being made by the Minister of Health and cabinet, because the LHIN board is totally accountable to the minister and to cabinet. They have to sign accountability agreements with them, as well as accountability agreements with the hospitals. But where is the accountability agreement with the communities? Where is the accountability back to the communities? That's my concern. It's flowing from the government down to the community, and any accountability should always go to the community first. That's where I see a lack in this bill. There should be accountability agreements signed with the community and not with the government.

Right now, we see hospitals having to sign accountability agreements with the government, and there are gag orders put on the hospitals for any of their funding changes. I sit on a fiscal advisory committee of our hospital, and we have been told what the budget cuts are. But we were also told at those meetings that we couldn't tell the public about any of those cuts because the hospital was under a gag order, and if they told the public about these cuts they were afraid they were going to lose the funding they might achieve from the government. This is wrong.

The public has a right to know what cuts are going to be introduced and what services are going to be affected in our hospitals. Making accountability agreements with the minister and cabinet, and then the hospitals having accountability agreements with the LHINs, is not the process that should be happening. The accountability should be to me as a taxpayer and to the public and the people who are in that LHIN. So the reverse needs to happen there. The gag orders that hospitals are being put under about their budgets need to stop. I as a citizen need to know what services may be taken out of my community and passed on to another hospital.

I'll give you an example. They talk about hip surgeries, knee surgeries and eye surgeries all having to be centralized and rationalized. Right now, they're performed in our general hospitals, and people have access to those hospitals. Someone in Campbellford only has to drive to Peterborough. If you make the one hospital in the LHIN that might be doing hip surgeries in Scarborough, that's a two-and-a-half-hour drive for that family. So if my mother has to be in that hospital and I live in Campbellford and my father no longer drives, how is he going to get there to see her?

I have experienced this myself. I had a child who, for two years, had to be in Sick Children's for chemo treatment. The impact on a family when that happens is devastating. First of all, the illness is devastating, and the travel is even harder. Now you're proposing this for the whole province? Until you're in the situation, you don't know how hard it is. I only had to travel from Oshawa to Toronto, but I had two small children left at home that I couldn't care for while I was travelling to Toronto.

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Take that and make it two and three hours for families having to travel for health care. What are you doing? This isn't improving our health care. What you're doing is making it harder on families, making it harder for women and families, because they are usually the health care givers for their elderly parents, their sick sisters and brothers and, a lot of times, their sick children.

This is a hardship that no one should have to undergo. What you're proposing with this bill is only going to make it harder for people in Ontario—sorry.

The Chair: That's fine.

Ms. Wilson: It may sound good; it's not.

Not only will families have to try to find the transportation, try to find the means to have people transported to these areas, but there's a cost incurred. The cost of travelling nowadays is not cheap, the cost of parking at any of these institutions is not cheap and the cost of an illness to a family is devastating. Add this on top of everything else, and what you're creating here is hardship for the people of Ontario.

I'm going to let Lorrie talk about the service cuts within the bill and the possible rationalization and privatization for profit of non-clinical services within the hospital.

The Chair: We do have your material, so could you just give a summary?

Ms. Lorrie Boake: Sure. We all know that there have already been cuts to hospitals. One of the biggest impacts has been to the support services cleaning the hospitals. With the cuts that have already occurred in health care funding, cleaning services in hospitals have been cut to a bare minimum. With this decrease in cleaning staff, there is an increased spread of the MROs: VRE, MRSA, ESBL, C. diff. and more.

With the competitive bidding and undercutting that will occur with services being contracted out to the private, for-profit sector, which we've already seen with the CCACs, profit and not infection control will be the driving force. The services will go to different companies, time after time, contract after contract.

We've seen the effects of SARS, and we know there will be great or greater challenges and possible pandemics out there. We should be focusing on preventing the spread of infection and increasing infection controls in the hospitals. Cleaning hospitals and health care institutions is not like cleaning a bank. The cost for trained health care cleaning staff is only a fraction of the cost of providing care to people, of increased lengths of stay and of increased drugs to treat MROs and other infections acquired because of the lack of cleaning.

The government plan is to regionalize hospital support services. With government support, with the HBS coming in, this organization would take approximately 1,000 employees out of hospitals and turn a significant portion of our work over to for-profit corporations. These are our health care dollars going to line the pockets of private companies rather than into health care. Like so much of the restructuring, these moves will have a major negative impact on hospital support workers, and they will not create seamless care for patients. Instead, they're going to create more employers bringing more for-profit corporations into health care.

In our own workplace, each hospital had a warehouse section for their stores department. Because we were merged, they have been eliminated. There is one now. Last year, there was a huge accident in Bowmanville, and the supplies they needed to treat that emergency had to be brought over in taxis. What happens now, when the warehouse is in Toronto? What will we do when we need those supplies in Bowmanville, in Cobourg? How will we get them there? It's not like GM. We can't shut down the line until the supplies get there.

The Chair: Thank you very much for your presentation.

Ms. Wilson: I'm sorry about getting so emotional, but this is something that the government needs to understand will affect people in Ontario hugely, not just the workers in hospitals and the possible job losses, but all of us as consumers of health care in Ontario. We have to look at not what is the cheapest way but at what is the best way to provide health care.

The Chair: Thank you. You certainly have a made very clear point and all of us appreciated your comments since they certainly affect you directly. I think we are here for that. The intention is to hear the arguments and suggested recommendations. I'm sure not only the opposition but also the government will be looking at changes. Your comments will be appreciated and shared with many other people.

INDEPENDENT FIRST NATIONS

The Chair: We'll move to the next presentation, from the Independent First Nations, Chief Paul Nadjiwan. Good morning, Chief. Please have a seat. Whenever you are ready, start your presentation.

Chief Paul Nadjiwan: I'd like to start off this morning by saying good morning to all the members of the standing committee. I want to thank you for extending an opportunity to the Independent First Nations to do a presentation here with regard to the LHINs and Bill 36.

I have provided some notes which we've left here. Since we drafted those notes, we've probably made a few little changes. I don't often read from a script, but I think, based on the time frame that we have here today, I will probably do that this morning. There aren't too many differences in what I have added to the paper that you have, but I'm sure that will all be recorded and that should work out.

My name is Chief R. Paul Nadjiwan from the Chippewas of Nawash unceded First Nation. I'm here to make a presentation to you today on behalf of 12 independent First Nations, which represent approximately one third of the total native population in Ontario. Geographically, these communities represent all of the social and economic constructs, from the largest First Nation to remote northern, fly-in communities.

The Independent First Nations come here to advocate for the transformation of LHINs as a health service mechanism that must address the health issues and needs of the independent First Nations.

There are a number of federal and provincial health initiatives geared toward First Nations, they've been implemented over the last 20 years. Some of them that have involved First Nation intervention and discussion are the Child and Family Services Act, 1990; the Midwifery Act, 1991; the Regulated Health Professions Act, 1991; the tobacco act of 1994 and the food and drugs act, natural health products regulation, 2004. Those are just some areas of legislation that First Nations have actively participated in and provided some guiding thoughts and values.

I guess the position that we find ourselves in is that when committees such as this choose to dialogue and entertain the suggestions and discussions that First Nations advocate, the purpose is always to improve something that is out there, something that will work better at the end of the trail down at the First Nation level. I would ask you to consider that many of these communities are isolated and the communities themselves don't see the types of integration and involvement and opportunities that you will often see in a large city like Toronto. So one has to really understand the factors that create the

challenges that First Nations face. More often than not, First Nations, because they're in this position, actively engage in a process of deconstruction and decompression. This is accomplished through our First Nation technicians and political representatives. This has become a fact of life in the First Nation community, and the LHIN bill, Bill 36, is a current example of policy that requires changes.

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It is well known that First Nations still face the poorest living conditions and routinely face boil-water advisories on a weekly basis. I see that in my own First Nation constantly. We can't even drink the tap water that we have, and it's treated. It's probably difficult to understand that, but it's something that is very real in many of our communities.

When we review our budgets, we typically find inappropriate and insufficient levels of resource allocation that fall short of fully supporting transportation to medical facilities and access to specialized health professionals.

One of the things that commonly happens to First Nations people is, when they go for a medical examination and it's discovered that they have, perhaps, diabetes or a heart problem or various other kinds of health-related illnesses, the doctors will prescribe name brand prescriptions, but when we get to the pharmacists, they're always replacing these things with generic brand drugs. Some of you may have seen that some of these drugs will always have, in capital letters, the acronym APO or GEN. You will often see that, and this is always in place of the name brand. What we know about name brands is that they do have a 20-year threshold for patent. Tylenol is a typical name brand product that has now been replaced with a generic fill-in, I guess. Some people find that when they ingest some of these generic products, there are side effects that exceed the name brand stuff. That's something that I think the health department ought to consider and look into.

The report itself identifies measurable outcomes that will only be achieved if proper planning, development and implementation of strategies are conducted with First Nations through meaningful participation. The Independent First Nations are genuinely concerned that the present LHIN model demonstrates an inferior process by which First Nations, at the community level, end up receiving a poorly designed delivery of health services. The Independent First Nations see the present LHIN model as ignoring the basic, fundamental delivery of health services at the First Nation level because, at the onset, it undermines the level of responsibility and jurisdiction that First Nations know they are capable of managing.

We know that for any health agenda to work, the Independent First Nations must be full and equal partners. In order for it to be an effective process, First Nations need to be involved, and this would include at the onset of policy development, in program planning, in the review stages and being part of all the demographic and geographical considerations found in these communities. The challenge for the crown is to ensure that legislative amendments flow with the traditional practices, legal obligations and the inherent and constitutional rights of First Nation citizens.

In order to effectively recognize existing First Nation governments and health administrative structures, Ontario must be true to the words that were written in a letter from Minister Pupatello of the Ministry of Community and Social Services to Grand Chief Stan Beardy, the chair of the Ontario Chiefs Committee on Health. She wrote, "Aboriginal health is a priority and the crown is committed to building positive relationships and productive partnerships."

The time has now arrived when the crown must engage in a renewed political agenda to establish bilateral relationships with First Nations citizens that work to achieve a network of health initiatives that serve the needs of First Nations citizens. The engagement of a bilateral process embraces unity at the forefront, whereby the crown and First Nations come to an agreement which recognizes the necessity to implement an operational work plan that facilitates well-defined administrative practices and resource-management contingencies.

Therefore, the bilateral process establishes a communication mechanism that objectively and holistically addresses the recommendations found in the report on the First Nations task force on LHINs dated November 2005. In this way, the bilateral process will achieve joint ownership and resolve the legal obligation and the duty to consult.

In closing, the Independent First Nations reiterate the significance of the report on the First Nations task force on LHINs dated November 2005, whereby the recommendations identified by the Independent First Nations echo an acceptable process by which legislative amendments to Bill 36 will facilitate the delivery of a health system mechanism that meets the special requirements of First Nations citizens.

On behalf of the Independent First Nations, I thank you for the opportunity to address the standing committee on social policy on Bill 36, the local health integration networks act.

The Chair: Thank you, Chief. Less than two minutes. Ms. Wynne, one minute.

Ms. Wynne: Thank you very much for being here this morning. I just wanted to clarify that you have been part of the dialogue with the Minister of Health on this issue.

Chief Nadjiwan: Yes.

Ms. Wynne: You've been involved, so the recommendations in that report are what he has before him and on which we're assuming the amendments will be based. So thank you very much for taking part in that dialogue and thank you for coming here today.

Chief Nadjiwan: Yes, and of course we remain available for any additional discussion or research material that may be required.

Ms. Wynne: Thank you.

The Chair: Mr. Prue.

Mr. Prue: Just a question so I can clarify here. The Chippewas of Nawash are primarily in the Manitoulin area and around?

Chief Nadjiwan: Just up on the Bruce Peninsula.

Mr. Prue: And you have been part of the process. How many other First Nations groups were part of the process, or did you meet independently? Did you meet one on one with the minister or did you meet in a group with other First Nations?

Chief Nadjiwan: It has been with a group.

Mr. Prue: How many First Nation groups were involved?

Chief Nadjiwan: I believe there was representation from the political and territorial organizations. So that would be perhaps a delegate from Treaty 9, Treaty 3, the Union of Ontario Indians, which I think did a presentation earlier, the Independent First Nations and the Association of Iroquois and Allied Indians. That would encompass most of the First Nation groups in Ontario.

The Chair: Thank you very much for your presentation.

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ARTHRITIS SOCIETY, ONTARIO DIVISION

The Chair: We will hear from the Arthritis Society. Whenever you are ready, you can start your presentation.

Ms. Jo-Anne Sobie: Thank you, Chair, and good morning. My name is Jo-Anne Sobie, and I'm the executive director for the Arthritis Society, Ontario division. I'll be sharing my time today with Kathryn Chambers, an arthritis consumer and volunteer.

To begin, I'd like to thank the committee for the opportunity to share the Arthritis Society's thoughts on Bill 36 and how it has the potential to impact on our ability to continue to provide specialized care and treatment to arthritis patients throughout Ontario.

To provide some context for my remarks, it is important to know that arthritis is the leading cause of morbidity and disability in our population, affecting 1.6 million Ontarians. According to the most recent statistics, two thirds of people with arthritis are women and nearly three out of every five people with arthritis are younger than 65 years of age, while one in five is younger than 45.

The Arthritis Society is the leading charitable organization dedicated to providing and to promoting arthritis education, community support and research-based solutions to those 1.6 million Ontarians living with arthritis. Reaching close to 150,000 Ontarians every year, the Arthritis Society employs a multidisciplinary and integrated team of occupational and physiotherapists, social workers, managers and program support staff. Add to this over 400 program delivery volunteers, and the Arthritis Society is capable of addressing many of the needs of arthritis patients in 98% of Ontario.

For over 50 years, the Arthritis Society has been partnering with the Ministry of Health and Long-Term Care to deliver the arthritis rehabilitation and education program. As a community-based rehabilitation program, it specializes in patients who are more chronic and severely disabled than the average population, with a larger number of co-morbidities.

The Arthritis Society's continued capability to provide this highly specialized program is based on its ability to apply its resources flexibly throughout the province. This can only be achieved by having the ability to apply central resources where necessary.

In underserviced areas, where need or cost cannot justify permanent staffing, meeting the need requires applying resources from other regions and partnering with external organizations. If the Arthritis Society is required to sign service agreements with the 14 LHINs, the ability to continue to provide care in underserviced areas will be significantly limited and, in some instances, eliminated.

The flexibility and adaptability of a centrally funded program is necessary to ensure that the Arthritis Society is able to continue to respond to the needs of arthritis patients throughout Ontario.

The Arthritis Society also feels that the charitable health care providers need to be identified as preferred service providers within the LHIN structure. The ability to apply donor dollars and volunteer resources to augment the delivery of government health programs provides valuable additional care and treatment that otherwise would require the implementation of supplementary cost-based programs. This value-added component is unique to the charitable health care sector.

Through the generous support of donors, the Arthritis Society is able to provide programs and services like our website, our 1-800 information line, our arthritis self-management program, educational forums and public educational displays.

The professional services supplied by therapists and social workers, as well as the donor-funded programs and services provided by the society, make up an integral part of the support team that is helping Ontarians live with arthritis and to better manage their health.

As we move forward in the implementation of the LHINs, the care and treatment of chronic diseases like arthritis must receive a priority focus. The effective treatment of arthritis requires access to care as close to home as possible. The Arthritis Society's rehabilitation and education program is designed to be delivered in a truly community-based setting: in our homes, workplaces, neighbourhoods and community centres. It must remain a priority of the LHINs to ensure that chronic disease management can be accessed by patients in the communities where they live and work, not where hospitals and centralized resources are located.

A provincial strategy for the care and treatment of arthritis will ensure that equal access and treatment is available for all Ontarians. This will work more effectively to address the cost burdens and inequities that prevent care and treatment in many areas. The ability to provide central funding for provincial programs will aid in the implementation of a provincial strategy for arthritis care and treatment in Ontario. Without a provincial

strategy for people with arthritis, the access standards across Ontario will remain inequitable.

Before I turn it over to Kathryn, I would like to say that the Arthritis Society strongly supports the transformation of the health care system in Ontario. The leadership from this government and minister has put us on a path that, with careful consideration, will achieve a better health care system for all Ontarians.

I would now like to ask Kathryn Chambers to share with the committee her personal experience as a person living with arthritis. Kathryn is not only a client of the Arthritis Society but also a hard-working and valued volunteer.

Ms. Kathryn Chambers: Thank you, Jo-Anne, and good morning. I would like to thank the committee for this opportunity to speak on Bill 36. I'm here today to provide a first-hand account of the importance of the work of the Arthritis Society and the need to ensure that the arthritis rehabilitation and education program can continue.

I can recall as a child hearing about the important work of the Arthritis Society. My father was actively involved in an organization that helped raise money for the Arthritis Society every year, money that he said supported important programs that help people and their families to improve the quality of their lives while living with arthritis.

Not once did I expect to be the recipient of these programs. Throughout my life I had committed to living a very active, healthy lifestyle that included riding my bicycle around Toronto as my favourite mode of transportation. It included swimming regularly, hiking and canoeing through Algonquin Park and tending to a community garden, all while working as a health professional in a busy downtown hospital.

In 2001, I began to deteriorate rapidly, to the point of being bedridden. It took all of the strength I had to get to work, let alone tending to sick patients in a busy downtown hospital. My career was slipping away from me. When I was finally diagnosed with a rare inflammatory arthritis in acute onset, I found myself accessing the services of the organization my father had spent so many years raising money to support. I was extremely grateful to reach someone at the Arthritis Society's 1-800 information line. I didn't know what to expect, really, just that according to the society's website, this was somewhere I could get more information about my disease as well as access peer support.

The information line volunteer that I contacted quickly forwarded to me relevant information about my form of arthritis and also connected me with the Arthritis Society's arthritis self-management program. I knew that this program was for me, since I was fiercely independent, and I felt that if I educated myself, I could move past this.

With pain and fatigue commanding my days, I met others in similar situations. I realized that many of the emotions I was feeling were completely normal. The arthritis self-management program taught me to set reasonable expectations, conserve my energy and helped raise my awareness of the various tools that reduce the load on joints. It also included meditation techniques and medication options. For the first time, I felt like I was taking an active role in my recovery from this disease.

Just after registering for the arthritis self-management program, I received a call from an Arthritis Society physiotherapist associated with my disease-specific peer group. There was an educational forum sponsored by the group to be held the next day. She made sure that I had transportation to attend. I met individuals coping with the same disease, and I became a member in a heartbeat. Many of these people have been inspirations to me as my journey continues.

Further support included a referral to the arthritis rehabilitation and education program. I met with an occupational therapist who was knowledgeable about the specific arthritis that I had. She not only gave me support through my insecurities and fears about the future, but assisted in the evaluation and adjustment of my home to allow for more gentle functional approaches to daily living. The physiotherapist was able to teach me disease-specific exercises and stretches and encouraged me to join a pool program. Even on days when every inch of my body screams with pain, floating buoyant lets me forget the hot spots all over my body.

The social worker helped with the emotional and logistical side of job loss. I had no idea what the future held, and she helped me to come to terms with this reality. Not only was I fatigued by the unceasing pain, but I knew my world had changed forever. My personal goals, hopes and dreams were put on hold or abandoned entirely.

As I began to feel a bit more comfortable with my situation, I needed to feel productive. The Arthritis Society offered me an opportunity to do this. That very same information line would be a source of comfort again, where I could use my medical knowledge, my experience and my desire to help others as a volunteer.

I am thankful to the Arthritis Society for the treatment, support and education that I received, and to my father for helping to leave this legacy for me when I need it most.

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The Vice-Chair (Mr. Khalil Ramal): Thank you very much. We have about four minutes left. We can divide them equally between two sides. Mr. Fonseca.

Mr. Fonseca: Jo-Anne, nice to see you again. Thanks to the Arthritis Society, and to Kathryn, for your own personal experiences with arthritis.

Through the LHINs, many presenters have talked about the regional disparity that exists in Ontario and the silo type of system that we have today. For a group like yours, wanting to meet with a community centre, wanting to be part of the hospital and address many of the hoops that the patient has to jump through to get the services that we've just heard about right now, would the LHIN model help in addressing that? Also, would we be able to

take those best practices that you may have in a particular community and deliver those across the province?

Ms. Sobie: Absolutely. I think there's every opportunity, and in fact we've already begun to engage very significantly in all of the LHINs across Ontario. We have already been working, and you mentioned that we are very much a community integrator to begin with. We work very closely at many levels with the government to try to ensure that best practice in arthritis care and treatment has been identified and is being disseminated, and we continue to work with centres of excellence, like the new Holland centre, and some of the other programs that are there. We have indeed developed our own best practice programs. Our Getting a Grip on Arthritis project, which is a community primary care provider education program, is an example of that.

We're quite comfortable working within a LHIN environment for planning. Where our biggest concern comes is because it requires critical mass at a provincial level with this highly specialized—keep in mind, there are over 100 forms of arthritis. We know osteoarthritis and rheumatoid are the most common. For the most part, people with osteoarthritis may very well be served in a much more LHIN-focused environment. For people who have extremely rare forms of arthritis that are extremely debilitating, it is very difficult to get referrals into support services, into specialized services. This in one of the critical pieces that, if we were required to provide those services separated in 14 LHINs, there aren't enough specialists to do that.

Being able to work in a community environment, but with a central specialized focus where we can then apply the resources at the best ability we have, working in between academic centres of excellence and community doctors, organizations, CCACs, is what we do best. We've done it for over 50 years. We would like to continue to do that.

The Chair: Ms. Martel.

Ms. Shelley Martel (Nickel Belt): Thank you for the presentation as well. I am going to point 3, which says that arthritis care and treatment requires a provincial strategy, which is what you were focusing on. What does the government need to do to ensure that? From your perspective, given that this legislation is also on the table, what signal, what work, what concrete actions does the government have to take to ensure that that's put in place?

Ms. Sobie: We're asking the government to identify arthritis once and for all as a priority disease in this province and to make it a strategy. This will allow us to work much more effectively at the civil service level with the Ministry of Health staff in coordinating those services and having an ability with those staff to bring the right people together to make the decisions.

One of the things that we've always suggested is that, yes, we know there are capacity issues, but we very much believe there's a huge opportunity through better coordination of current services in arthritis management, care and prevention to get a lot more out of it. But without a strategy, arthritis continues to be addressed in its pieces. We have a huge priority on the government's part for total joint replacement. This is an end-stage treatment for arthritis. There is much more we can do and are beginning to do to address this disease in a more holistic way.

Calling it a strategy, providing the ability for staff in the Ministry of Health and in health promotion to address this disease as a whole and not just in hospital is absolutely critical to moving this forward. Thank you.

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

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 79

The Vice-Chair: Now we invite the Canadian Union of Public Employees, Local 79. I believe the president, Ms. Dembinski, is here, and I believe there is somebody is with you. State your name, please.

Mr. Tim Maguire: Tim Maguire. I'm the second vice-president and chief steward.

The Vice-Chair: Thank you very much. When you're ready, you can start. You have 15 minutes. You can use it all for your deputation or you can divide it between questions and answers.

Ms. Ann Dembinski: Thank you for the opportunity to speak to you today. I just wanted to tell you a little bit about CUPE Local 79. We represent city of Toronto workers, Bridgepoint hospital members and also the Toronto Community Housing Corp. We are the largest municipal local in Canada, with 18,000 members, and probably the largest local anywhere in Canada outside of even the municipal field. Some of the areas we work in are homes for the aged, public health, social services, parks and recreation, housing and court services. We are hospital workers, long-term-care workers, RNs, public health nurses, child care workers, city planners, ambulance dispatchers, etc.

We're here today to speak to you about this legislation. The stated purpose of this legislation, according to the act, is "to provide for an integrated health system to improve the health of Ontarians through better access to health services, coordinated health care and effective and efficient management of the health system at the local level by local health integration networks."

In the preamble, the act states that the government is "establishing local health integration networks to achieve an integrated health system and enable local communities to make decisions about their local health systems."

CUPE Local 79 will always support any measure that truly enhances and improves the delivery of health care services within a public, not-for-profit health system. However, we have a number of concerns about the proposed Bill 36. We question whether the proposed legislation will ensure that the stated intentions are fulfilled, or will Bill 36 in fact hinder the declared purposes?

The boundaries for the local health integration networks governing the city of Toronto health care facilities defy all logic. The configuration of the LHIN boundaries means that Toronto is served by five LHINs. Only one LHIN is totally contained within the municipal boundaries. The city of Toronto's 10 homes for the aged and related services will report to five separate bodies for planning and funding purposes. Each of the city's homes for the aged has already developed critical linkages and work relationships with health, social service and community partners. These relationships have strengthened the care and service the homes provide. For example, at present, a municipal home for the aged in the far west end of the city may collaborate with a downtown hospital for purposes of providing a particular type of program. In the new configuration, the hospital and the home would be in different LHINs.

The homes for the aged are already fully integrated with their local communities and have strong historic relationships with them. The consequences of dividing Toronto among several LHINs will mean not only a loss of accountability to the respective communities currently served, but also to the city of Toronto within whose municipal boundaries all these homes are located.

The city of Toronto is a unified community already doing what the LHINs advocate. The city of Toronto accurately determines community needs and priorities and recognizes the diversity of interests and communities. The city of Toronto is accountable to the communities it serves and has developed effective community engagement mechanisms. The city of Toronto builds on the successes of existing coordinating networks and accumulated knowledge to coordinate health and social services into a coherent system.

Some of these LHINs cover only limited portions of the city and include substantial portions of suburban and rural areas surrounding the city. This raises the distinct possibility for integration decisions being made by LHINs whose composition is not city-friendly and whose orientation is suburban or rural. These LHINs will have little to no understanding of the specific and unique needs of our richly diverse communities, including multilingual needs.

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It is conceivable that CUPE Local 79's membership might be dispersed and integrated into service providers whose primary focus is outside of the city of Toronto, controlled by employers whose head offices are located outside of the city. It's possible that these for-profit service providers could be from outside of Canada. CUPE Local 79 is not alone in these concerns about the jurisdictional structure of the LHIN boundaries. We've heard that there has been similar apprehension voiced throughout Ontario.

The impact of Bill 36 on our members—I just wanted to speak about this. Local 79 has made several presentations recently on the proposed OMERS legislation, and it almost seems that I'm here more than I am at city council. That's really quite alarming, when I'm spending my days up here. Certainly, I can tell you that's not what our members expected, to see me up here all the time, fighting this government on their behalf.

We highlighted during the OMERS presentation the inequitable situations created by the legislation which would affect our members, especially those earning modest wages. Many of these members work in homes for the aged and at Bridgepoint hospital. The majority are women. A significant number of them are also women of colour. This government is again jeopardizing our members who work in the homes for the aged, and now our members who work at Bridgepoint hospital, this time by creating five different LHINs.

The impact of Bill 36 on our members will be severe as well as disruptive. Bill 36 allows bargaining units to be combined and forces the seniority among separate bargaining units to be merged. This is accomplished by the power and discretion of the Public Sector Labour Relations Transition Act.

Local 79, better than anyone, understands the seriousness of labour-force impacts from its experience with the amalgamation of the city of Toronto. I see Mr. Balkissoon sitting here. He dealt with it. You were there when the chaos was created. That process has certainly been one of the most chaotic things we've ever seen. I think Kathleen Wynne was a community leader at that time, who, along with John Sewell, was very vocal about the damage that amalgamation would do to Toronto. I can say that Local 79 and the city of Toronto have not yet, eight years after amalgamation, sorted through all the issues of amalgamation. We urge this government to consider the experience that the city of Toronto had as it moves to finalize Bill 36.

I want to just talk a bit about the new city of Toronto act, which states: "The purpose of this act is to create a framework of broad powers for the city which balances the interests of the province and the city and which recognizes that the city must be able to do the following things in order to provide good government:

"(1) Determine what is in the public interest for the city.

"(2) Respond to the needs of the city.

"(3) Determine the appropriate structure for governing the city.

"(4) Ensure that the city is accountable to the public ... "

There are others.

"The assembly recognizes that the city is a government that is capable of exercising its powers in a responsible and accountable fashion.

"The assembly recognizes that it is in the interests of the province that the city be given these powers."

The proposed legislation removes Toronto's ability to plan and deliver the city-operated and funded health services that are included in the LHIN legislation. Toronto's power as a government is being severely eroded by Bill 36. Again, this government is creating jurisdictional chaos with the LHIN boundaries.

CUPE Local 79 strongly supports the city of Toronto's recommendation for the development of one LHIN, city-wide. If this model is not possible, we would support the city's position that the legislation contain clear authority to prescribe a five-LHIN/city of Toronto collaborative table, composed of equal representation from all five LHINs and Toronto to ensure joint decision-making about those services currently included in the LHINs legislation that are operated by, or receive funding from, the city.

Without going into great detail, because I could, we again question why there are two sets of rules: one for not-for-profits and one for profit-making entities. There are many questions we could ask about that. It's not difficult to see a shrinking set of non-profit providers while the for-profits continue to gain new market opportunities as the system is restructured in this way. The proposed legislation will significantly alter the playing field from an unfair system, which already favours for-profit providers, to the two-tiered system that the government always denies it is advancing.

CUPE Local 79 strongly opposes privatization of health care services, competitive bidding and contracting out. We believe this legislation promotes privatization in several ways and facilitates the spread of competitive bidding throughout the hospital system. The LHINs may move funding, services, employees and some properties from non-profit to for-profits. Cabinet may order the wholesale privatization or contracting out of all support services in hospitals.

CUPE Local 79 members work in Bridgepoint hospital, which is Canada's largest and most extensive integrated health care organization for specialized complex care services: complex rehabilitation, complex care, long-term care and community-based care. Bridgepoint provides a continuum of care that links different services and facilities to ensure that people receive the right and best type of care at the right time.

There is nothing in Bill 36 to prevent services in Bridgepoint from being contracted out to private sector providers. The government has given itself the power to define who is a service provider—

The Vice-Chair: Excuse me, you have one minute left, if you want to conclude.

Ms. Dembinski: CUPE Local 79 urges you to give careful consideration and attention to our concerns and requirements. Again, we'll state that we think the proposed legislation must be amended to revise the boundaries for the LHINs.

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

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CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 2191

The Vice-Chair: Now we'll call on the second group, the Canadian Union of Public Employees, Local 2191, Toronto; Fred Hahn, president. Welcome. Mr. President, you can start at any time.

Mr. Fred Hahn: I know there are only 15 minutes, so I'm going to try to be as brief as possible. I will tell you a little bit about myself. I'm the president of a local union of just over 1,000 social service workers here in the city of Toronto. I am here on behalf of our members, not on behalf of the employer. The agency we work for is Community Living Toronto; it's an agency funded by the Ministry of Community and Social Services. We support well over 5,000 people with intellectual disabilities and their families in Toronto. I want to try to emphasize some of the concerns we have not only as community members and workers, but also as advocates for people with disabilities in the community, because for our members it's impossible to separate those things.

I'm going to try not to repeat some of the things I know you've heard, not only today but in other presentations, and hopefully allow some time for questions, and actually some questions that I have as well.

In terms of community input and control, our members work for a community-based agency that is controlled by a board that is elected, which represents people who receive services and people who are concerned community members. In fact, our agency in the city of Toronto recognizes that the city itself is actually too large to provide real community control. We have four regions in the four old cities that also have elected councils that also do that kind of democratic leadership and advocacy. What we're concerned about in this legislation, the way we read it, is that LHIN boards not only are not elected, but are not accountable to people in the communities. By legislation, they're only accountable to the Minister of Health. We also believe, of course, that there has to be a consultative structure put in place in terms of real community input, and there is nothing in the current legislation that would imagine that in a structured way.

We've heard a lot about the geographic concerns about the LHINs in Toronto. Residents in Toronto will have five different LHINs. For workers in our agency who help people with disabilities to access health care, our concern is that there really isn't anything that clearly articulates, in the legislation, that each particular LHIN in the city will have the same kind of service and the same kind of access to those services. For example, it seems conceivable that user fees might be introduced in one LHIN and not in another. If we're assisting people with disabilities who require assistance to access health care services, there are, as you might well imagine, working in the same city, huge concerns that we might have. As well, currently, people whom we support can go to one place and get a series of supports in one location. We're not sure—I don't think anyone is—what the results of the legislation might be in terms of creating centres of excellence, of specialization. Does that mean we will have to assist people with disabilities to go to five and six different locations, when now they are served and supported by one?

Basically, we're concerned about what we perceive, at least what our membership perceives, as a real lack of

consultation in relation to the structure of the legislation. It seems to us that the current government never ran on this when they were being elected by the people of Ontario. It was never part of any policy or any platform, and it's our view that people didn't actually vote for this. Sure, governments have to govern while they're elected, but in our view, let's have a real consultation before introducing something that could vastly change the way in which health care is delivered.

There is also, it seems to us, quite a hurry. The legislation was introduced during the midst of a federal election, second reading happened just before Christmas, and here we are with third reading. It seems quite fast, considering a huge amount of change is possible and imagined by the legislation. We believe, and think that many of you believe, that public consultation is the cornerstone of good public policy. That's what these hearings, of course, are for. But many of us have 15 minutes to talk about a variety of concerns, and it is really a challenge to do that. So we would hope that part of what you may recommend is that there be a more extensive consultation process entered into so that people can actually be more aware and more involved in this discussion.

One of the things we discovered, talking with our members—well over 1,000 of them, as we said, well plugged into the community and their communities in Toronto—was that many of them had no idea that the LHINs existed, that the legislation existed and what potentially it meant. We entered into a discussion with them that was in many ways an education process. We feel that our members represent the public and that if our members didn't know about it, then many people in the public don't know about it, and there are a lot of changes being proposed here that people might not know are coming.

We're concerned, and you've heard from lots of people, that the legislation may enable privatization. There is nowhere in the bill that we can see in reviewing it that ensures, requires or even encourages the Ministry of Health or the cabinet to preserve the public, not-for-profit character of the health care system. We think this has to be absolutely, clearly defined in the bill. Talking about whether or not a particular service would be delisted, that kind of stuff, is quite a narrow definition of privatization. What we're quite concerned about is moving, wholesale, huge chunks of the health care system out to the private sector.

We've seen that in home care. There has been a lot of discussion about the possibility. While it's not clearly articulated in the bill, it seems clear to us that it opens the door to competitive bidding. If the minister is clear, as he seems to have been in the media recently, that this is not the intention, then why not put it in the bill? Why not just say that there will be no competitive bidding model, that there will be strong efforts to maintain the public, not-for-profit nature of the health care system in Ontario? Why not just be clear about that in legislation?

Of course, there is the potential for labour unrest. You've heard about that in the previous presentation and in many other presentations. In fact, you have heard from a number of local unions, health care workers and other parts of the trade union movement, but also from community groups and others, who are concerned that there may be, with the way that the legislation could be enacted and its impact on representation votes and bargaining units, the potential for the legislation to actually overstep negotiated collective agreements. Surely anyone in this room, each and every one of you in this room, would understand that the response that might generate would not be a healthy or helpful one. What we're suggesting is that there be real consultation to ensure that that kind of labour unrest doesn't happen.

Part of what is most concerning for our members is that those of us who have come forward to the committee have been accused of fearmongering, of using rhetoric. Of some of the concerns we have voiced it's been said that there's no research, that they're baseless. In fact, that isn't true; there's a lot of research. I could spend the whole day with you—I wish I could, but I've only got 15 minutes—articulating the things that I've learned in a very short period of time. I feel that there is a great deal of research, a great deal of concern, not just from unions but from health coalitions, community partners, employers, health care providers and community-based agencies. It seems to me and to our members that it would be good public policy to listen to the vast majority of people who have come before this committee and to say, "Look, there are some real concerns here." If it is not the intention of the government to encourage privatization, to cause labour unrest, to cause havoc in the health care system, then let's slow the process down. Why not enter into a more protracted kind of real consultation with stakeholders and a real consensus built to restructure health care in a way that will help people and workers in the province of Ontario?

The last thing I wanted to say is that we have also been, it seems, accused of not having any good ideas, of just wanting the status quo. Part of the trouble is that it's really hard to come up with an alternative in 15 minutes when you're responding to a piece of legislation which, quite frankly, has all kinds of things in it; any one of us could spend 15 minutes talking about just one piece. It seems to us that labour unions have talked about many good ideas, like a provincial benefits plan, for example, a way of saving money for workers across the system. That idea hasn't been picked up or talked about. Sometimes it feels to those of us in the system like we propose ideas that could actually cause efficiencies and they're not picked up or listened to.

Again, what our members—over a thousand of them—asked me to do was to come here on their behalf and say that we think the process needs to be opened up, slowed down. We urge the committee to strongly recommend to the Minister of Health and to the government that the current bill be set aside and that we have a fuller consultation with local communities, health care workers and the public about how health care can actually be transformed in a way that will be helpful, in a way that

will be more inclusive and satisfactory, and in a way that will guarantee the public nature of our health care system. Thanks.

The Vice-Chair: We have four minutes, to be divided equally among the three parties. We're going to start with Ms. Martel.

Ms. Martel: Thank you for your presentation today. I'm going to focus on page 5, "Privatization enabled by legislation." You say in your remarks, "There are no provisions in the bill—anywhere"—that's highlighted—"that ensure, require or even encourage the Minister of Health ... to preserve the public, not-for-profit character of our health care system." You are correct: There's nothing in the preamble that references trying to maintain that not-for-profit character of the system. There's nothing in the objectives of the LHINs that would point that out. Nowhere does it say that that's what the point of the matter is, that in any change that's going to take place we are indeed not only going to preserve and protect but enhance the not-for-profit nature. Given that the bill doesn't seem to say anything, what would you like to see in this regard so that if the minister really means that, we might actually have it in the legislation?

Mr. Hahn: We think it would be important to embed in the legislation a clear commitment to preserve public, not-for-profit health care. It should be clear that there would be no competitive bidding model that would be used in the LHINs. That should be clearly articulated in the legislation. In fact, it seems, based on reading the papers, that the Minister of Health himself has said that's not the intent, so why not just be clear about it?

What we think should happen also is that there be a requirement that before developing any provincial strategic plan like section 14 of the bill talks about, there would be a province-wide consultation on the appropriate funding formula in a LHIN and for any of the subsector health service providers in the LHIN. We also think that section 28, which I know you've heard a great deal about, needs to be withdrawn from the legislation to make it fair and clear.

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Ms. Martel: And perhaps we should put the principles of the Canada Health Act somewhere in the bill too, while we're at it, in the preamble or in the objectives; that the work of the LHIN should be to support, maintain and enhance the principles of the Canada Health Act.

Mr. Hahn: That would make perfect sense.

The Chair: Ms. Wynne.

Ms. Wynne: Thank you very much for being here today. I just wanted to pick up on the consultation issue for a second. You talked about the need for more consultation. The minister began, in 2004, to talk about this idea with various groups. We had the town hall consultations. So 4,000 individuals and groups were part of that. We've had seven days of hearings, well over 200 groups have come before us, and I guess the thing for me that is the most important is that embedded in the bill is a provision for ongoing consultation, because this is an iterative process. This is not a framework that is going to be put in place and then is forevermore that thing. There are going to be discussions about the plans. There is going to be an engagement process. Section 16 is all about that. I know there will be amendments that will come forward to expand on the specificity of section 16. So I guess I'd like your comment on just how much more consultation could be done, and I'd especially like your comment on the part of the bill that lays out that need for ongoing community engagement. Is that not a good thing?

Mr. Hahn: Of course it should be in the bill that there would be ongoing community consultation.

Ms. Wynne: But it is.

Mr. Hahn: What seems unclear is that a LHIN and its directors, who aren't elected by that community and aren't clearly accountable in any way because they're not elected by that community, can actually declare that whole parts of their meetings aren't open to the public, and that any decision they make can be appealed but only within 30 days and there's only one right of appeal.

Part of the discussions the minister has had around the province on the options around health care—right now there is a structure, a concrete thing that's being proposed. It seems to our members that the majority of the people who have come forward are expressing concerns about that particular structure and the ways in which it is being particularly proposed and some particular holes that may be in there.

Naturally, whatever system is there, we think it would be important to have ongoing, open and full consultation that also takes into account all stakeholders: the public, but also people who work in the health care system because those people are experts. They provide the services. They are, in fact, health care heroes, as we knew during the SARS outbreak here in Toronto. So it's important to build that in. It's not clear in the legislation that that will actually be there and it's not clear in our members' minds that even in the outgoing consultation that the minister did for the last year or so, these particular provisions were going to be what we may be dealing with.

So I think what we're trying to say is, now that we have something concrete that we can look at and say, "Here are some concerns and problems and issues," instead of making this law, because we all know that once something is law it becomes even harder to change it, why not slow down the process? Make it better, make it so that more people feel like they can support it. Then make it law—and build in consultation, absolutely. What's the rush? What's the hurry?

The Chair: Thank you very much. Mr. Miller.

Mr. Miller: Thank you for your presentation. You have a section in your presentation to do with the makeup of the LHINs in Toronto. I know the LHINs, in theory, are supposed to be based on referral patterns, although it does seem a little strange to have five separate LHINs for the Toronto area. Do you have recommendations on how many LHINs you think there should be in the province, and specifically for the Toronto area?

Mr. Hahn: What we included was the motion from the city of Toronto, and the previous speaker and the city have talked about importance of having one LHIN for the city. It seems to us that Toronto may be the only city that's broken up in this way, based on the proposed boundaries. So I think it presents a particular challenge for Toronto and I think it makes sense for all of the health care provision in a city to be incorporated in one geographic LHIN.

Mr. Miller: Very good. Your comment about the makeup of the board members of the LHINs—elected versus appointed. Obviously the government has decided to go with appointed members. Can you see an advantage, in terms of health outcomes, to having appointed members, or what's the problem, I guess I would ask you, to do with having elected members?

Mr. Hahn: We don't think there would be a problem with having people elected. We actually think it would be important to have people elected. The thing about being appointed is that it's unclear to us what accountability there is back to the community. The whole idea, based on what I've been reading and what the minister is saying, is that this about localizing health care, localizing control. But if the people in a community or an area have no way of picking the people who will represent them, then what's the accountability if the legislation says those people are only accountable to the Minister of Health? And why not let MPPs from the LHINs be ex-officio members of the LHINs, so that there's some accountability to the public though MPPs?

The Chair: Thank you very much for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES, TORONTO REHABILITATION INSTITUTE EMPLOYEES

The Chair: We now go to the next presentation, the Canadian Union of Public Employees, Toronto rehab hospital employees; Paul MacDonald. Good morning, Mr. MacDonald. You can start any time you're ready; 15 minutes total.

Mr. Paul MacDonald: Good morning, everyone. Good morning, ladies and gentlemen of the committee. My name is Paul Macdonald. I'm here today as a concerned provider of direct patient care in our currently public health care system. As vice-president of our union local, representing over 200 dedicated and caring members at five sites that make up the Toronto Rehabilitation Institute, this is my second time before a committee here regarding an attack on the providers of health care at our facility and many others across this vast province, the last time regarding contentious aspects of Bill 8. Our health care members, both unionized and non, have many concerns regarding aspects of this bill, and here are just a few that I'd like to present.

I guess I would start with the concern of centralization of health care services. The LHINs are local in name only. The bill would grant little real power to local communities and providers to make decisions. Rather, it transfers control over local, community-based providers to the minister and cabinet and to their agents, the LHINs, thereby centralizing rather than localizing control over health care and certain social services in Ontario. The bill grants unprecedented authority to the Minister of Health and cabinet to effectively control most public health care service providers and to completely restructure public health care delivery, including the power to turn delivery over to for-profit corporations.

Community control and provincial government accountability: The LHINs cover vast and very diverse areas. The LHIN boundaries have been formed based on hospital referral patterns, overriding municipal, provincial and social boundaries. The proposed LHINs are not local, they are not based on communities and they do not represent communities of interest. As a result, they lack political coherence. Example: LHIN 9 goes from Toronto practically to the border of Algonquin park. 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 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 the cabinet and may be removed at any time without cause. Each board member will make about $350,000 in salary and then they get $350 per meeting. Elected members on hospital boards are voluntary.

LHINs boards will be responsible to the government rather than local communities. This is in contrast with the long history of health care and social service organizations in Ontario, which as a rule are not appointed by the provincial government; for example, hospitals. They have doggedly pointed out the need for better care in their communities with significant success. Recently, however, the government has found a way to blunt criticism of underfunding and privatization. The key was to replace community boards with government-controlled boards. This, unfortunately, is the model for LHINs. The result of this experiment in community care access centres suggests that this is a very poor model for LHINs to follow.

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Next I'd like to focus on service cuts. The government plan is to regionalize hospital support services. With government support from Ontario Buys, dozens of hospitals across the north are planning to consolidate supply chain and office services by turning work over to a new employer, Northern Ontario Hospital Business Services. Likewise, with government support, 14 hospitals in the greater Toronto area plan to regionalize

supply chain and office services by turning work over to another new organization, Hospital Business Services. This organization would take approximately 1,000 employees out of the hospitals, turn over a significant portion of the work to for-profit corporations and sever roughly 20% to 25% of existing employees, and more such plans are in the works.

Next I'd like to focus on clinical services threatened. By April 2005, the government admitted as much, with the health minister publicly calling for the centralization of hospital surgeries. Mr. Smitherman was on record as saying, "We don't need to do hip and knee surgery in 57 different hospitals." Instead, he suggested that about 20, i.e. a 60% cut, might be appropriate. He said, "Each hospital in Ontario will be given an opportunity to celebrate a very special mission ... but not necessarily operating with as broad a range of services as they're tending to right now." This squarely raises the prospect of even more travel for health care services.

The government has also begun to move surgeries right out of hospitals and place them in clinics. The first instance was the recent creation of the Kensington Eye Clinic. This clinic, in the recently closed Doctors Hospital in Toronto, is supposed to remove 1,700 procedures from hospitals and do an additional 5,000 cataract surgeries. This, the ministry says, is only the beginning.

The creation of new surgical clinics only fragments health care, creating more employers and more destinations for seniors to run around to as they tend to their health care needs. It also raises the possibility of the establishment of for-profit surgical clinics. A better solution would be to create surgical clinics in the facilities and organizations in which we are already invested. Hospitals have the infrastructure needed to support these surgical clinics. There is no need to duplicate their human resources, stores, payroll, purchasing, cleaning, food, lab and other support services. Hospitals also have the resources to deal with emergencies that may occur during operations. And this would actually help advance the seamless care that this reform is supposed to create.

I'd like to focus on the impact on bargaining units. 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, 1997, to many of the potential changes in employment that could result. 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.

CUPE is closely examining the impact that Bill 36 and its use, in some cases, of the Public Sector Labour Relations Transition Act to deal with the labour relations issues raised. But we can note that 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 with the right to a union representation vote. We would also like to make crystal clear that the employment security protections of our collective agreements cannot be overridden by this bill, and we propose to protect bargaining unit and employment security rights.

Suggestions:

(1) Provide in the bill that the Public Sector Labour Relations Transition Act applies regardless of whether a person or entity is a health service provider, and regardless of whether the primary function of the person or entity is to provide services in the health sector.

(2) Remove from the bill the proposed cabinet authority to exempt application of the Public Sector Labour Relations Transition Act.

(3) Provide that nothing in Bill 36 or the application of the Public Sector Labour Relations Transition Act can have the effect of overriding negotiated employment security provisions.

The experience with competitive bidding in social services: Competitive bidding is also doing damage in social services with its introduction by Human Resources and Skills Development Canada. The new bidding process has, in the first round of proposals, disrupted over a third of the long-standing arrangements with community organizations. Three organizations are losing so much of their funding that they will have to close their doors. Four contracts have been awarded to the for-profit sector. Clients have no idea where they will be served, if at all, while the programs and linkages created over decades of work are being lost. Laid-off social service workers are being forced to re-apply for their same jobs at a lower rate of pay and benefits.

I'd like to read some summaries: The estimated cost to maintain the LHINs bureaucracy, an estimated 500 new bureaucrats added and not a single new care provider, is $55 million annually; $20 million to dismantle district health councils; and $21 billion of an annual budget to be spent by LHINs.

In summary, LHINs will take services, mostly from hospitals, and have them delivered at a handful of sites located over huge geographic regions. LHINs will not align critical parts of the system not presently covered. LHINs will sharpen regional inequalities. LHINs fail to address the real drivers of health care costs: pharmaceuticals, CEO salaries, new technology and private sector entities currently in the health care system.

LHINs will create a large new bureaucracy. LHINs mean institutionalization chaos: no end to mergers, amalgamations, rationalization. LHINs open the door to more private sector for-profit delivery of health care. The ability of communities to influence which services are offered locally is diminished. LHINs threaten job security and put downward pressure on wages and benefits through competitive bidding.

I'd like to quote Ian Urquhart from the Toronto Star:

"What the government has in mind here is the consolidation of services now being offered in many hospitals in a region—say, cataract removals or hip replacements—into just one hospital or even a doctor-owned clinic....

"Now, all this is fine provided you are not either a hospital employee ... forcibly transferred, or a patient who has to travel 100 kilometres for a routine procedure."

The Chair: Thank you. The time is—unless there are any other concluding comments, we thank you for your presentation.

ALLIANCE FRANCOPHONE DES RÉSEAUX DE SANTÉ

The Chair: The next presentation is from l'Alliance francophone des réseaux de santé. Bonjour, monsieur. Please start any time you're ready.

Mr. Denis Constantineau: Thank you. I have a brief presentation in French, and then if there are any questions—

The Chair: That's fine. Ça va.

M. Constantineau: Monsieur le Président, chers membres du comité, l'Alliance francophone des réseaux de santé est, par le biais de ses partenaires, le porte-parole provincial de la communauté francophone dans sa diversité en matière de santé en français.

Au cours des audiences précédentes, votre comité a entendu des représentants de la communauté franco-ontarienne partout dans la province, dont les représentants de nos quatre réseaux, exprimer leur voeu que la réforme majeure du système de santé de l'Ontario reflète une amélioration en profondeur des services de santé en français.

Vous les avez entendus vous décrire leurs réalités dans différentes régions de la province en ce qui touche l'accès à des services de santé en français, un accès qui dans plusieurs régions n'existe tout simplement pas ou très peu et qui s'est dangereusement détérioré ailleurs malgré l'adoption de la Loi sur les services en français et même dans des régions où vivent de fortes concentrations de francophones.

Votre comité a appris de plusieurs témoignages que la santé des Franco-Ontariens et des Franco-Ontariennes, à cause de ce manque d'accès, est moins bonne que celle de la majorité de la population de l'Ontario. Le manque d'accès a un impact négatif sur la santé des Franco-Ontariens, car il est démontré qu'ils attendent d'être plus malades avant d'avoir recours aux soins de santé, ce qui occasionne inévitablement une augmentation dans les coûts du système de santé. Il est inacceptable que l'on oblige nos francophones dans leurs plus grands moments de vulnérabilité à obtenir des services de santé dans une langue qui n'est pas la leur.

1150

L'application de la Loi sur les services en français par le ministère de la Santé et des Soins de longue durée a été, sinon un échec total, à tout le moins très peu utile à assurer des soins de santé de qualité pour les francophones de la province. Cette sombre situation est principalement due à l'approche minimaliste du ministère face au maintien et au développement des services de santé en français.

Vous avez entendu des histoires d'horreur sur l'impact qu'ont ces politiques du ministère sur la façon avec laquelle sont traités les francophones dans notre système de santé. On pourrait vous entretenir pendant quelques journées d'audiences à vous en raconter d'autres. Des personnes âgées, des enfants, des unilingues francophones, et même des gens bilingues à leur plus vulnérable sont laissés pour compte.

Il n'y a aucun doute qu'à cause du manque de services de santé en français, les francophones occupent souvent des lits d'hôpitaux ou des bureaux de médecins plus longtemps que nécessaire, parfois beaucoup plus longtemps que nécessaire. Ça coûte de l'argent, et ça bloque le système de santé pour tous les Ontariens.

On vous a même dit que le simple fait d'être minoritaire francophone en Ontario est un déterminant social qui peut influer sur la santé des minoritaires, au-delà de tous les autres déterminants sociaux. En d'autres mots, être Franco-Ontarien peut vous rendre malade.

On vous a renseignés sur l'étendue de nos droits constitutionnels et légaux, confirmés par plusieurs jugements de la Cour suprême du Canada et, spécifiquement en santé, par le jugement historique de la Cour d'appel de l'Ontario dans le cas de l'Hôpital Montfort. Ces droits se résument à deux principes fondamentaux :

Premièrement, aucun gouvernement au Canada n'a le droit de prendre des décisions qui encouragent, directement ou indirectement, l'assimilation des francophones minoritaires à la culture et à la langue de la majorité.

Deuxièmement—et ceci est particulièrement important dans le contexte de la réforme actuelle—plusieurs jugements de la Cour suprême ont confirmé que la minorité linguistique est la mieux habilitée à prendre les meilleures décisions pour les services offerts à la minorité. Faire le contraire ne représente pas une pratique exemplaire en santé.

Monsieur le Président, membres du comité, si vous n'y étiez pas déjà, vous êtes maintenant au courant de la situation de la francophonie ontarienne en santé, et parce que vous êtes maintenant au courant, vous en êtes aussi responsables. Nous respectons votre pouvoir de décider et d'agir, mais vous ne pouvez le faire dans l'ignorance des faits. Vous nous avez écoutés, et maintenant, vous devez nous démontrer concrètement dans vos décisions et vos actions que pour un gouvernement qui se préoccupe des siens, ça commence dans le système de santé.

Dans ce sens, il est probable que certains parmi vous subissent des pressions de la part de gens mal informés, résistants au changement, douteux de nos intentions réelles et, il faut le dire, d'une minorité carrément hostile et très vocale à tout ce qui est de langue française. Il est possible que ceci vous incite à entrevoir des épouvantails comme le « French backlash ».

Permettez-moi de dire deux choses là-dessus : premièrement, l'Ontario a changé. Notre population est très ouverte à la minorité francophone, et une majorité de la population de l'Ontario considère que la dualité linguistique est une valeur fondamentale du Canada, comme l'est aussi l'accès à des services de santé publics. Deuxièmement, les Franco-Ontariens et les Franco-Ontariennes ne craignent pas le ressac anglophone. Nous en avons trop vu, trop entendu pour avoir peur aujourd'hui.

À travers notre histoire, nous avons appris une chose extrêmement importante. La grande majorité des gens respectent deux qualités au-delà de toutes les autres chez leurs représentants politiques ou autres : l'intégrité et le courage. Le ministre de la Santé et des Soins de longue durée a fait preuve d'intégrité et de courage en impliquant pour la première fois les francophones dans une initiative majeure du ministère de la Santé.

Le groupe de travail présidé par M. Gérald Savoie a étudié toute cette question pendant presqu'une année en collaboration avec le ministère de la Santé. C'est sans précédent, et c'est d'une importance vitale. La communauté franco-ontarienne est impatiente de voir ce document rendu public, de même que la réponse du gouvernement à ses recommandations.

L'Alliance francophone des réseaux de santé a reçu le mandat de la communauté de présenter les amendements que nous aimerions voir dans le projet de loi 36 pour qu'il respecte les droits et réponde aux besoins et aux réalités de la communauté francophone. Nous respectons absolument le rôle des législateurs à formuler ces amendements. Par contre, nous déposons devant vous un compendium des principes importants que la communauté souhaite voir ajouter à la loi. Fondé sur le principe que le gouvernement et les ministres changent, il importe pour nous d'assurer la protection et la prise en compte de la situation de la minorité francophone à même le texte de la loi et de la réglementation qui y est associée dans l'éventualité d'un gouvernement futur moins ouvert à notre communauté.

En bref, nous voulons premièrement voir une modification au préambule de la loi reconnaissant le rôle des francophones dans la planification et la provision des services de santé en français au même type que les Premières nations et les autochtones;

—de même, un amendement spécifiant que l'intérêt public implique le respect et la protection constitutionnelle des minorités linguistiques;

—une autre modification permettant un dialogue continu et permanent entre la communauté francophone et le ministre de la Santé;

—de même, une provision assurant que les décisions qui touchent les services de santé en français sont prises au niveau local par les francophones, fondées sur le droit et sur le principe que la réforme du système de santé est centrée sur les communautés et sur le patient;

—en fin, les plans ministériels et locaux de services de santé devraient tenir compte des services de santé en français. Il est imputable dans ce sens.

Le système de santé de l'Ontario doit être imputable de l'argent des contribuables et nécessairement des services de santé en français : la meilleure, sinon la seule façon d'y parvenir et d'assurer une prise de décisions francophones pour les questions francophones.

Il n'est pas question de proposer un système de santé francophone séparé, parallèle au système dans son ensemble. Les services de santé en français doivent être totalement intégrés au système de santé de la province.

Monsieur le Président, l'Ontario est un carrefour crucial de son histoire en santé. C'est aussi un moment décisif pour sa communauté franco-ontarienne. L'Ontario a un rôle vital à jouer, non seulement au nom de la justice et l'équité sociale mais au nom de la confédération. L'Ontario, qui abrite plus d'un demi-million de francophones, soit la moitié de tous les francophones minoritaire au Canada, doit servir d'exemple. Nous ne pouvons nous permettre d'échouer; le prix pour tous les Ontariens et les Ontariennes est trop grand. Merci.

The Chair: Merci beaucoup, M. Constantineau. Thirty seconds each. M. Ramal, s'il vous plaît.

M. Ramal (London–Fanshawe): Merci, monsieur le Président. Merci pour votre présentation. Je pense maintenant au ministre de Santé parlant avec la communauté francophone, et travaillant pour établir un mécanisme spécial pour la communauté francophone de l'Ontario. On sait que tu as pensé bien à une méthode alternative pour la communauté.

M. Constantineau: C'est une excellente méthode. On parle du comité de travail de M. Gérald Savoie. Ce dialogue-là est très positif, et c'est quelque chose qu'on voudrait voir continuer tout le long du processus d'intégration, même après l'adoption de la loi, pour pouvoir sonder la population et aller voir quels sont les intérêts, les besoins en développement des services de santé en français. On recommande que ce mécanisme-là soit intégré à la loi pour que ça continue.

M. Ramal: Je pense maintenant au ministère—pour un changement d'un élément de la loi 36. Je pensais aux accommodations des besoins de la communauté francophone de l'Ontario. Maintenant, le ministre de la Santé travaille avec la communauté francophone pour changer cet élément de la loi 36.

M. Constantineau: Nous, on attend encore les propos du rapport Savoie, que le ministre a entre ses mains. On aurait espéré qu'il soit rendu public avant les audiences pour qu'on puisse prendre connaissance—évidemment, tout ça est un secret. Alors, on ne sait pas ce qui est recommandé par le groupe de travail Savoie, mais on est confiant, étant donné la représentation à ce comité-là, qu'ils ont l'appui de la communauté lorsqu'ils vont recommander au ministre de représenter vraiment les besoins de la communauté.

Le Président: Merci. M. Arnott, s'il vous plaît.

M. Arnott: Merci, monsieur le Président, et merci pour votre présentation.

The Chair: Thank you. M^{me} Martel, s'il vous plaît.

M^{me} Martel: Merci, M. Constantineau, pour être ici ce matin. Nous savons très clairement que M. Savoie et

d'autres personnes avaient fait un énorme travail à propos de la situation de santé de haute qualité pour les Franco-Ontariens.

Malheureusement, nous n'avons pas de recommandations devant le comité. Alors c'est bien difficile pour nous, comme comité, de faire face aux recommandations ou de proposer des amendements qui pourraient peut-être améliorer la situation.

Nous avons en ce moment vos recommandations : ce sont les recommandations de toute l'alliance, de tous les réseaux. Alors, ça représente le point de vue de la majorité des francophones à propos du service de santé.

M. Constantineau: C'est ça. C'est le point de vue de l'alliance. C'est difficile pour nous aussi parce que, pour être honnête, il y a eu une crainte que ce qu'on allait demander là était moins que ce que le comité de M. Savoie allait recommander. On avait peur un petit peu de se couper l'herbe sous les pieds en demandant moins que le comité de travail de M. Savoie avait recommandé.

Mais il y a un consensus sur les éléments là-dans. Le plus important pour nous est le préambule. Dans le préambule de la loi, on accorde aux autochtones et aux Premières nations le droit de participer au développement, à la planification et à la livraison de services de santé dans leur communauté. À tout le moins, il faut y avoir la même reconnaissance pour la communauté francophone.

Simplement dire qu'on va respecter la Loi sur les services en français n'est pas acceptable, parce que la Loi sur les services en français ne nous a pas servi jusqu'à date. On a un système « patchwork » au niveau de la province dans les services de santé en français. Ce n'est pas suffisant pour assurer une pleine participation des francophones au développement des services. Il faut aussi que, peu importe le système qui est mis en place, les francophones participent activement à la gestion de ces services de santé-là.

On a vécu, au niveau de système d'éducation, des comités consultatifs. On avait deux ou trois francophones sur notre comité de 10, 12, 14 anglophones, puis là c'est une compétition pour les dollars. La question francophone est toujours le pauvre cousin dans la déduction.

The Chair: Merci beaucoup, monsieur. We have finished our early session of the day. We will recess until 1 o'clock, after lunch. Thank you again.

The committee recessed from 1201 to 1308.

SERVICE EMPLOYEES INTERNATIONAL UNION

The Chair: We have a quorum. Even if the other parties are not present, I think we should move on so we can keep on schedule.

The next presentation is from the Service Employees International Union, Local 1, Huntsville; Susan Hughes and Janet Green. Would you please have a seat at the front, and you can start your presentation whenever you're ready. There are 15 minutes total time for your presentation. In any time left, we can ask some questions of you or make some comments.

Ms. Janet Green: Good afternoon, ladies and gentlemen, members of the standing committee on social policy. My name is Janet Green. I'm an RPN who has worked in the health care field for the past 25 years. I'm here as a representative for Huntsville District Memorial Hospital. I'm a member of SEIU Local 1 and an advocate for our community. I came here to give you an understanding of the community where I live and work—the size, the conditions etc.—but I've decided to scrap that presentation and address only the LHINs Bill 36.

What right does the government have to pass a bill as devastating as this with no public input and no public awareness? This bill ultimately affects people's lives. It affects the people who deliver the medical care, excluding doctors. Why is this? It affects the public, who need the medical treatment, and the people who give the treatment and care. It opens the door to contracting out—again, more trouble.

The Canada Health Act specifically says all residents in Canada will receive universal care. The idea of hiring or appointing people to the board in each LHIN area has me wondering why these people are not elected. Secondly, have these people any medical knowledge, since their decisions affect medical health in Ontario? We don't know, as the government has decided this is hush-hush. Bill 36 is not something to be kept quiet.

I, as a nurse, have taken an oath with the College of Nurses. I also practise a core value: Do unto others that which I would want done unto myself. I also take my job very seriously. People are putting their lives in my hands day after day.

With Bill 36, the government seems to have taken the public out of the equation. I can see that the OHIP system is faltering and changes need to be made, but at whose expense? The government talks about accountability, but for whom? The hospitals, the budgets, the government or the public?

Bill 36 needs to be looked at and studied more closely, not just rushed through and passed as law. I feel that the consumer needs to be fully aware of its global effects, as well as the medical personnel who work in the health care field. We may be able to help get OHIP back into shape.

Mr. Romanow put out many recommendations in his report to the government. His words were, "There is no quick fix." The LHINs structure is very much like the model used in the UK and Australia, which still have many problems. Good strategy does not come overnight. As part of the public, I wish to have more time to understand Bill 36 and its implications before it is passed. As well, I think the public has the right to know more.

Amendments need to be made, which include perhaps a panel of public members elected to oversee the LHIN boards. The LHIN board members should be contracted in for two-year periods. I think these positions should be elected as well.

I did up a very simple picture of a tree—I'm not an artist; I'm a nurse. The picture shows basically a very simple structure of the health care at our hospital and the system in our community. I took the roots as being the

community; the ground being the government, which nourishes the tree. The tree is broken up into different departments: the ER, X-ray, SCIU, lab, OR. If you took your finger and put it over this maple tree in any one of these sections, it's called "limbing the tree." The tree may die. Without these sections in the hospital, it does not flow properly.

With what I see in Bill 36, it basically says to me that they may contract out these positions. We have a very structured way in our hospitals, and to contract out to a company may be substandard. That is one of my worries. The lab: I've heard in the media that they've used sub-standard needles at some of these contracted out clinics down in the States. It bothers me.

Another area is physiotherapy. You cannot run a hospital, whether it be your ER, SCIU or OR, and not have physiotherapy for some of these people. That's another area that's being looked at. We have acute care and long-term care—again, places that need extensive physiotherapy.

Then we go up to the branches of the tree, which are some of your sort of smaller clinic areas and clinical services that are also offered. If you start limbing off a tree, if you take too many limbs, the tree is going to die. Those are extra services within the hospital. They all back up the main trunk of your tree. The maple leaves on top, to signify Canada and Ontario, are the staff and your support services that back up the main services. If you lose the limbs of the tree, you lose the staff who work in those areas.

My main concern is that when you start with Bill 36, you're opening the door for contracting out. You're opening the door for massive leaving of staff to go to private clinics to make more money, because they won't want to stay in the public system.

I don't fully understand Bill 36. I've read it over. I've read over the summary and I just feel very strongly that if I don't understand, and I'm in the medical system, and the public doesn't even know about it, there should be a longer time frame. Let the public know. Thank you very much.

The Chair: Any other comments? If there are none, there is a minute and a half. I'll start with Mr. Ramal. Less than a minute, please.

Mr. Ramal: Thank you for your presentation. You were talking about elected boards. Did you check what happened to other jurisdictions with elected boards? My second question: You were talking about not enough consultation, not many people knowing about it. Don't you think your presence today is great evidence that we are willing to consult with everyone, and that's why you're sitting before us here to tell us about your story? Is it not a consultation? Could you answer that point too?

Ms. Green: The second question first: If it were as well known in the public, I could walk up to basically anybody in my community and ask them about Bill 36, and they would have some reference to it. No one in my community that I have talked to, other than the hospital staff or medical staff in our community, knew anything about Bill 36—nothing. I find it very odd that when it has to do with your medical treatment, you don't understand anything about a bill that's being put into legislation.

To answer your first question, I did not check out fully about the elected positions. I do know from elections provincially and federally just how crazy it can be, and I find that, yes, it might take a longer process, but on the other hand, to have someone with a medical background elected and appointed from your communities would be far more appropriate for that position in the hospital.

Mr. Ramal: But our record shows that elected boards didn't work very well. That's why we went to appointed ones, to deal with experts in that field, to appoint them in order to force the issue and fix our health care.

Ms. Green: Are these people going to be announced who will be on the boards for each LHIN?

Mr. Ramal: Of course. Some of them sat before our committee here. We listened to them, we checked their credentials and they were passed by this committee—not this committee, but a different committee.

Ms. Green: But the communities themselves? We're very tightly knit up north in Muskoka.

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

Ms. Martel: It would make very good sense to have people elected from the community, because the problem with the bill is that the board members are accountable entirely to the minister, not to the community. You see that in many details in the bill: from their appointment, how long they serve, what they get paid, that they're defined as agents of the crown, that their accountability agreements are signed with the minister—the list of their attachment to the minister goes on and on. There is not a similar attachment to the community they're supposed to serve.

I wanted to focus on your concern about privatization, however, because you are quite right: The bill has more than one provision that would allow for privatization. The one I want to focus on, because you work in a hospital setting, is section 33, which essentially says that the minister can order a hospital to cease performing any prescribed non-clinical services. It doesn't have any kind of date on it, it doesn't say who they're supposed to go to and it also doesn't define non-clinical services. About some parts of your tree, we might say, "Well, that's a non-clinical service," but that's open to interpretation. Certainly, your laundry, your housekeeping, your dietary, I suspect, would be under that rubric. So what do you think about a bill that says the minister can just go ahead and order any hospital to stop performing those kinds of services, and not only stop performing, but transfer them to another entity that could be a not-for-profit or a for-profit?

Ms. Susan Hughes: At Huntsville hospital, we lost our laundry service probably about 10 years ago. Our laundry service is contracted out, and there have been nothing but problems. Every Tuesday morning, I go upstairs and look for washcloths, towels and linen of any sort, because Tuesday is delivery day. Depending on the volume of patients we may have through our department

at one given time, laundry can be down. Infection control states that we need to change pillowcases, that we need to keep our area clean, that we need to be able to wash patients, dry them etc. That's not there, so we search for it. We complain, but that is a contracted-out position. They have no control over that, and we are expected to make do.

The Chair: Thank you. Mr. Arnott.

Mr. Arnott: Thank you very much for your presentation. I apologize that I missed the first part of it. I went back to my office over the lunch hour and I had a number of phone calls. But you've got a written presentation here that I know all the committee members have, and I look forward to going through it in detail. I'm certain that my colleague Mr. Miller would want me to pass along his very best wishes to you. He's got the same problem: He has gone to a meeting and has been delayed. Thank you very much for your presentation.

1320

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.ON

The Chair: The next presentation is from Julian Mazur, Service Employees International Union. Sir, you can start any time you are ready. It's a matter of 15 minutes.

Mr. Julian Mazur: I would like to introduce my colleague, Cathy Carroll, who is also from Service Employees Union, Local 1.on.

My name is Julian Mazur. I am a SEIU Local 1.on member. I have worked as a janitor at Toronto East General Hospital for 27 years. I have come here today before this committee to give voice to my deep concerns regarding what impact the local health integration networks will have for Ontario's health care system. LHINs will be bad for patients and health care workers alike.

I am the sole breadwinner for my family. I have an eight-year-old son to support and a mortgage to pay. I am worried that if my job is outsourced to a for-profit organization, my wages will be so low that I will not be able to support my son. I have seen hospital workers in British Columbia lose their jobs—and many, their homes—when Premier Gordon Campbell gutted their collective agreements and outsourced their jobs. Health care workers in that province now earn $11 an hour working for companies such as Sodexho, Aramark and Compass Morrison, and all lost their pensions and benefits.

I earn $33,500 a year. Minister Smitherman, in his opening remarks to this committee, said that 80% of the health care budget is related to human resources. This is exactly what the government wants to cut in order to achieve its balanced budget for the 2007 election. This government is going to balance its budget on the backs of those in the health care system who can least afford it. Many health care workers are immigrants and single-parent women trying to support families. Does this government really want to create a low-wage ghetto of health care workers? Is the Wal-Martization of non-clinical services jobs going to really make a difference in balancing the provincial budget when top health care administrators in hospitals earn $600,000 plus per year?

The real cost drivers of the health care system are doctors' fees. Last year, the Ontario government agreed to give general practitioners a 30% increase over four years. The escalating cost of drugs is also a factor.

The LHINs bureaucracy will add 550 more highly paid bureaucrats to our health care system at a cost of $52 million on an annual basis. That's about $95,000 per bureaucrat. Their only function will be to eliminate jobs like mine or sell them off to a for-profit company.

It will cost $200 million to get the LHINs operational. It will cost $20 million to dismantle the district health councils, and DHC members served for free, while all LHINs positions are paid. Twenty-one billion dollars of the $33-billion health budget will be downloaded to LHINs. For a hospital janitor, that's a lot of money to place in the hands of unelected Liberal appointees. And I object to seeing my public health care dollars being transferred over to the private sector. Put our health care dollars to work to build a better health care system.

The new LHINs bureaucracy will not add a single new caregiver to the health care system. Does this government really want to balance the budget on the backs of the lowest-paid workers in the health care system?

I have seen what the competitive bidding process has done to my fellow union members in the home care sector. It is a travesty that these workers are subjected to poverty-level wages and do not have the same rights to their jobs, when their home care agencies are flipped, as would any other Ontario worker whose company may be sold to another. They have successor rights to their jobs, and home care workers do not. Fix this system. Do not try to foist it on any other health care workers.

In the greater Toronto area, 16 hospitals have joined together to form Hospital Business Services. All material handling at each of the 16 hospitals will be turned over to this new entity on April 1. Supervisors will no longer be hospital employees; they will be HBS employees. I believe these are just the beginning stages of the privatization of non-clinical services in hospitals. HBS is the model, I think, that all LHINs will use to move functions not related to direct patient care over to for-profit enterprises.

In Toronto there are five LHINs. Each is to develop an integrated health service plan for its specific geographical area. How then can the HBS operate as a superstructure across the GTA LHINs if the LHINS, according to Bill 36, have exclusive jurisdiction in determining what services and how services are to be delivered in their area?

Sections 26 and 28 of Bill 36 give the LHINs wide-ranging powers to privatize. The bill allows for the transfer of services from public to not-for-profit entities. Section 33 allows the Minister of Health and the government to transfer services or to have a health care provider cease performing any prescribed service. This

bill, which allows a health care program or service to be moved from one location to another, means that health care employers can apply for Public Sector Labour Relations Transition Act votes frequently. It will create labour relations chaos. The government must amend the legislation to ensure that workers' jobs will not be sold off to the lowest for-profit bidder. Health care workers must not be stripped of their union collective agreements.

As a hospital worker, I do not want to see the end of central provincial collective bargaining. Central bargaining has given stability to labour relations in the hospital sector. With the creation of the LHINs, will each LHIN become responsible for labour relations? Since a LHIN's main purpose is to cut costs, the first thing a LHIN has to do, as the minister already has, is find ways to reduce the human resources component of the budget. With the introduction of the LHINs, is there any more need for the Ontario Hospital Association to act as a lobbyist or the lead negotiator in labour relations? I repeat that health care workers must have a right to a fair and impartial system of resolving collective bargaining disputes.

The Minister of Health says that this legislation will not close hospitals, but he cannot guarantee that services will not be transferred or that some hospitals may just become walk-in clinics or be converted into long-term-care facilities.

The minister said in his opening remarks to this committee that this legislation is not going to extend the competitive bidding model to the entire public health care system. He said that the words "competitive bidding" are not in the bill. This is exactly why health care service workers are very nervous. The weasel word here is "entire." Non-clinical services will be contracted out if this legislation passes. If the government side of this committee takes the minister at his word, then I say, put it into the legislation that health care service workers' jobs will not be put on the auction block to the lowest bidder.

Why should any hospital try to save money in their budgets or create a budget surplus if the hospital has to hand back any surpluses to LHINs? Numerous times in front of a hospital audience at open forums, the president of the Toronto East General Hospital, Rob Devitt, has said how pleased he is that our hospital has a surplus in the budget or that the budget is balanced. He is concerned that the LHIN chief executive officer will take any surplus in the Toronto East General Hospital budget away for the LHIN's own use. He wonders what the point is of cutting hospital costs and carefully managing the hospital budget. Where would the incentive be to cut costs and save? How can the 14 LHINs co-operate and coordinate with each other should a plague like SARS or pandemic bird flu strike Ontario, since public health is not included in the LHINs model?

I wish to thank this committee for your time.

1330

The Chair: Thank you. There are about 30 seconds each. I'll start with Mr. Arnott.

Mr. Arnott: Thank you, Mr. Mazur. You've raised some very important points. We've heard from a number of the representatives of the Service Employees International Union over the course of these days of hearings. Obviously you have good reason to be quite concerned about Bill 36, because a lot of these issues that you've raised haven't been properly addressed by the government in terms of clarification or reassurance that what you're concerned might happen will not happen. So I look to the government to bring forward the amendments in clause-by-clause that will address some of these issues, and we'll see how they respond. Thank you very much for coming in today to offer your advice.

Mr. Mazur: Thank you, sir.

The Chair: Sir, just one second.

Mr. Mazur: Sorry.

Ms. Martel: You want to run away.

I just want to focus on page 3. I'm not sure if you know this answer, Julian, or Cathy might. You referenced Hospital Business Services. What else do you know about this organization? What have you been told—I gather they're dealing with a number of unions that will be impacted by this—other than that people are going to go to this new entity on April 1? How many? Are they going to be doing their same jobs? What's the corporation's status? Is it a not-for-profit or a for-profit organization?

Ms. Cathy Carroll: Hospital Business Services is actually funded by this government.

Ms. Martel: By the ministry?

Ms. Carroll: There was money that was put in as start-up money from the Liberal government, and then hospitals were also contributing some money to it. The purpose of Hospital Business Services was to amalgamate backdoor services, as they call them: clerical, payroll, human resources.

Mr. Mazur: Stores, materials management.

Ms. Carroll: There were a number of things they started out with. Basically it's been put on hold. We have been very involved in the HBS process, and there is some collective agreement language that bars them from moving forward with their plans on some issues. But they certainly have said that they are going to start the human resources on April 1. Human resources, because it's non-union, wouldn't be covered by collective agreements, and therefore there would be an easier transition period for that time. But it certainly opens the door to the privatization of health care services, backdoor services, in the hospitals.

The Chair: Ms. Wynne.

Ms. Wynne: I'd just like to follow up on that. For Ms. Martel's information, as well, Hospital Business Services is a not-for-profit organization that's being created in order to facilitate the integration of those services for hospitals. I think it's exactly the kind of thing that we want to see happen in terms of cutting down on those administrative costs and keeping those costs in a not-for-profit system. So that answers Ms. Martel's question.

Ms. Carroll: But just—

Ms. Wynne: Can I just ask you a question on your presentation? You talked about the concern for jobs and the transition planning, that kind of thing. We have had

some of the union groups talk about the need for a human resources plan. Could you speak to that and whether you would support that idea as something we should be looking at?

Ms. Carroll: Absolutely. The government should be sitting down with the unions to develop a human resources plan. I would have hoped that that human resources plan would have been developed prior to the legislation coming into effect, that we would have had our input on the problems that would have come around the legislation as it related to the human resources issue.

You mentioned the models of BC and Alberta. In Saskatchewan there was major health care restructuring. The thing that happened in Saskatchewan was that the government went to the unions before they introduced the legislation. They consulted fully with the unions. The unions even went into the workplaces with the government to introduce the legislation and what the effects of restructuring were going to be, so that there was a harmonizing kind of air around the restructuring that the government wanted to do. We're not opposed to restructuring; it's the processes that are put into place for restructuring.

Ms. Wynne: So you would support a human resources plan being put in place?

Ms. Carroll: Absolutely. It wouldn't be in our best interests not to do that.

Ms. Wynne: Okay, thanks.

Ms. Carroll: Just to answer on the HBS, because I think it's important that you know: With the HBS, yes, it's the restructuring of it. Where the problem lies is these workers' pensions. These are hospital workers who belong to a pension plan. If they are moved into this private entity, they lose their pensions because they're no longer employees of the hospital; they're employees of the HBS.

The Chair: Thank you very much for your presentation.

CARE WATCH

The Chair: We'll go to the next presentation, from Care Watch; Bea Levis, chair. Good afternoon, ladies. Please have a seat. You have 15 minutes to make your presentation.

Ms. Bea Levis: With me is Charlotte Maher, who is the treasurer of Care Watch.

Care Watch is an incorporated, not-for-profit education advocacy organization with a particular interest in community-based long-term care. We try to help people use existing services effectively, and we advocate with the Ministry of Health and Long-Term Care and others for better access to more and improved services. We are strongly in favour of client-centred, integrated health care.

From the perspective of our particular interests, integration of services means a long-term-care continuum, which includes in-home supportive services for persons with disabilities, chronic illnesses and those with age-related disabilities.

We have been very distressed that supportive home care has all but disappeared in Ontario. This has happened without consultation or even public recognition from the Ministry of Health. We hope that the community engagement provisions in the act will be taken very seriously by the ministry so that the cynicism that many people feel after so many structural changes in health care delivery will be dissipated. We trust that everyone involved realizes that a major attitudinal shift must accompany restructuring if it is to succeed in creating positive change. It is encouraging that the committee has scheduled extra time for hearings in Toronto, and we certainly appreciate this opportunity.

Integrated health care has always sounded attractive. While the Canada Health Act, which Canadians value so highly, never contemplated anything beyond the cost of doctors and hospitals, current experience has shown that health care today has many more sectors than we have listed. Most Canadians will at some time or other need care from one, two, three or more of these sectors, often simultaneously. Integrating all sectors of our system could produce what many of us have dreamed about and talked about for years: a seamless continuum of care within which patients could move as their health needs required among various levels of care and move without delays or undue difficulties. With our currently fragmented health care system, integration means a lot of changes, and change is never easy.

In looking at Bill 36, we are looking at how its provisions would affect us and what opportunities it would provide for input from all of us, including ordinary citizens and organizations that serve and advocate on their behalf.

Our first concern is with the provision, repeated several times in different sections, that LHIN boards and organizations of health providers must make no decisions that are not in accord with the strategic plan being prepared by the Minister of Health. That plan has not, however, been made public, so that we are, in effect, being asked to comment on the means to an unknown end. Furthermore, we have had no indications that public consultation about the strategic plan is being contemplated.

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We have not forgotten that the crucial matter of defining LHIN boundaries was carried out through a method chosen by the ministry. Public input was invited only on minor adjustments to the boundaries. Yet this may have been the most critical decision in the whole transformation process.

Our next concern is with the foundation of all policy-making, which is funding. No policy can be put into effect unless adequate funding is made available. There has, so far, been no indication of the basis on which funds will allocated to the local health integration networks. Will it depend on the population viewed through an age/gender lens? Will it be considered with a more finely differentiated lens? Will it depend on the persuasiveness of the board chairs in negotiations? Will it be adequate to enable all the services planned by the boards?

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

Managed competition in home care is another sad example. Community-based not-for-profit agencies have been squeezed out in favour of mostly large corporations with no community ties or commitments. The essence of caring has suffered greatly. We have lost the contribution of agencies that have for many years provided excellent service and, equally important, played a substantial role in promoting caring, coherent neighbourhoods and communities.

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

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

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

The provision for a health professionals advisory committee seems reasonable, but it is disappointing that no provision has been made for seniors advisory committees, which the many community and health provider organizations affiliated with the Elder Health Elder Care Coalition have been urging for well over a year. The integration of care for the elderly should be an immediate and crucial undertaking for the LHIN boards, because we all know that seniors, proportionately, are the major users of health care. Priority-setting workshops across the province recognized that senior health care and care for the mentally ill should be the top priorities for service integration. The voices of seniors need to be continuously available to every LHIN board.

Many of our members are wondering if the whole LHIN project is a backdoor way to bring in two-tier medicine. We trust this is not the government's intention, but there's not much in the legislation to reassure us. Are "the purchaser-provider split" more palatable words for managed competition? We have not forgotten how public-private partnerships were given the more palatable name of "alternate financing initiatives."

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

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

Care Watch has, therefore, concentrated our attention in this submission on two crucial questions: Will there be adequate opportunities for ongoing public input? Will there be adequate guarantees that our health care be delivered only by non-profit public health entities?

There is no question about the validity of increased service integration. We believe that such change is possible if the ministry increases its capacity to engage the community in a more forthright manner and if a collaborative rather than a competitive climate between providers is cultivated.

The Chair: Thank you very much for your presentation. There is no time for questions. I know you were ready for them, but we don't want to have the other people waiting. Thanks very much, though, for making your points.

Ms. Charlotte Maher: It was a good presentation, though.

The Chair: Yes, it was—super—and we have it in writing too.

SUDBURY MINE, MILL AND SMELTER WORKERS UNION, LOCAL 598

The Chair: The next presentation—it's a teleconference—is from the Canadian Auto Workers, Local 598. Do we have Anne Marie MacInnis on the line?

Ms. Anne Marie MacInnis: Yes, I'm here.

The Chair: Good afternoon. Would you please proceed with your presentation?

Ms. MacInnis: I certainly will. Good afternoon, ladies and gentlemen. My name's Anne Marie MacInnis, and I am an activist. I've been a long-term-care worker for 25 years, and I am a member of the Sudbury Mine, Mill and Smelter Workers Union, Local 598, Canadian Auto Workers.

I was pleased to hear from Kevin Dwyer, indicating I could make a presentation to the standing committee on social policy regarding the legislative directions proposed by the government in Bill 36, the Local Health System Integration Act, 2006. I will begin with a brief summary of how health services have been affected in my community.

Citizens in our northern community in the Sudbury Basin have been experiencing challenging times in an effort to access health services. Our community was in an emergency crisis situation. There was a limited amount of long-term-care beds to meet the needs in our geographical area. People who lived, worked, raised their families and have paid taxes had to leave our community and be placed in other regions. They were taken out of our community, away from their loved ones and placed in an unfamiliar environment. Recently, we have been allocated an additional 20 long-term-care beds as a temporary solution.

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Residents in our community received health care services delivered by three independent hospitals until the late 1990s. Those three independent locations will be combining services into one facility, Hôpital régional de Sudbury Regional Hospital. The one-site hospital construction has been stalled for years. Phase 2 of this project will now move forward. This phase will be put to tender, proposals will be received and reviewed, and a contractor will be chosen.

Non-clinical services and front-line jobs have been eliminated in the Sudbury region due to the AFP redevelopment. For many years, the Victorian Order of Nurses, with roots in our community, provided quality care to people in their homes. In the late 1990s, VON lost the home care contract through the competitive bidding process. Hundreds of workers lost their jobs and many are now working for the private companies that deliver home care services for a profit. Health care services to some of the most vulnerable people in society have been cut. Clients have told me personally that they do not voice their concerns or complaints because of fear that they will be labelled as trouble and will lose the minimum services they receive.

Long-term-care residents and workers may be some of the hardest hit in the restructuring process. The government-funded long-term-care facilities had 2.25 hours per day, per resident. That funding structure was replaced by the case-mix index and case-mix measure system, which is solely based on documentation. Residents do not receive the dignity that they deserve. Staff are overworked and understaffed and corners are cut. These facilities are their last homes. They truly deserve more in their final stages of life.

This legislation covers all hospitals, some mental health facilities, charitable homes for the aged, community health centres and government-funded health service agencies. This bill, as written, needs significant amendments. This proposed legislation must include a democratic process for community input and control. The public must have a system to appeal LHIN or ministry restructuring orders. LHINs must be accountable to the local community and to the elected government.

This proposed legislation must include protection for all workers who will be affected by the amalgamation of services and/or closures. Most health care workers in our province enjoy the benefits and protection of collective agreements negotiated by the unions that represent them. There must be accountability and transparency at all times in our publicly funded, publicly controlled universal health care system.

The Chair: We have about a minute each for questions, and I will start with Madame Martel.

Ms. Martel: Hi, Anne Marie. How are you today? It's Shelley. Let me ask you about competitive bidding, because you are right: The VON lost its nursing contract through the cutthroat bidding process at the CCAC after 80 years in the community. I remember that the chair of the board at the time said the reason they lost it is because they had benefits and it was too expensive to pay for their benefits. So we lost them after 80 years to a for-profit company that didn't even have an office in the community, much less staff.

Given what we saw with respect to that loss and the disruption both to clients of the CCAC who had been VON clients and to the workers themselves, what do you think is going to happen if the LHINs are allowed to acquire the rest of their services in that manner? I have had an ongoing debate with the government members, who say, "The minister said in his opening remarks that competitive bidding will not be the model that's used for the LHINs to acquire services, but there isn't anything in the legislation that prohibits them from doing so."

If it is extended, given what you already saw or what we saw in our community, what do you think will happen to other workers and other patients who get affected by that kind of purchase model?

Ms. MacInnis: I think exactly what's going to happen is what we have experienced specifically in our community. What happened was that services were cut to clients who were receiving the services. We have workers out there who used to have a not bad wage with VON. Now these workers are being paid $8 and $9 an hour. What's happening is that there is no morale, and it's so competitive that these poor workers are working two and three jobs to make ends meet at $8.50 an hour. What's happening is that we're really lowering the standard of living for people.

The Chair: Thank you. Mr. Ramal.

Mr. Ramal: Thank you for your presentation. I agree with you that health care in Ontario is facing a lot of problems. That's why our government and our minister are introducing Bill 36, in order to consolidate the efforts and resources to fix health care.

I was listening to Ms. Martel and you talk about competitive bidding. We cannot include all the details in the bill, but actually, what the minister in his opening remarks was very clear and obvious about was no expansion of competitive bidding. That's what he said. That's what he's going to do in the future.

I want to ask you a question. Do you think the LHIN is a good mechanism to engage many people in Ontario instead of people coming to Toronto seeking support and help and working with the minister in Toronto? Now we're shifting it to 14 jurisdictions, and every jurisdiction will be in charge of its area and will look after the people, especially people in the north.

Ms. MacInnis: I guess my response to that question would be that there are going to be service accountability agreements that certain agencies or institutions are going to have to sign. My concern is that when it comes to procedures in hospitals—I know that the cataract procedure has often been used—what's going to happen is that the hospital that bids the lowest to perform these procedures is where people are going to have to go. I'm from the Sudbury region. In the event I needed cataract surgery and, say, Toronto won that, that would mean I would have to travel, that I would have to leave my area to go down and receive that treatment.

One of the biggest things with this is that there has to be some democracy and communities have to be involved. There has to be a process in the event that we don't agree with what's happening. We should certainly have a voice.

Mr. Ramal: Definitely. It's very clear in the bill that community involvement and input are very important to us, to our government and our minister. It's stated very clearly in the bill. I wonder if you have read the bill or not.

Ms. MacInnis: I'm sorry?

Mr. Ramal: Actually, we have said it many different times in this committee during the last seven days. Many people ask about community involvement, and we have said very clearly that community input is very obvious and very important to us in order to proceed with our services.

Ms. MacInnis: Absolutely.

The Chair: Mr. Arnott, please.

Mr. Arnott: Thank you very much for your presentation. You've made a lot of very interesting points. You've highlighted some of the concerns I've had about this bill, having gone through a number of days of public hearings now. Really, there needs to be an independent and impartial appeal mechanism for communities that disagree with a LHIN decision. Somehow the legislation has to be amended to allow for that, so that there's a fair and independent appeal mechanism. I assume you would agree with that and would support an amendment of that—

Ms. MacInnis: Yes, I would.

Mr. Arnott: Okay. There is another big concern I have. You mentioned the issue of democracy and so forth. Bill 36, of course, is not the law of Ontario. It hasn't passed through the Legislature. However, notwithstanding that fact, the government moved ahead without the authority of the Legislature, without any legal basis, to set up the LHINs, hiring 14 executive directors and installing a number of board members. Do you not think that is, to some degree, contemptuous of the legislative process and contemptuous of the Legislature?

Ms. MacInnis: Hello?

Mr. Arnott: Can you hear me?

Ms. MacInnis: Yes. I can now. I'm in the car. I'm travelling. Was there a question?

Mr. Arnott: Would you agree that the legislative process has been usurped and the government has demonstrated, to some degree, contempt of the Legislature by moving ahead with establishing the LHINs without the legislative authority to do so?

Ms. MacInnis: Once again, I totally believe in the democratic process. I believe there should have been input from citizens, from the public and from the communities, and certainly recommendations. I believe there should have been some input.

The Chair: Thanks very much for your presentation.

Just for the record, I have been reminded that the Speaker of the House ruled in May 2005 that what the minister did was acceptable.

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CANADIAN AUTO WORKERS, NATIONAL OFFICE

The Chair: The next presentation is from the Canadian Auto Workers, national office. We have a team. Good afternoon.

Mr. Corey Vermey: Good afternoon. Unfortunately, Paul Forder, our director of government relations, was unable to attend. He's recovering from the announcement of the federal cabinet earlier this week, and we're trusting the health care system in Ontario will stand him in good stead.

With us today on behalf of the CAW national office is Darlene Prouse, the Ontario health care council president and a vice-president of CAW Local 2458; Nancy McMurphy, who sits on the CAW national executive board and is president of Local 302; and Barb Maki, who is with CAW Local 229 from Thunder Bay and sits as vice-president of that local as well.

We thank you for the opportunity to present some very brief remarks. We have a fuller submission, to which we hope those who want to engage in the issues we raise will refer in terms of the supporting rationale. Obviously, we wouldn't have the opportunity to engage fully in this debate within the 15 minutes allotted by the clerk to our presentation today.

We certainly welcome this opportunity and want to preface our remarks by clearly supporting the effort toward integration and indeed the broader transformation of the health care system. It's one that our union and I think all advocates for medicare and a publicly funded and delivered health care system can endorse. The issue, however, with the legislation as proposed does give us several concerns. We see inadequacies in several fundamental areas, sufficient that without significant amendment to the bill, and we understand there are substantive amendments that have been brought forward to the attention of the standing committee, our union, CAW Canada, cannot support this legislation short of those

issues being addressed, and we trust the committee will so advise the Legislature in its report.

The two key areas of fundamental concern for us are the absence of any meaningful public consultation or civic engagement. We have read the proposed legislation and are aware that there are references to obligations to engage in civic engagement. We believe that the statute, if passed by the Legislature, should set out very clearly and substantively what those obligations are and what the respective parties bearing those obligations will engage in in terms of ensuring a democratic and equitable representation of the diversity within our province and our communities.

We had hoped that this juncture in health reform and transformation would have been a jumping-off point for permitting communities and the people of Ontario to more actively participate in the policy dialogue and the policy choices and debate surrounding health care delivery, and they are clearly significant issues for the people of Ontario.

Secondly, as the largest private sector union in this province, we also represent some 20,000 health care sector workers. We would wish for no less for those 20,000 health care workers than we work for on behalf of our private sector membership, and that is that there be a labour adjustment strategy in the first order, a provincial sectoral strategy, in which the effect upon health care workers is addressed, and in specific instances, in terms of transformation, integration or coordination by the LHINs, there are human resource plans negotiated to address those effects.

One considerable concern we have in the legislation is the distinction that is drawn between professional and, therefore, non-professional, and between clinical and non-clinical. Quite recently, we had a hospital approach us as the bargaining agent and advise that they were taking a classification, "patient service associate," a generic, multi-skilled classification that they had employed for over 10 years—it was essentially a patient-centred, patient-focused single point of service within a hospital setting—and preparing to disentangle the various functions and return to the dietary, housekeeping and nurse's aide roles that had existed in the past. It was very clear that that initiative flowed from their reading and understanding of Bill 36 and the distinction in that proposed act around "non-clinical." To us, that certainly does not seem to be an effective care model to be pursuing.

We certainly will continue to engage the government and our communities on the proposed legislation and the ongoing efforts around transformation. We are trusting that it will be understood that the CAW will not accept any rollback or lessening of the current standards with regard to the fundamental areas of concern for us; namely, the democratic input and engagement of citizens. We would expect no less than what would be current in terms of involvement and disclosure with public hospital boards, for instance, nor anything less in terms of the participation within our communities and recognition of rights of health care workers.

I turn it over to Nancy at this point.

Ms. Nancy McMurphy: We recommend that the proposed application of Bill 136, Public Sector Labour Relations Transition Act, 1997, under section 32, extend to any integration under the act without exception, including when the successor employer is not a health service provider or its primary function is not the provision of services within or to the health services sector.

We further recommend that the proposed section 33 of the bill, permitting by regulation an order that a public hospital cease performing any prescribed non-clinical service and transfer such services to another entity, be removed from the act, or alternatively, that subsection 33(3) be amended to clearly provide for the application of Bill 136 to any order, direction or decision affecting non-clinical services performed at a hospital or other health service provider.

We insist that the transformation or integration contemplated under this proposed act not proceed without a negotiated provincial labour adjustment framework and LHIN-based human resources plans or programs to deal with the potential adverse impact on workers that may arise.

We would recommend that the bill be amended to require the minister, prior to issuing the provincial strategic plan, and the LHIN, prior to the release of an integrated health services plan, both develop a human resources plan through negotiation with affected employee representatives that sets out the labour adjustment obligations necessary to minimize any potential adverse effects of integration strategies or health service workers.

Ms. Darlene Prouse: Legislative purpose: We recommend that matters set out in the preamble be included in the purpose of the act, reflecting the earlier legislative intent adopted in Bill 8, and particularly to affirm that a strong health system depends on collaboration between citizens and their communities, health service employees and employers, and government.

We would also like to recommend that the proposed purpose of the act at section 1 include "improving patient safety; enhancing workplace health and safety and improving quality of service and outcome," to provide greater balance to the current wording, "effective and efficient management," by focusing on both.

Civic engagement: We recommend that the references in the preamble to enabling local communities to make decisions about their local health systems be expressly added in the purpose clause and strengthened with express obligations for equitable representation of the diversity within our communities in the development of the provincial strategic plan and of local communities in the development of integrated health service plans.

We would also like to recommend that the bill be amended at subsection 16(2), which requires the LHIN to establish a health professionals advisory committee, to also require separate advisory committees for representatives of the various communities and for non-professional employee representatives from the health services provider within the LHIN, including represent-

atives from the major health bargaining agents and labour council bodies.

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We would also like to recommend that, at a minimum, the LHIN board be subject to:

—the same obligations as in Bill 123, requiring openness and access for the public to meetings of provincial and municipal boards, commissions and other public bodies; and

—conflict-of-interest guidelines, as previously applied to the district health councils and other non-profit voluntary boards in the health sector, must apply; and

—appointments be restricted to Ontarians who have demonstrated in their public life to the people of this province or their local communities a clear, non-partisan commitment to the principles of medicare.

Ms. Barb Maki: In conclusion, we commend the government for its ongoing commitment to securing the future of medicare in Ontario through adoption of many of the recommendations of the Romanow Commission. As the Minister of Health stated to the Legislature on November 27, 2003, in presenting Bill 8, the Romanow report came to one pivotal and irrefutable conclusion: the pursuit of corporate profit weakens, not strengthens, health care. The test of both Bill 8 and Bill 36 in recognizing the legacy of the deep and profound commitment of Canadians to medicare is whether such legislation strengthens and deepens the ability of the people of Ontario to hold their provincial government, LHIN board and local health care providers accountable for strengthening health care. As well, there must be a strong resolve to resist creeping privatization that threatens access, quality and sustainability of universal public health care.

The Chair: Thank you. There's about three minutes. Mr. Fonseca, one minute, please.

Mr. Fonseca: I'd like to thank the CAW for your presentation. I know many of your comments were made around community engagement and, really, that was at the heart of this piece of legislation as it was being put together. The minister wanted to make sure that the definition of "community" was one that would be broad yet inclusive, so that it would involve patients, individuals and health care workers, and did not want it to be constrained in any way in terms of how that engagement would work. From the beginning, he's had much consultation with the community. Some 4,000 to 6,000 people have come forward at different town hall meetings. We're going through this process right now in committee. But moving forward, I think what the minister is envisioning and what communities want are town halls and any way that they can put their voice forward and engage in this process. How would you see it happening in terms of community engagement? What would be some of the best vehicles towards having that dialogue?

Mr. Vermey: Our first proposal would be that the model of governance in the school board and municipal sector be relied upon. The LHINs will be entities with substantial resources, covering a much larger jurisdiction than existing school boards or municipalities. But clearly, we have a long tradition in Ontario of electing at those levels representatives from our communities to engage in the governance of those systems. We're somewhat disappointed that that hasn't been part of the discussion the minister has had with the province.

We understand that those long and deep traditions cannot be created overnight. We understand that there may be a need to evolve towards a situation where the people of Ontario are ready to govern their regional health structures in such fashion.

Mr. Fonseca: One of the things about that is that in Ontario, because we were the last to bring in a form of regionalization, we were able to learn from many of the other jurisdictions, which did bring forward elected types of boards, and they've all reverted to appointed because they found that it didn't work. What we've done is learn from their mistakes and bring forward the best, so that these appointees can have the knowledge and skills that are needed to be able to address large concerns and issues around health care. We want to make sure that people have the right skills to make those educated decisions for the community.

The Chair: Thank you. Mr. Miller.

Mr. Miller: Thank you for your presentation. You said at the beginning of your presentation that you support integration but you wouldn't be able to support this bill until you at least see the amendments that will be coming forward. On that point, Mr. Chair, a question for you that was also asked of me by the Grand Council Chief of the Anishinabek First Nation, John Beaucage, that the committee be able to see the amendments, particularly as they relate to First Nations, as soon as possible. I'm wondering when the government might have the amendments to do with First Nations and when the opposition will be able to see those amendments.

The Chair: When the whip has a seat, I will ask her to potentially answer your question, if she has an answer.

Ms. Wynne, there's a question for you, if you can answer. Mr. Miller would like to know if the amendments that the minister is—

Mr. Miller: Particularly as they relate to First Nations, when we might be able to see them, when they'll be ready, to be sure that we're going to have enough time to—

Ms. Wynne: My understanding is that the committee will receive the amendments at the same time as all the amendments come forward, but the minister is in an ongoing conversation. There will be another conversation with the First Nations folks. So they, I hope, will see the amendments before we do. I think that would be appropriate.

The Chair: Okay, thank you. Ms. Martel.

Ms. Martel: Thank you for your presentation today. A comment and then—maybe two comments. Let me see if I get a question out of this.

The first one has to do with the absence of any meaningful public consultation or civic engagement. The bill is so bad that when a LHIN makes an integration decision, the only group that has to be advised of that is the health services provider. There's not even a mechanism

here for the community that's going to be affected to have a say. Where's the meaningful consultation and dialogue when that kind of decision-making can go on? Over and above that, the service provider has 30 days to respond, and he or she responds back to the same group that made the negative decision in the first place. So it's hard to imagine much of a positive change happening from that process.

Secondly, I'm glad that you made the point about the provider, who for 10 years has had this patient service associate position and is now advising you, as the bargaining agent, that they want to change the makeup of that position. There's been quite a debate in this committee around section 33 and whether or not it opens up for privatization. I have consistently argued that yes, it does. It's one of several sections in the bill that does. It does from the fact that it is completely limitless in terms of when any of these orders can be made by the minister for a hospital to cease and desist from providing a service. Over and above that, "non-clinical" is not even defined, so that leads us to significant interpretation from one side or the other about what non-clinical is.

Given that you've already brought to the committee's attention today a very real scenario that flows from this section, how concerned are you, if we don't repeal that, that you're not going to see more of the same, not only with you as bargaining agents representing workers, but other unions representing other workers facing a similar thing in their own hospitals?

Mr. Vermey: Very concerned. Obviously, in this situation that we've brought to the attention of the standing committee, it's a very large tertiary hospital in one of our large urban centres in the province. Because it is a multi-site hospital, on one of the sites there is a for-profit multinational cleaning contractor.

It's very clear that as long as there is fiscal pressure on that hospital, there will always be a sort of knee-jerk reaction. One of our concerns is that the past history of restructuring in Ontario has always focused on the labour side as the easy area of savings. As opposed to looking at clinical utilization, looking at harnessing our medical and nursing protocols of care or diagnostic testing and really making sure we're efficient in those respects, we immediately look for very quick-fix solutions around how housekeeping or dietary services are provided. That's an indictment of health care service providers as much as it is of any policy of a government, present or previous. However, the issue is, this clearly has been a signal received by the health care providers, and we're very concerned about that very specific aspect of this legislation.

The Chair: Thanks very much for your presentation.

1420

NATIONAL PENSIONERS AND SENIOR CITIZENS FEDERATION

The Chair: The next presentation is from the National Pensioners and Senior Citizens Federation; Art Field, president. Mr. Field, if you can have a seat, there are 15 minutes for your presentation and potential questions. You can start any time you're ready.

Mr. Art Field: Thank you. I don't have a brochure to hand out like everybody else. I have 10 points to bring up, and we'll go from there.

I'll explain our organization first. I'm Art Field. I'm the president. The National Pensioners and Senior Citizens Federation was incorporated in 1954 in Saskatchewan. We're a federal organization. It's not by design, but our first vice-president is from British Columbia; our secretary is from Saskatchewan; I'm the president, and I live in Ontario; the treasurer lives in Ontario; our third vice is from Windsor, Ontario; our second vice is from Nova Scotia; and up to our last convention we had a third vice, who was a past president, from Newfoundland. Our main objective is that we go to Ottawa and meet with the government and the opposition MPs with briefs from our convention.

I live outside Lindsay, Ontario. There's a high density of seniors. That's one of the reasons I'm here. I've been very involved in my community in all sorts of activities, so I have an idea of what is going on.

I am concerned. Central East: city of Kawartha Lakes, Northumberland, county of Haliburton, Durham region, Scarborough and Peterborough. I don't know what Scarborough would have in conjunction with Lindsay or even Peterborough. I think it's too big an area. We've gone through this with the school boards. I don't know if it's working or not, but they do have elections.

As I said, we have a high population of seniors. Lindsay hospital has an elected board. I go to the board meetings when they have elections. I've never been on the board. Lindsay hospital has 400 volunteers in its auxiliary. I don't know how that hospital would run if it didn't have the 400 volunteers. It also has an excellent emergency service. I am told by the people in the hospital that it is probably the most used emergency service in Ontario because people come in from Oshawa or whatever. I know, in my trips there, I always count the people in there. There are lots of people, but they're getting the service.

The other thing is, I don't think we need any more contracting out. I understand, through my vice-president in British Columbia, that BC has sort of the same system and they're not too happy with it. One of the appointments to their board or LHIN, as you call it here—I don't know what they call it out there—was the CEO from London Drugs. I don't know if he has a conflict of interest or not, but it would be scary. I think that this will lead to more privatization of health care systems, and it's creeping into Ontario now. Our association is definitely against that, and we've had a lot of resolutions at our convention on that.

Point number eight is the lack of democracy and the lack of access to information.

Number nine: A community loses input—I picked up a couple of things here listening to the presentation ahead of me. Seniors aren't a minority group anymore. We're a

majority, but sometimes we've been treated like a minority. I realize it has nothing to do with here, but the new federal government—that I saw, anyway—didn't appoint anybody to the seniors portfolio.

Those are just some short things that I have brought from our travels around. As I say, I didn't have anything put together. We are a volunteer organization and we don't have an executive director. We went through that scenario and went broke. So now we're on the other scenario of getting it back together. I just hope that I put some input to help things here. I will answer any questions, if capable.

The Chair: There is time. There is about a minute and a half for each group to ask and for you to reply. I will start with Mr. Miller.

Mr. Miller: Thank you very much for your presentation. It sounds like you're very involved with the community. You highlighted all the good work the 400 volunteers do at the Lindsay hospital, and certainly I'm sure they're valuable, as they are at all hospitals across the province.

One of the points you made was that the LHIN for Lindsay also includes Scarborough. It's large, for one thing, and the boundaries aren't necessarily where you think they are. The government has split the province up into 14 local health integration networks. Have you got any recommendations on how, if you're going to go to this regional strategy that they're heading towards, you would split the province up other than that? They claim it's based on referral patterns.

Mr. Field: We're still rural Ontario, and you're putting Peterborough in with us, which has a fairly large population, as you know, and then Scarborough and even Durham region. I worked in Oshawa for 35 years; I was a CAW member, so I was listening to the presentation before. There's a difference. We always had the little joke that once you get over the ridges, the thinking is different. The thinking is different in politics and all the other things that go on. I don't see why our health system has to be tied, in even with Durham region, to be truthful, even though General Motors is the largest employer in the Peterborough, Lindsay and Halliburton area. Still, I think to keep ourselves under—that way, we don't need those big centres. Will they be the big ones and control it? I don't know. I just think it's wrong because you're getting different people with different thoughts and a different lifestyle.

As I say, we have the 400 volunteers. I don't know how other hospitals work. I know there are some problems in the Oshawa one, because we, the CAW, used to donate a lot of money to them through payroll deductions and everything, or the union would give, and I think we had a member on the board. I know there are problems there, but the Lindsay one seems to be going very well. Of course, there's a lot of usage there, but I've seen that it's well run. All my children were born there, and my wife just came out of the hospital last week after a woman's operation. So my agenda, even though I'm in a national organization, is that I just want to keep us with our situation. I have nothing against the Durham region or Oshawa or Scarborough, but there are different thoughts there.

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

Ms. Martel: Thank you for being here today. You know that I'm from Sudbury, and we used to say, "The thinking is different when you get past Wonderland."

Mr. Field: Well, you've come a long way.

Ms. Martel: If you go to northwestern Ontario, it's when you get past Sudbury that the thinking is different too, but we won't talk about that.

From my part of the world, the North East LHIN goes from James Bay down to past Parry Sound and points in between—34 hospitals—with a major regional centre in Sudbury and some bigger centres, clearly, in some of the more major centres of Sault Ste. Marie, Timmins and North Bay. Folks at home are worried about this: They look at this bill, see the words "integration" and "consolidation of services," and say that the real aim here is going to be for the minister, through the LHIN, to figure out how we can centralize a lot of hospital services either in Timmins, North Bay or Sault Ste. Marie, or then further centralization into Sudbury, because it is already designated as a regional centre. Those concerns are legitimate, because we know people travel now to Sudbury for cancer, for neonatal services, for cardiac. Sudbury might benefit by having even more people travel, but I don't want to see that. I want to see people get their services close to home.

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When you look at your LHIN and the composition, which is rural, suburban and then very metropolitan, are the folks saying those kinds of things to you too? Is their concern that by the time this is all over, community hospitals at which you used to receive services, which they have supported through their tax dollars and perhaps through the municipality and through fundraising, are going to be hospitals that no longer have those services, and they're going to be travelling long distances to a major medical centre to obtain what they could have got close to home before?

Mr. Field: Yes, that's what we're concerned about. But the other thing is, some of us who are active in the community understand what's going on. I like to say we want to keep it rural, but we also are a bedroom community to Toronto, Oshawa and whatever, because they do travel, and some people don't take part in it. I just think the LHIN with Peterborough, Durham and Scarborough is wrong. I understand what you're saying; you've got a lot more land or more people—not people, more area—

Ms. Martel: More land.

Mr. Field: Our area is growing. They're building houses all over the place. But I just think it's wrong. Maybe you appoint somebody from Lindsay and another person is from Scarborough or whatever, and the thinking is different. There's nothing wrong with it, but I think we should be all on the same page here.

The Chair: Ms. Wynne.

Ms. Wynne: Thanks, Mr. Field, for being here. A couple of things: Right now, as it stands, the planning is done centrally in Toronto. There isn't a LHIN board that you can contact or that you can go to a meeting of, where you can hear what the local planning is. There really isn't anywhere you can go to get a sense of what the gaps in service are or what the future plans are for service in your area. You'd have to come to the ministry. You'd have to talk to people at Queen's Park.

We're trying to set up a structure that will allow you to have a place that you can contact. You'll have a group of people who are dealing with the service gaps in your area, albeit a broad area, and you will then be able to contact those folks and you'll know what the service plan is for your community.

I think the reason that the LHINs are shaped the way they are—and you mentioned it, or one of the opposition members mentioned it—is because of referral patterns. When people need a particular service that's maybe a once-in-a-lifetime service, they go to the larger centres. But there's nothing in this bill that suggests that all the services would be sucked out of the Lindsay-Peterborough area and put in Scarborough. That's not the idea. The idea is that when people need a service, they can get that service in a reasonable amount of time.

That's why we're putting the local health integration networks in place; in fact, the opposite of what you're saying or being told, that the community will lose input. We're trying to set up a situation where there will be a board of people who will actually be connected to you. I just wanted you to comment on the part of the bill that says the local health integration network must have a community engagement strategy, they must engage the community. And that means all the communities in their local area. They must engage those communities in a dialogue about the plan. Is that, to your mind, a good thing?

Mr. Field: In my mind, I think if you've got to make the change, there are not enough LHINs. You've got 14, you've got a billion-dollar budget and Ontario is the highest-populated province in the country. There are not enough of them. Your diverse thinking or lifestyle is different, and you're sort of putting us all in this one pot here. It doesn't work, and people don't take part in it.

Ms. Wynne: The Chair is going to cut me off, but just so you know, there is a mechanism whereby more LHINs can be created if, in the future, that's deemed to be necessary. Thank you for your input.

Mr. Field: That would be tough. Once it's in, you generally don't want to add them.

The Chair: Thank you very much for your presentation.

ST. CHRISTOPHER HOUSE

The Chair: The next one is from St. Christopher House; Susan Pigott and Odete Nascimento. Good afternoon.

Ms. Susan Pigott: Good afternoon.

The Chair: You can start any time you're ready.

Ms. Pigott: All right. Thank you, Mr. Chair. Good afternoon, committee members. My name is Susan Pigott, and I'm the chief executive officer at St. Christopher House. With me today is the director of our older adult centre, Odete Nascimento.

I'm going to make a presentation and, when there are questions, I think both of us will take the questions.

Before I begin the formal part of our submission, let me point out that one of the other things I have the privilege to be involved in is as a board member of the Hospital for Sick Children here in Toronto. I have been on that board for the past seven years, and that experience has given me some sense of the pressures that are on institutionally based parts of the health care system, particularly the pediatric health care system, and has led me to understand how important it is that we have a good continuum of care that makes full use of the capacity of the community-based sector, if we're to make intelligent economic decisions around health care. That doesn't mean off-loading of services from the hospital sector on to the so-called cheaper community-based sector, but it does mean careful planning and adequate resourcing of this kind of transition.

Having said that, let me get into the submission, and you'll see we come back to these themes throughout. Very briefly, by way of introduction, we have provided written submissions, so I'm going to trip over this pretty quickly.

St. Christopher House is a community-based, multi-service agency in the downtown west end of Toronto. We've been providing services to the people in our community since 1912. We provide a wide range of services to people from all different cultures and all different ages. A significant amount of our work is done with elderly and disabled people, and also people with mental health problems.

Our services that would be of particular interest to you would include client intervention and assistance, Meals on Wheels, home help, respite and homemaking, transportation, friendly visiting, an Alzheimer day program, a frail elderly program, and caregiver counselling and training. In addition, we have an elderly person centre where we do socialization, fitness, wellness and health promotion activities. We provide our programs in four main languages: English, Cantonese, Portuguese and Vietnamese. These languages correspond to the primary language groups in our neighbourhoods of our downtown west end. We also run the Meeting Place, a drop-in for homeless individuals at Queen and Bathurst. Many of the people in this program unfortunately have drug addiction and mental health problems.

That's a little bit of a sense of who we are, and we're very pleased to have this opportunity to provide some input to your deliberations. We share the aspirations of the LHINs to better integrate health services and to develop a seamless continuum of service that is easily accessible to clients, and a system that makes efficient and effective use of health care dollars.

One of the things I want to spend a bit of time on now is what we've called in our paper "Understanding the role of community-based agencies in the LHIN." We are aware from previous deputations and from ongoing discussions we've had around health care issues that our sector is poorly understood. People want to know, why are there so many agencies like yours? Isn't there a better, more efficient way of organizing? I want to try and get beneath some of those questions and provide you with a bit of a sense of why we think we're so vital.

We are one of hundreds of locally based community agencies which, taken together, form a strong web of support for many of the most vulnerable people in our communities. We think that understanding how we work and the role we play in the system will be very important to the overall success of the LHINs.

First of all, we are the health care providers who help people to live independently in their communities, and in so doing, to prevent unnecessary hospitalization. We are also the providers who allow people to leave expensive hospital settings, because we support them in the community. We think the maintenance and ongoing development of the community-based sector is critical to the success of the LHINs.

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In addition to providing some of the hard services I've outlined, we also fulfill the following functions.

We're the eyes and ears on the community. We can inform the LHINs on an ongoing basis about emerging community needs, either new populations or new health problems.

We have a long history of collaboration. You are hoping in the LHINs legislation to encourage collaboration. You would have been hard put to find better examples of collaboration than what exists presently among the community-based sector. We're very experienced at working in partnership.

For example, in Toronto, community-based agencies, a network of 11 agencies, for many years now have worked together to provide transportation for seniors. We've managed to accomplish on our own a very effective transportation system for seniors. We have long-standing partnerships, many of us with hospitals. In our case, our older adults' centre has worked very closely with the seniors' wellness clinic at the Toronto Western part of the University Health Network for many years. What we've managed to do is provide the ability for the hospital to reach people in many different languages and across culture lines.

To give another example, the West End Urban Health Alliance is a long-standing network of community-based, hospital health centre organizations in downtown west Toronto that very effectively, again on our own initiative, have been working to try to improve the continuum of care in our community.

We are the conduits for health promotion information. Agencies like St. Chris, in our case through our innovative Health Action Theatre by Seniors—many of you may be aware of HATS—are able to reach out and do health promotion in many languages and to many different cultural groups.

We work well with our clients and participants in our programs to address the broader determinants of health: poverty; inferior housing; we work with people who are lonely and isolated; we also bring together segments of the community to address some of the bigger systemic issues.

We are an integral part of crisis response because we are nimble, close to the ground and can mobilize volunteers in our communities. We've seen two examples of this recently. One was with SARS, and the other was the blackout in Toronto, where, I have to say, in our part of town, our Meals on Wheels volunteers were the people who actually were on the ground with so many seniors who were in apartment buildings, terrified in their rooms with their door shut and no lights. The people who were there and able to get to them were our Meals on Wheels volunteers. We even had a volunteer who climbed 32 floors to get to the top of a building during the blackout because there was no elevator. This is not something to overlook in a time of crisis.

Finally, we harness the power of thousands of volunteers and other resources beyond the Ministry of Health. We bring those to the LHIN system.

These are the attributes of our community-based sector, and we are very concerned that Bill 36 and the implementation of the LHINs process does not undermine our capacity to fulfill these functions.

For that reason, we want to emphasize a couple of the recommendations—

Interjection.

Ms Pigott: Two minutes? I'll touch on them very briefly. You've heard about most of these from the Ontario Community Support Association.

We are very concerned that the local health advisory committees have inclusive representation from organizations that are in the community-based sector. We can only be an effective part of the LHINs planning if we're at the table, up front, making the plans along with the other players. It will not work if the plans are made and then dumped on us and we're expected to mop up or to pick up the pieces of decisions that are made that are not likely to be well executed in the communities.

We're very concerned about issues related to community engagement that we've heard about before. We are particularly concerned about language issues in a city like Toronto and in communities like ours, where there are very many people who are not going to be easily engaged unless we're attentive to their language needs.

I would just say, finally, that we're very much feeling that the role of the CCACs should be confined to the health care services they currently broker. We are not big fans of managed competition. We believe in accountability. We believe in quality of services. But we believe, more than anything, in ease of access and continuity of care for people who need our kinds of services.

I've really cut short the recommendations, but they're not ones that you haven't heard before. They're in our submission.

In closing, let me just say how much we look forward to playing a role in the implementation of the LHINs, but in order to do that we have to be at the table and we have to be part of the planning of health care services in our communities.

The Chair: I want to give 30 seconds each to ask questions.

Ms. Martel: Actually, I just want to make a point. Thank you very much for reinforcing the attributes of the community-based sector.

I'm a cynic. Maybe I've been here too long, but I look at this and think that this legislation is a mechanism for the government to essentially reduce the number of not-for-profit community agencies out there, saying that there's too much duplication, whether it's in the mental health sector or the community support sector etc.

What I know from my communities is that those organizations have had long-standing relationships, for many years now. They didn't have to be told to get rid of duplication and to work together. They've had to by necessity; in our part of the world, sometimes by necessity of geography. But certainly they have been working together for many, many years now. The issue among them is not finding savings by getting rid of it. What they really need is some more money to provide the very good services that they're trying to deliver.

I just want to say thank you for reinforcing why so many of these not-for-profit providers have a particular place in the whole continuum of care, one that we should respect and not be looking to get rid of in the name of duplication or whatever name you want to attach to it.

Ms. Pigott: Thanks.

The Chair: Mr. Fonseca.

Mr. Fonseca: Susan and Odete, thank you very much. As you know, my grandmother is one of the members at St. Christopher House.

Ms. Pigott: We do know that.

Mr. Fonseca: Following up on some of the remarks that Ms. Martel made, we want to use a situation like yours, where it's community-based. I've seen the excellence that you provide in terms of care and service, and how you've worked to collaborate and integrate with all other community providers and our hospitals etc. What we're trying to do with the LHIN—do you feel this is a good process?—is to take your model and transplant it all over the province. It's not happening everywhere, but we want to make sure that those best practices do happen in other communities so that people could get the great care that I know my grandmother does at St. Christopher House.

The minister has toured your facility at Dundas and Ossington. He's well aware of the great work you do, and he has said that this is what he wants to see in communities across Ontario.

Ms. Pigott: Thank you very much for that. Of course, I'm not going to say that we wouldn't like to see that happen everywhere, but I just want to make the point that there are certain conditions in our environment for doing business that allow us to be able to do what we do: We have some long-term stability in terms of being able to plan and to attract and maintain excellent staff and volunteers, to be able to locate our services for seniors alongside services for other populations so it doesn't become a sort of ghettoized situation, and the ability to not try to do everything but to concentrate on what we're good at and work in partnership with other organizations.

These very factors that help us be as good as we try to be are things that we are fighting to protect in this current health funding environment. We just want to make sure that the LHIN process does not inadvertently undermine the very conditions that allow us to provide relatively inexpensive, high-quality care in our communities.

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

Mr. Arnott: On behalf of the Progressive Conservative Party of Ontario, I want to express my appreciation as well to your organization for the good work that you do.

I don't have a lot of time, but I just wanted to ask you about community engagement. What would you like to see in terms of a response by the government to ensure that good community engagement takes place at each and every LHIN across the province?

Ms. Pigott: I think what would be very helpful is if we could actually see in the LHIN legislation itself a little bit more language about community engagement that at least refers to the fact that we live in a multilingual, multicultural society, and that there are extra efforts that have to be made, particularly where there are large non-English-speaking populations.

Then in the fine tuning, I think it would be very important to try and have each LHIN determine what is the appropriate level for community engagement in that particular LHIN. Community engagement is one of these terms that really can be a once-over-lightly kind of thing, and we want to see that it's meaningful and deep.

In terms of actual changes to the legislation, what we would like to see addressed at the very least is the language issue. It seems hard to believe that it wouldn't be in a province like this in this age.

The Chair: Thank you very much for your presentation.

Ms. Pigott: Thank you for all your hard work. Good luck.

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TORONTO HEALTH COALITION

The Chair: The next presentation is from the Toronto Health Coalition. Good afternoon, ladies. You can start any time you're ready. There are 15 minutes in total.

Ms. Pat Futterer: I am Pat Futterer of the Toronto Health Coalition. My colleague on my left is Christine Mounsteven, and Gerda Kaegi is on my right.

The Chair: Welcome.

Ms. Futterer: Thank you. The Toronto Health Coalition, a non-partisan organization founded in 1998, is one of over 50 local health coalitions in communities across the province. Although our members come from

all walks of life, all political parties and diverse cultures, we have a common goal: to maintain and enhance a quality, universal public health care system under the principles of the Canada Health Act. We are closely affiliated with the Ontario and the Canadian Health Coalition.

The first duty of any government is to protect its citizens. Public trust is at least partly predicated by taxpayers' faith that their government is advocating on their behalf, getting the best deal possible and, in this case, ensuring that we all have universal access to quality health care.

Certainly the aim as presented in the preamble to the Bill 36 legislation regarding the integration of health care in Ontario would suggest that the government is indeed advocating on behalf of all of us in Ontario. No one could possibly object to a commitment to equity and respect for diversity, better co-ordination of health service delivery to make it easier for people to access health care, public accountability and transparency, and so on.

In the Toronto Star on February 5, 2006, our Minister of Health and Long-Term Care was quoted as saying that critics of Bill 36 are "wedded to the status quo." Not so. It would be very naive on our part to pretend that we have a perfect health care system; we don't. We know that our system is ailing. It needs to be revitalized, and so the promise of an "integrated health system" that will "improve the health of Ontarians through better access to health services" as outlined in Bill 36, is very seductive. However, we are members of a watchdog organization committed to the preservation of public, not-for-profit health care, and although we applaud the intent of Bill 36 as outlined in the preamble, we have some serious reservations about what is revealed and what is not revealed in the remainder of the legislation.

Ms. Christine Mounsteven: Since the purpose of the legislation is "to provide for an integrated health system," why does it not include family doctors, dentists, optometrists and so on? How can a truly integrated system be achieved without the involvement of some of the major providers of primary health care?

Since community participation is a priority, why are the LHINs made up of boards of directors—appointed by the government, not elected by communities—whose qualifications lean primarily towards business and administration? Where are the health care consumers and service providers from the non-profit system? According to the information on the government website, however, you have not completed your hiring process. We hope you will aim for a more equitable balance of board members.

My colleague has already mentioned our commitment to a public health care system under the Canada Health Act. When we attended a LHINs workshop in November 2004, Gail Paech, lead for system integration, assured us that the principles of the Canada Health Act would be upheld by the LHINs. We have noted, however, that nowhere in Bill 36 is there any reference to the Canada Health Act, which is, after all, the centrepiece of medicare. Was this just an oversight? We hope that in your revision of the legislation you will make a clear commitment to the principles of the Canada Health Act.

As members of the Toronto Health Coalition, however, we are particularly concerned about the erosion of our universal health care through creeping privatization. I'm sure this isn't the first time you've heard about the threat of privatization during these hearings. In the remaining few minutes of our presentation, we will focus on what we fear may be an ever-deepening threat of privatization in our health care system as revealed both explicitly and implicitly in Bill 36.

In part V, sections 28 and 29, the bill stipulates that "the minister may ... order a health service provider ... that carries on its operations on a not-for-profit basis to ... cease operating," or "to amalgamate with one or more" other "health service providers." This legislation does not apply to a for-profit health service, however. Why are for-profit providers exempt from such regulations? We are deeply concerned—in fact, we are outraged—that the not-for-profit providers are in danger of being squeezed out while for-profit providers gain more and more control of our health care system. We strongly recommend that all providers, whether they are for-profit or not-for-profit, be covered by this legislation.

The term "competitive bidding" is never actually used in Bill 36. The fact is, however, that a price-based, competitive bidding system in home care services, first introduced by the Conservatives, has been retained by the Liberals. As a result, non-profit home care providers such as the VON have lost out in the bidding wars to for-profit companies. Under such legislation, LHINs would have the power to allocate funding, and therefore services, to entities that underbid others. Since the government has supported the competitive bidding model in home care, why wouldn't we be concerned that the minister might include the same model in his strategic plan for the entire health system? We strongly recommend that Bill 36 be amended to ensure that the use of competitive bidding in selecting appropriate service providers be prohibited.

In the Toronto Star on June 29, 2005, Ian Urquhart asked Mr. Smitherman whether the LHINs might be considering an expansion of for-profit health care. Mr. Smitherman responded, "I wouldn't say that is a goal of this model. I wouldn't say that it's envisioned and therefore it's speculative." Urquhart described his response as "cryptic."

Ms. Futterer: Thank you for taking the time to listen to us today. The fact that you've made it possible for individuals and organizations from all over Ontario to take part in these hearings is encouraging. As we mentioned earlier, we appreciate the intent of Bill 36. We hope you will be able to use some of our recommendations in revising the act and that the Minister of Health and Long-Term Care will keep our concerns in mind as he prepares his strategic plan. After all, we must believe everyone sitting in this room today wants an improved health care system that meets the needs of all Ontarians. Thank you.

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The Chair: Thank you for your presentation. There is less than a minute each. Ms. Wynne, please.

Ms. Wynne: Thank you very much for being here. Two quick things: First of all, is it reasonable to you that within a local health integration area there would be a plan that would have particular services that might be offered by a variety of providers and that there might be some sort of process—you could call it a competitive bidding process—whereby the provider with the best capacity and ability to provide that service would be granted that service? Does that make sense? I'm talking about the non-profit, public providers. That's my first question.

Secondly, a number of groups have talked to us about including the principles of the Canada Health Act in the preamble. Is that what you are envisaging?

Ms. Mounsteven: We would like to see the Canada Health Act mentioned. Nowhere is it mentioned at all.

Ms. Wynne: And you want it in the bill somewhere.

Ms. Mounsteven: Yes, absolutely.

The Chair: Mr. Arnott.

Mr. Arnott: A number of groups have asked for that specific amendment, that there should be some provision in the preamble to make reference to the principles of the Canada Health Act, and that Bill 36 would conform to those principles. We'll be interested to see if the government brings forward such an amendment.

You expressed concern about three major issues. You suggest in your brief that the purpose of the legislation is to provide for an integrated health system. Then you asked the rhetorical question, "Why does it not include family doctors, dentists, optometrists and so on?"

Quite a number of doctors have come before this committee, and I think the Ontario Medical Association as well is in favour of the establishment of a medical advisory committee to be associated with each LHIN. Would you agree with the Ontario Medical Association that that would be desirable so that there would be an ongoing mechanism for input from Ontario's doctors?

Ms. Gerda Kaegi: I think the committee has heard from me before, but I will try to respond. Yes, in principle, but not exclusively. In other words, the advisory committees have to have a breadth of the range of service providers, and it has to be stipulated, in our view, that that breadth must exist, and it's got to go beyond the medical association.

The Chair: Ms. Martel.

Ms. Martel: Thank you for your presentation here today. I'm glad to see that you came and that you raised your concerns and criticisms. I'm glad to see that you took on the minister head-on when he said that anybody who is a critic is wedded to the status quo. He also says that health care workers are only interested in keeping their jobs, as if people shouldn't worry about their jobs or the important health care services they deliver through those jobs.

In any event, let me get back to competitive bidding. The legislation deals with both for-profit and not-for-profit providers—for-profit particularly in the long-term-care sector. So it's hard to imagine how you could have a scenario where you might have some kind of competitive bidding process just among the not-for-profits when the sectors that the LHINs are responsible for are bigger than that. Having said all that, you've referenced competitive bidding. It's not in the bill. If the government means what it says, you're suggesting that it should. Further to that, what are the concerns you have with respect to competitive bidding, and what could happen if indeed this was brought in to include not only home care, which it does now, but also any of the broad range of services that the LHINs will have responsibility for?

Ms. Kaegi: Competitive bidding has tended to drive down the quality of care. It's the lowest possible price for the service. It has led to lack of continuity and a drop in quality of service. There's lots of documentation and research that's been done in the area, and we feel it's been destructive. So we don't believe that competitive bidding, as it's carried out now, has been appropriate at all. I think what we're talking about is, look at the quality and the needs and the service provision that people have a record of providing, their links in the community. There are other ways of evaluating service providers rather than the dollar figure, which has tended to drive much of what's taking place. We use the example of the VON, which has disappeared in many communities, including the one that Mr. Arnott represents. They have been driven out, and it's been tragic.

Ms. Martel: They lost in my community too, after 80 years.

Ms. Kaegi: Yes, in many parts of Ontario.

The Chair: Thank you very much for your presentation.

PSYCHIATRIC PATIENT ADVOCATE OFFICE

The Chair: The next presentation is from the Psychiatric Patient Advocate Office; David Simpson and Lisa Romano. Welcome. You can start your presentation whenever you are ready.

Mr. David Simpson: Good afternoon. My name is David Simpson. I'm the acting director of the Psychiatric Patient Advocate Office. With me today is Lisa Romano, legal counsel to the Psychiatric Patient Advocate Office. We'd like to thank the committee for its invitation and the opportunity to share our recommendations. You'll see that we've made some 36 recommendations in our submission. We're hoping that these recommendations will be adopted to further strengthen Bill 36 and the health care system in Ontario.

This legislation will bring about one of the most significant transformations of our health care system in Ontario, shaping and profoundly impacting how this and future generations will access care and treatment. It is because of the significance of these changes that we are here today.

What are our concerns? We are concerned about the availability of health care services throughout commun-

ities in Ontario. We are concerned about the accessibility of a full range of mental health services and supports to Ontarians in need of these services. We are concerned about the accountability of the Ministry of Health and Long-Term Care and the local health integration networks to the public by means of effective checks and balances.

What are the questions that we have about the proposed legislation? How will the new structure improve the delivery of health services in Ontario? How will the system be accountable to the people it serves? What rights-protection mechanisms are in place to protect not only the public but vulnerable populations such as those with mental illness? Why doesn't the legislation include rights-protection mechanisms reflecting a clear commitment to patients' rights? This would include such safeguards as an independent health systems advocate, a patient bill of rights, a transparent complaints process and a sunset clause that requires mandatory review of the legislation after a period of time. How will a system that has a local perspective take into account a provincial perspective? How will the power and authority of the minister and the LHINs be tempered with checks and balances that protect the public interest?

Let me begin by saying that we are supportive of the fundamental intent and purpose of this legislation but feel it could be strengthened via specific amendments for the benefit of all parties, including those with serious mental illness and addictions who will receive direct services under the proposed new structure. The proposed amendments would provide increased public protection, transparency and accountability. This is necessary because the LHINs are not accountable to the community but to the minister, and thus the necessity to have enhanced rights protection mechanisms included in the proposed legislation. We are here today to provide recommendations and offer solutions.

For the past two decades the Psychiatric Patient Advocate Office has provided independent advocacy and rights advice services to patients in the 10 current and divested provincial psychiatric hospitals in an effort to protect and promote their legal and civil rights. With over two decades of experience, we believe we are uniquely qualified to comment on the LHINs legislation, rights protection mechanisms, transparent complaint processes, transforming the health care system to better meet the needs of patients and the potential impact that it may have on our clients.

Although our experience within the health care system is specific to mental health and addictions, we believe that many of our recommendations are equally applicable to the broader health care sector and will lead to both enhanced system accountability and adoption of a client-centred, client-first and client-directed perspective.

The PPAO is supportive of the development of the LHINs, provided that a full range of mental health and addiction services, supports and treatment modalities continue to be available and accessible to patients, including both hospital and community-based programs. This includes timely access to services available in the home community of the person, and where those services are not available, the LHINs must have a legislated responsibility to connect the person to the appropriate service they require. Moreover, clients must not be asked to pay for such services, as they should continue to be provided by a publicly funded system.

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In cases where the client is required to travel to another LHIN to access services, a system of reimbursement of expenses similar to the northern health travel grant must be put in place. Many individuals with mental illness may not have the funds necessary to travel outside their community to access services. Funding must also be made available to individuals who choose to access mental health and addiction services outside of their home community due to concerns regarding conflict with a service provider, confidentiality, privacy or the quality of care that they would receive in their home community.

Mental health has been described as an orphaned child of the health care system, and for this reason, care must be taken to ensure that mental health services are neither eroded nor inaccessible to patients. It's hoped that each LHIN will have a champion for mental health, mental illness and addictions. The provincial government must continuously monitor the LHINs to ensure that individual service delivery areas and specific services are not neglected, underfunded or simply abandoned.

We would also like to recommend that the Minister of Health and Long-Term Care form an advisory committee on mental health, mental illness and addictions to provide advice and consultation to both the minister and the 14 LHINs on issues related to this sector.

The process for engaging with clients: It would be helpful for the legislation and corresponding regulations to specifically articulate the process whereby community or citizen engagement is undertaken and how such consultations should be conducted. The process for community engagement must be developed in consultation with a broad range of stakeholders, and the proposed legislation must specifically define what the term means. Further, the legislation must clearly define the community engagement process and include a mechanism for reporting back to the community the results of the consultation process. This will heighten accountability and further the public interest by having a real and meaningful process defined in the law.

We're also of the opinion that Bill 36 should define in law the basic basket of services required to be provided by each LHIN as well as the reasons why these services should be available in each local community. This will generate greater public discussion regarding health services and the expectations of the community to be able to receive care and treatment close to home.

Enhanced rights protection mechanisms would also be available if the legislation appointed or introduced an independent health systems advocate. That would be an important step forward in transforming health care in Ontario. An independent advocate could access not only

individual complaints but systemic complaints. This environmental scanning would allow for the identification of emerging issues and trends with recommendations for the allocation of health care resources. The health systems advocate could report annually on the state of health care in Ontario and make recommendations both to the LHINs and the government on how to improve the system at large, while also reporting on the overall health of the system itself.

We also believe that Ontario should consider adopting and implementing a patient bill of rights for the health care sector. This again would heighten accountability and public awareness with respect to quality care, service delivery, outcomes and expectations, and provide guaranteed access to services.

We're also of the opinion that a complaints process should be enshrined in the legislation that specifically talks about timeliness, a fair process and a transparent process, with clear timelines and possible outcomes for resolution defined in the legislation.

In terms of commitment to consumer-survivor involvement, it's our opinion that the legislation should specifically mention the role of consumer-survivor in the mental health and addiction sector. It's also our opinion that the legislation should require that all in-patient mental health care programs have a consumer and family council that's fully funded and has autonomy. Consumers and families have a more extensive role to play and much more to offer than is currently recognized or acknowledged in Bill 36.

We would also like to see recognition and inclusion of peer support workers and peer support specialists in the legislation. This would send a clear message about their importance in a transformed health care system. It would recognize the value-added contribution the peer support workers could make to mental health and addictions programs and lead to peer support for all medical conditions being seen as important and endorsed by the community.

Again, we'd like to suggest that the minister develop a consumer-survivor advisory committee on mental health, mental illness and addiction that's parallel to the health professionals advisory committee.

The Chair: One minute left, sir.

Mr. Simpson: Last, transformation and devolution of decision-making to LHINs must also be supported by a transformation of how services are provided and how clients and patients are viewed by the system. It must have a recovery orientation and move away from a purely medical model of care provision. Once integrated, the health care system in Ontario must have a wellness and recovery focus, with a defined and shared philosophy of care. This made-in-Ontario model of care will result in an astounding transformation.

Working together, we can all contribute to a system that is responsive to individualized needs and provides the best care and treatment possible while respecting individual rights and heightening public accountability.

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

The next presentation is from the United Association of Plumbers and Steamfitters, Local 46; Mr. Bill Signal. Is he here? No? All right, we'll go to the next one.

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.ON, IROQUOIS FALLS

The Chair: Is the Service Employees International Union on the line?

Interjection.

The Chair: Is anyone here who needs to speak to us?

The Clerk of the Committee (Ms. Anne Stokes): Shirley Cummings-Hall is here.

The Chair: Okay. Can we hear from Shirley Cummings-Hall, the 4 o'clock deputation? In the meantime, maybe you can get in touch with the next one, please.

Interjection.

The Chair: Oh, we've got it? Shirley, just have a seat, please.

Who do we have on the line, then?

The Clerk of the Committee: Ted Marcotte.

The Chair: Good afternoon, Mr. Marcotte. Would you please start your presentation. You have 15 minutes. Please proceed.

Mr. Ted Marcotte: Good afternoon. My name is Ted Marcotte, and I'm representing the Service Employees International Union, Local 1.on, from Anson General Hospital in Iroquois Falls, and South Centennial Manor, also in Iroquois Falls. SEIU, Local 1.on, represents about 40,000 health care workers in hospitals, nursing homes, home care, retirement homes and community support services across Ontario.

Bill 36, the Local Health System Integration Act, 2006, in its present form, will radically alter the kind of health care services Ontarians receive, how these services will be delivered, who will perform them and who will lose as a result of the integration, amalgamation and devolution of health care services. Contrary to the language of Bill 36, this legislation will remove any local control over health care and place the control of health care services solely within the power of the Minister of Health and Long-Term Care and the Ontario cabinet.

The Minister of Health and Long-Term Care professes his commitment to the Canada Health Act, but this legislation is an attempt to further circumvent the principles of the Canada Health Act. At the very least, the preamble and section 1 must contain specific commitments to ensuring that the principles of the Canada Health Act are maintained. As this bill now reads, every health care service not covered by the Canada Health Act will be subject to privatization.

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The government is moving this legislation forward without a strategic plan for the delivery of health care in Ontario in place. A provincial strategic plan needs to be in place before the LHINs can even start to develop their plans—sections 14 and 15.

SEIU Local 1.on asks the members of this committee to delay third reading until this government has held broad consultations with all stakeholders. The Minister of Health and Long-Term Care must develop a strategic plan in consultation with the public. The plan must also include a human resources plan. I will say more about this later.

This legislation is flawed because its premises are based on cost-containment of health care services and not on ensuring Ontarians have equal access to quality public health care services. In effect, Bill 36 is nothing more than the Ontario Liberal government's cost-containment strategy. Privatization schemes that will reduce human resources costs is the route the government has chosen to take.

In 2003, little more than a month after the Liberal government was elected, in an economic update, the Finance Minister, Greg Sorbara, alluded to the fact that there must be a way to control the compensation and salary costs of the health care budget. The following spring, the health tax was introduced. Health care workers are now subsidizing their own wages, up to $900 per year. Every hour a nurse works, 50 cents goes to the Liberal health tax. Apparently, the government believes health care workers can sacrifice even more.

In this section, I'll talk about the LHINs. They are undemocratic. LHIN boards are unelected. Each LHIN director, appointed by order in council, is only accountable to the Minister of Health and Long-Term Care. Sections 7 and 8 of Bill 36 must be amended to provide for the election of LHIN boards of directors. The compensation of LHIN boards must specify that all members of a LHIN are residents of their LHIN.

If it is the government's purpose to move towards greater local control and allow communities to determine local priorities—though we fail to see how this is possible, given the large geographic expanse of the LHINs and an unequal mix of large metropolitan centres dominating rural areas—it is essential that real control reside with local citizens, not those appointed by the Minister of Health and Long-Term Care. That this legislation will give greater control over health services to local authorities is just false. With the size of LHIN 13, how can nine people be local?

If Bill 36 passes in its present form, what chance would a small community have to decide what health services it wants when this community is lumped into a LHIN with larger metropolitan centres? Citizens in small communities will have little or no voice compared to large population centres.

Section 9 suggests LHIN board meetings are to be public, but what citizen could travel 200 kilometres or more to attend a board meeting? Has any of this been addressed so this would be looked after?

Section 16 states that the LHIN is to "engage the community." At what level? What community interests are to be taken into account, and to what degree? Reconsiderations of LHIN decisions, as outlined in sections 26 and 27, do not allow affected parties much time to appeal—30 days. Will unions holding bargaining rights have the right to a reconsideration process? The very short time frame of any party to make a submission for reconsideration and to study the impact a LHIN board decision will have on local health services suggests the government wants to limit this appeal process.

Why does the government draw the line at the health care providers as defined in the act? Why are independent health facilities, physicians, laboratories and ambulances not included in this? Why are independent health facilities outside the scope of this legislation? Is it because ancillary services at these clinics can be charged to patients, and services these clinics provide can more easily be delisted?

The establishment of standalone specialty clinics belies the government's intention for greater local control over health care services. These independent health facilities could be operated as private clinics but funded by public health dollars.

We note also that a LHIN is to establish an advisory committee of health professionals, but physicians are excluded from this legislation. How can doctors act in an advisory role without being part of the entire health system?

Sections 14 and 15 of the act must be amended to allow for community control and input in the planning process.

That the LHINs at this point have no idea of what they are to do is highlighted by these examples. One: The chair and CEO of the Central East LHIN, speaking to the Campbellford Memorial Hospital's board of directors, said, "As this is our first plan, we expect the 14 plans to be pretty macro. By the time we get to our third annual plan, it'll settle out on a level of detail that'll be much greater than the first one will be"—Community Press Online, January 19, 2006.

The second example: A Sarnia Observer reporter tried to get an answer about LHINs from the people who are supposed to know. He spent a day trying to find out why the Ontario government is acting on legislation it hasn't passed yet. He claims he never really got a satisfactory answer. The new CEO of the Erie-St. Clair LHIN, Gary Switzer, told the reporter to call Toronto. A Ministry of Health and Long-Term Care bureaucrat refused to be quoted. MPP Di Cocco was finally reached and commented, "It's a work in progress and not a foregone conclusion that the bill will pass. It's very complex"—Shawn Jeffords, Sarnia Observer, January 6, 2006. If the bureaucrats and elected members can't tell us what is going on with Bill 36, why should the legislation pass until citizens know how it will affect their health care system?

As Bill 36 now stands, the underlying philosophy of the legislation is to ensure that any health services outside the Canada Health Act are open to privatization. This legislation gives near-dictatorial powers to the Ontario Minister of Health and Long Term Care. The Minister of Health will have greater control over the kind, type and amount of health care that is provided in each LHIN in Ontario.

Section 26 of the Act allows a LHIN to provide all or part of a service or to cease to provide all or part of a service; provide a service to a certain level, quantity or extent; transfer all or part of a service from one location to another; transfer all or part of a service or receive all or part of service from another person or entity; carry out another type of integration of services that is prescribed; do anything or refrain from doing anything necessary for the health service providers to achieve anything under any of the above listed, including transfer of property or to receive property from another person or entity.

Section 28 of the bill allows the Minister of Health to order a health service provider that carries out its operations on a not-for-profit basis to cease operation, to dissolve or to wind up its operations, to amalgamate with one or more health service providers, to transfer all or substantially all of its operations to one or more persons or entities, and to take any other action necessary to transfer property.

LHIN powers to order integrations are limited only by the fact that they cannot order health service providers to cease operations, dissolve or wind up, but what the LHINs lack in power, the Minister of Health can do.

Section 33 will allow the government to order health service providers to cease operating and—section 28—transfer their property. This leaves the door wide open to greater privatization of health care services. For example, a LHIN could require the transfer of health care services such as chronic care from a public hospital to a private, for-profit nursing home.

I'd like to talk about LHIN finances. The Ontario Liberal government promised it would deliver a balanced budget before the next election in October 2007. This legislation will make the promise a reality and the only promise apparently this government intends to keep. The only way this government can balance its budget is to take a big bite out of the health care budget.

No LHIN will be allowed to have an operating deficit. Each LHIN must make do with the monies allocated to it by the provincial government. A LHIN cannot borrow without the approval of the provincial government.

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The Chair: Mr. Marcotte, you have used the 15 minutes. Can you please conclude?

Mr. Marcotte: Okay. Bill 36 is a revolution in health care. There will be a lot of carnage left on the battlefield if this legislation passes.

As a union, we would like for you to reconsider passing this bill in March and to delay it until further consideration is done. Thank you very much for having me speak.

The Chair: Thank you very much, and you look lovely on TV.

Mr. Marcotte: Thank you.

The Chair: I understand that there is a friend of yours who is going to speak to us from the same studio, am I right? Can we speak with Judy Shanks?

Mr. Marcotte: Yes. They're ready to slide in, I believe.

The Chair: Thanks very much, sir. Mr. Marcotte, if you don't mind, if you can send to us your material by fax or e-mail we will be happy to share it with the rest of the committee—your presentation.

Mr. Marcotte: Okay. No problem.

The Chair: Thank you again. Good bye.

CANADIAN MENTAL HEALTH ASSOCIATION, NORTHEASTERN ONTARIO BRANCHES

The Chair: Ms. Shanks?

Ms. Judy Shanks: Yes, it is. Good afternoon.

The Chair: You can start your presentation any time you are ready. There's 15 minutes in total.

Ms. Shanks: Thank you very much. This is a presentation by myself, Judy Shanks, the chief executive officer, on behalf of the Canadian Mental Health Association branches in northeastern Ontario, which is made up of the Cochrane-Timiskaming branch, the Nipissing regional branch, the Sault Ste. Marie branch and the Sudbury branch.

The Canadian Mental Health Association branches located in northeastern Ontario are pleased to participate in the public consultations regarding Bill 36, the Local Health Systems Integration Act. We are non-profit health care organizations that deliver a wide range of mental health services to our communities. We routinely work with local agencies to assess the needs for mental health treatment and support, and have functioning partnerships with other health and social service agencies in order to deliver comprehensive recovery-focused services. Many of our programs are funded by the Ministry of Health and Long-Term Care; hence, our operations will be immediately affected by Bill 36 if it does become law.

First, we wish to congratulate the government for moving forward with the health system integration. We commend your courage in challenging the status quo in a fundamental service required by all citizens. We believe and support the enactment of the stewardship role for the Ministry of Health and Long-Term Care for the health care system. We also support health care management, strategic long-term planning and system accountability mechanisms being closer to local communities and health care partners. We look forward to working with our North East local health integration network to ensure equitable and effective health care delivery in our region. We recognize that system integration needs to be guided by province-wide, evidence-based standards for all types of health care, while at the same time being operationalized in a flexible manner so as to account for local diversity of population needs, available resources and unique community characteristics that shape health care delivery.

Bill 36 must serve as the strong foundation for integration of Ontario's health care system. The content of this bill is vitally important to each and every citizen. We need to take time and give careful consideration to the details of the bill so that they are clearly defined, functionally appropriate and balanced in terms of dem-

ocratic principles and rights. Undoubtedly, health care system integration within a framework of public accountability means there are and will continue to be very challenging and difficult choices to be made in terms of what, where and how health care services are delivered to Ontarians.

Bill 36 must ensure that health care system delivery and management occur according to best practice standards and processes across the province; all types of health care are equitably funded; and finally, the public has ongoing, transparent access and opportunities to participate in all levels of the health care system.

Collectively, we must take the opportunity presented in the passing of this important legislation to redress significant imbalances in our delivery of health care and place the focus on proactive and balanced models of health and health care delivery that embrace the mental health, emotional, physical and spiritual needs of Ontarians.

To this end, we wish to highlight six points relating to Bill 36 as it is currently drafted. We trust that these issues will be given full review by the standing committee on social policy. We have these specific concerns:

(1) Overall, the act is silent regarding the fundamental principles of health care in Canada enshrined in the Canada Health Act. How health system integration in Ontario will safeguard principles such as comprehensiveness, universality, accessibility, portability and public administration is not evident. A vague term, "acting in the public interest," is the only principle encoded, and no means is provided as to how citizens may appeal policies which are not "in the public interest." This leaves the door open to wide variations of interpretation and action on the part of governments and bureaucracies, including the ministry and local health integration networks. It offers little assurance or protection to Ontarians. We recommend that the bill more directly relate the health care system principles to health service integration.

(2) The role for the general public in the management of the health care system and in health integration decisions is largely absent in this legislation. All members of the LHINs boards are to be appointed by order in council. While all citizens may apply, government appointments are often made to include a select few who share the dominant political view of the day. Health care providers, funded by the Ministry of Health and Long-Term Care, are not eligible to be part of these boards, yet the same exemption is not in place for the private, for-profit health care providers. Overall, the total number of positions available on these boards, which will have expansive health care system management responsibilities in the amount of almost $20 billion, is small. Other venues and opportunities for meaningful public involvement need to be defined in the administrative directives for the LHINs.

"Engagement of the public" is not defined in this act and is being left to possible definition by the less-scrutinized, regulation-making process. Again, this is a key principle that requires full explanation in the act to ensure that all Ontario citizens will be accorded the same opportunities of engagement, frequency of engagement, and input on important, as opposed to mundane matters.

Community engagement needs to be fully recognized as a sustainable process fundamental to health care system operation. The present wording in the act places maximum emphasis on the responsibility of health service providers for community engagement. While this is both necessary and appropriate, this process demands adequate resources and skilled facilitators to ensure the general public becomes and remains informed. The same requirement for public engagement is not imposed on the LHINs structure. This is a significant oversight that must be addressed directly in the legislation.

(3) The degree of power awarded to both the Minister of Health and Long-Term Care and the LHINs through this legislation, with respect to health service integration decisions and orders, is almost absolute. The intent appears to be to provide a means to redirect health care funding dollars when health care providers are failing to meet required standards, and to respond to local and provincial integration priorities and decisions. While such punitive measures may be required, there's no mention in the legislation of incentives or other positive measures that should be enacted to encourage health care providers to embrace the new standards that will be defined for Ontario's health care system.

While expectations for health care delivery will increase significantly under the act—for example, public engagement, voluntary identification of opportunities to integrate and development of service plans that dovetail with LHIN and provincial strategies—there are only negative consequences defined for health care providers that fail to comply.

Furthermore, there appears to be little devolution of authority to the local levels of the health care system. The minister alone retains the right to make the decisions that would substantially restructure the health care system.

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(4) Reconsideration of integration decisions or orders is severely limited to one appeal during a 30-day period, and is only available to the affected health care provider. The health care provider may not have received any type of advance notice from the LHIN with regard to an integration decision. The provider would have to seek legal counsel, develop a challenge and present this to the LHIN or the minister. Thirty days is an insufficient amount of time to ensure due process.

The second issue relates to the stipulation that an appeal may only be launched by the affected provider. This runs contrary to the spirit of the overall direction to bring health services management and planning closer to the citizens of Ontario. The general public, as well as people served by the affected agency, deserve full and open access to integration decisions or orders as well as the right to be heard in an appeal of such decisions. While the political process might be the default appeal for citizens faced with this situation, the timing for appeal prescribed by the act would inhibit effective access and response via an elected member and the Leg-

islative Assembly. Fair and reasonable access and longer time frames are called for in this appeal process.

(5) A critical omission in this draft legislation is the lack of a diversity provision for the board, operating structure or accountability mechanisms in order to safeguard the interests of marginalized populations served by Ontario's health care system. This oversight is of utmost concern to agencies like ours, as we serve people with serious mental illness who daily experience systemic discrimination with the health care system and the larger society. Without diversity provisions, there is a high risk that the level of systemic discrimination will increase and harm our most vulnerable citizens in most need. Not only could this trigger challenges under the Canadian Charter of Rights and Freedoms, but it also runs contrary to values of our society that adhere to the principle of universal health care.

(6) By extension, marginalized populations are also at further risk because the legislation is lacking in detail as to the criteria that the LHINs and the minister will use to effect integration plans and decisions. Such criteria need to be fully transparent to ensure that community-based health care providers and larger providers of acute health care services are to be treated on equitable terms for funding and any changes in operation. This detail needs to be explicated in the legislation. As well, the legislation must ensure standard implementation across the 14 LHINs in Ontario.

At this time, we wish to thank you for your consideration of our brief. We look forward to seeing the redrafted legislation. The Canadian Mental Health Association of northeastern Ontario will be prepared to assume its full role in a reformed provincial health care system.

The Chair: Thank you, Ms. Shanks. We received the e-mail of your deputation. We thank you for that. We will be distributing it to the members.

There are less than three minutes. I'll start with Mr. Arnott, if there are any questions.

Mr. Arnott: Ms. Shanks, I don't have any questions. I want to thank you very much for your presentation and for offering this committee the view of your organization, the Canadian Mental Health Association of northeastern Ontario. It's been very helpful. Your comments were well taken. Thank you so much.

The Chair: Ms. Martel.

Ms. Martel: Thank you, Ms. Shanks, for your participation today from my part of the world. I appreciate that.

You have really focused on a lot of the omissions around community input, community participation and community ability, for example, to respond to integration decisions or orders. What are you worried about in this respect? You have stated very clearly that this seems to run counter to the stated objective in the bill, which is to deliver care closer to home with the community involved in that. You've certainly pointed out a difference between what is stated as an objective and what the reality is when you look at the provisions of the bill. Why are you worried about that?

Ms. Shanks: From our perspective, it still sounds like the minister has a lot more control. For it to be given to local communities and local input, we feel we've lost sight of that in terms of how the legislation is being presented. At a local level, we feel we have been cut out of that process, even in terms of the election of the boards.

Ms. Martel: I think you're right. Thank you.

The Chair: Ms. Wynne.

Ms. Wynne: Thank you very much for being with us. I want to address the issue you raised about boards excluding health care workers but not participants in the for-profit sector. The general government public appointment guidelines will cover that kind of conflict-of-interest situation, so it wasn't necessary to be explicit about that in the legislation. Does that make—

Ms. Shanks: Fair enough, but what I'm concerned about is the fact that there won't be the experience from the field to have input into the LHINs.

Ms. Wynne: That's why we've got the health professionals advisory committee set up, and that's why the community engagement section is in the legislation. We want that formalized input from the health professionals advisory committee, but we also want ongoing dialogue between the LHINs and the community. That's why that section is there.

A lot of groups have said to us that they would like to see that community engagement section expanded and made more specific. I think you'll see amendments coming forward from all sides on how to do that.

Ms. Shanks: That certainly covers the point.

The Chair: Thank you, Ms. Shanks, for calling us from Timmins, and also Mr. Marcotte. Have a nice evening.

SHIRLEY CUMMINGS-HALL

The Chair: The next presentation is Shirley Cummings, finally. Thank you for coming. I know you were ready to speak to us an hour ago, and we thank you. In fact, we are ahead 15 minutes.

Ms. Shirley Cummings-Hall: My name is Shirley Cummings-Hall. I am a personal support worker.

Bill 36 threatens to dehumanize, degrade and destroy the employees like myself and our clients. It will guarantee a competitive bidding model in health care forever. Cheap labour will cause employees to work longer, more arduous hours.

In my opinion, most of the employees in my field are immigrant women. Most of us are single grandmothers and single mothers. Then, there will be no one at home to supervise the children. The streets will become their friends. This leads to guns, gangs, etc. The longer hours and cheaper wages we work for lead to stress. Stressful employees cannot operate and give optimum service to the clients.

I work for $13 an hour, few benefits and no pension. I use my car and I'm only given 21 cents per kilometre, which does not cover the cost of gas. Because of the cost factor to get to my clients, I'm also subsidizing the client's care plan. Millions of dollars have already been saved by exploiting underpaid workers like myself.

As a personal support worker, I'm also a psychologist, a nurse, a domestic and sometimes even a plumber. I love my job, but how long can I continue to subsidize Ontario's home care system? The only people who will benefit from Bill 36 are the fat cats who can afford to open nursing homes and retirement homes and agencies. Again, they will have a cheap labour force, and most of these people are like myself. This bill must ensure that health care workers like myself are protected. The committee must make amendments to ensure that there is no competitive bidding process in the home care sector.

Ms. Caplan said that competition is good, but research has found that it's not really so. It doesn't work. I can remember the SARS epidemic, when most of the contract workers did not show up for work. The fundamental elements of a home care delivery process must be continuity and quality of care that the patients receive.

1550

My union, SEIU Local 1, in its brief to this committee, pointed to the need for a human resources plan for the health care sector. That plan must ensure home care workers have equal employment rights with those enjoyed by all other Ontario workers. It must guarantee home care workers these conditions:

—Guarantee a new agency to continue to employ the employees of the home care agency they plan to replace. Many people lose their jobs and work for less whenever a new agency takes over.

—Guarantee to recognize and provide the same working conditions, seniority, wages and benefits the employees had with the displaced agencies. Wages and benefits must reflect the prevailing union or highest wage rate within a CCAC's geographical jurisdiction.

—Recognize a union representing the employees of the home care agency that is being replaced. The successful home care agency in the RFP process must be bound to any existing collective agreements with the union that represented the employees with the previous agency. Only a stable, professional and fairly compensated workforce will ensure Ontarians that they will have quality, as well as continuity, of health care service.

As I said before, the most exploited people in home care are immigrant women. We are always the burden bearers of a developed society like this. The people who have drafted this legislation have no idea and no understanding what it means to be a dedicated, loving and compassionate caregiver to society's most vulnerable—seniors and the disabled—and the only reward we get for that is poverty wages. It appears to me that the bottom line is what the Minister of Health said in his opening remarks to this committee: "We must stop the cost curve from rising any further in the health care sector." Apparently, the only cost this government wants to contain is wages, such as mine.

I must repeat: Millions of dollars have been saved from people like myself. I go to a job for two hours and end up spending four because of the condition of the client. This country and most developed, westernized countries are built on the backs and the blood, sweat and tears of people like myself. I'd appreciate some understanding and some empathy on behalf of people like myself. Thank you.

The Chair: Okay. There is a minute-plus each, and I'll start with Ms. Martel, please.

Ms. Martel: Thank you, Ms. Cummings-Hall, for your presentation today about how you are impacted now as a health care worker under competitive bidding. You will know that, regrettably, even though Ms. Caplan did a report on competitive bidding, she was very clearly given a mandate that did not include recommending getting rid of competitive bidding as a model in home care. So we are stuck with this very destructive model in home care. Because the bill before us doesn't prohibit very specifically this model from being used in other sectors, my fear is that we will see an extension of what has been so destructive in home care to other sectors of health care that the LHINs are going to be responsible for.

I have said to the government very clearly, "If it isn't your intention to extend competitive bidding to other sectors, then put it in the legislation." We will see whether the government brings that forward as an amendment when we start to deal with amendments next week. But you have certainly clearly shown to the committee what it's like to be a worker in this sector. I don't know how people live on the wages that they do in home care. You are, if I might say this—don't take this the wrong way—actually one of the fortunate people because you at least have a union. I don't know what workers are doing out there in home care who don't even have union representation these days. I have no idea how they're making ends meet.

I just wanted to thank you very much for bringing your personal story forward to show why competitive bidding should have no place in home care.

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: Thanks for being here. The reality is that what Ms. Martel is suggesting in terms of this legislation actually wouldn't help your situation. I think what we have to do is take a broader look at the conditions of health care workers. For the first time ever, there actually is an assistant deputy minister in our ministry looking at health human resources. The conversation that your organizations need to have with, that man in the ministry—Dr. Josh Tepper is his name—is a really important one, because even if we were able to do what Ms. Martel is asking in this legislation, it wouldn't change the situation for you.

What I think is really important is that we need to make sure you and the people who do the kind of work you do get a better deal, and that the guidelines and conditions are better for your work, because your work is vital. It's the caregiving work that I absolutely understand is done by women, and it's done by immigrant women. It's a burgeoning field, because as people age, and we have an aging demographic in this country, we need more people doing this work and it needs to be valued, quite frankly. Outside of this legislation, there's a lot of work that has to be done.

Thank you for coming and for sharing your point of view with us.

The Chair: Mr. Arnott.

Mr. Arnott: I just want to compliment you on your very effective and powerful presentation today, because I think it's given all of us on this committee a great deal to think about. Hopefully, as the government moves forward with the amendments to Bill 36, some of what you've said will be reflected in their response.

Ms. Cummings-Hall: Thank you very much.

Ms Carroll: I think that's why we find it so important that the competitive bidding process is addressed in the legislation. We don't want to see other health care workers end up in the type of situation that these workers go through. It's very stressful for them.

The Chair: Thank you very much. The next presentation is from CARP: Canada's Association for the Fifty-Plus. Is there anyone here? The next one is Empowerment Council. Is there anyone here from Empowerment Council, or from the Ontario Federation of Community Mental Health and Addiction Programs?

If not, we'll take a five-minute break, if you don't mind. We'll try to be here at 4:05 and see if anyone does show. We are about 16 minutes ahead, so we'll just wait a few minutes. Thank you.

The committee recessed from 1558 to 1609.

CARP: CANADA'S ASSOCIATION FOR THE FIFTY-PLUS

The Chair: We will convene again. We'll start with our 4:15 presentation from CARP: Canada's Association for the Fifty-Plus. Mr. Gleberzon, the floor is yours. You have 15 minutes.

Mr. William Gleberzon: Thank you very much for the opportunity to express CARP's views on Bill 36 on the LHINs. If you don't know who we are, CARP is Canada's Association for the Fifty-Plus. We have 250,000 members in Ontario and about 400,000 across the country. Our mission is to promote and protect the rights and quality of life of older Ontarians and older Canadians. Our mandate is to develop practical recommendations for the issues we raise. CARP reflects the concerns of consumers, patients and caregivers—the general public—and that's the perspective I'll talk from this afternoon.

CARP believes that the LHINs are a step in the right direction in that they represent what we regard as a somewhat limited integrated approach to health care. For example, doctors, paramedics—ambulance services—and family caregivers are not part of the networks. We believe that these people should all be partners in the new move towards the integration of health programs and services, which we see as a very positive step.

The LHINs should be strengthened by making them truly local through community engagement. This can be achieved by the establishment of an advisory committee drawn from the population served by the LHINs, consisting of young and seniors, family caregivers, rural and urban residents, multicultural individuals, and the like. The advisory committee could be modelled on the provision in subsection 16(3) of the bill that service providers must engage the community when developing and setting priorities for the delivery of health services.

Accountability by the LHIN boards and staff should include regular reports to this advisory committee as well as to the minister. CARP also recommends that the legislation be amended to enjoin the minister to ensure that appointments to the board include individuals who understand the specific needs of those who live within the LHIN boundaries. As you know, the LHIN boundaries in many cases are quite large and encompass a large and diverse population. The CEO and top managers of the LHINs should be appointed by the minister from among the best available candidates, with appropriate skills to understand the needs of those who live within the LHIN boundaries. As the new staff for the LHINs are hired, staffing in the Ministry of Health and Long-Term Care's central office should be examined to identify unnecessary duplication of functions and/or candidates for transfer from the central office to the LHIN bureaucracy.

The role of CCACs should not be expanded beyond their current roles as contemplated in part VII, section 39 of the bill. Moreover, we find that the language in this section is vague and too open-ended. In fact, the role and function of CCACs should be reviewed, we believe, in light of the concerns raised in earlier public consultations regarding CCACs. The experiences for many clients and family caregivers are that CCACs are not providing services in an effective and efficient manner, and we keep hearing this from many of our members.

The focus of case managers within the CCACs must be on the welfare of clients rather than the CCACs' bottom line, and they must not operate so as to force family caregivers to become the real case managers by default. It's for that reason we believe that family caregivers should be part of the advisory committee that we're suggesting. CCAC board members should include representatives from the local communities within the individual LHINs, although the CEO and other staff can be hired from among the best candidates, regardless of residency.

The authority of the minister to suspend operations, integrate or amalgamate not-for-profit health providers on the advice of the LHINs must be revised, we believe. In order to ensure full transparency and accountability to the communities within the LHINs boundaries, the minister and the LHINs must justify any of these actions to the advisory committee, which would have the right to appeal the decision as part of the explicit public consultation process noted in part V in regard to the devolution of any "power, duty or function" of the minister or his or her delegate to the LHIN. And this appeal process should be increased to six months from the current 30 days, which we believe will just not give enough time.

Thank you very much for this opportunity. I welcome any comments or questions.

The Chair: We have at least a few minutes each. I'll start with Ms. Wynne, please.

Ms. Wynne: Thank you very much for coming today. A couple of things: I just wanted to be sure you were aware that in this legislation a return to community boards is in place for the CCACs. You're of that?

Mr. Gleberzon: Yes, we are.

Ms. Wynne: Would you like to comment on—

Mr. Gleberzon: We think that's a good move, obviously. Very much so.

Ms. Wynne: You're very happy about that.

Mr. Gleberzon: Yes, we are.

Ms. Wynne: Okay. Because I think that addresses your concern about the representatives of the individual communities.

Mr. Gleberzon: For the CCACs but not for the LHINs.

Ms. Wynne: Yes, for the CCACs. As far as the LHIN boards, what we envisage there and what is happening already is that people from the LHIN are being appointed to the board. In other jurisdictions, what we found is that people weren't coming forward to stand for election, and so the public appointment process, which has specific guidelines in place, is intended to get the expertise and the regional representation on those boards. That's why we've opted for that.

The last thing I wanted to talk about was your last point about increasing the reconsideration process to six months. I think the concern there might be the slowing down of integration processes. Can you comment on that?

Mr. Gleberzon: Our concern is that decisions—for example, in York region a decision was made regarding the local and well-established service provider, which was cut out of the RFP process. There was quite a hubbub about that. We hope that won't happen again. We're suggesting six months, but the point we're trying to make is more than 30 days, to allow the community time to organize and make sure that whatever its concerns are, they're heard.

The Chair: Thank you. Ms. Martel.

Ms. Martel: Thank you for your presentation today. Let me go to page 4, where you say, "The role of CCACS should not be expanded beyond their current roles." The committee has heard two different perspectives about that, to share that with you. Of course, the Association for Community Care Access Centres came and said they would like to have more of a role in the system as system integrators, their case managers doing not only home care but, I gather, other services. They said the minister had made that invitation to them at a conference, I think, that he spoke at and they did a proposal in response. So we've heard from them saying they should have a bigger role and hoped the minister agreed with that. And we've heard from primarily the community mental health sector and CHCs also saying that system navigation shouldn't be the purview of one particular agency or set of agencies. Is your concern about the role of CCACs and that it not be expanded has to do with what you hear from families and those who use the system about what is inadequate in the provision of care now?

Mr. Gleberzon: That's correct, yes.

Ms. Martel: Do you have some more specific examples that you could share with us?

Mr. Gleberzon: I can. I think it's summed up in the statement, where we talk about case managers that "they must not operate so as to force family caregivers to become the real 'case managers' by default," and they should not be guided simply by the bottom line. We understand that there is a limit to what can be spent, but, as I'm sure you know, for families that are in distress, it is an extra distress when they don't get the kind of service they need when they need it. That's the concern about the case manager, who is not always providing that kind of service. The family members must turn into advocates. Many of them find they're stressed taking care of their loved one, and here they have additional stress being added.

That's part of the concern we have there and that we've heard from a lot of our members. My colleague Judy Cutler, had she been able to join us today, could have talked about her own personal experience in that regard. She ended up taking care of her brother, who was both schizophrenic and had cancer, and ended up trying to navigate the system that she, because she knew something about it, was able to navigate somewhat easily, but certainly not the way a case manager could have. It was a constant battle.

The other issue you raised was about the mental health side of things, because the concern is—again, I'm not sure of the actual role of the CCACs in this, but it's something that has to be looked at very seriously, and that is the gap between mental and physical health that a lot of families encounter, in home care particularly. These are the kinds of concerns such that if we're going to integrate the system—and we think that's the only way to go and the best way to go; we're 100,000% behind it—it should be integrated from the bottom so families really can get the service they need, and when these situations arise that don't fit very nicely into little boxes, the system is able to accommodate the needs of those people.

The Chair: Thank you very much for your presentation.

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EMPOWERMENT COUNCIL

The Chair: The next presentation is from the Empowerment Council; Jennifer Chambers. Good afternoon. Please have a seat. You have 15 minutes total for your presentation and potential questions.

Ms. Jennifer Chambers: Thank you. The Empowerment Council is a non-profit organization that is dedicated to acting as a voice for people who have been in the mental health and/or addiction systems, particularly the clients of the Centre for Addiction and Mental Health. The Empowerment Council's board, general membership

and staff consist of people with this personal experience. Our catchment area is Ontario, consistent with that of the Centre for Addiction and Mental Health. We are fiscally responsible to CAMH, but responsible only to our membership for our policies and practices. This is the way we keep the integrity of our independent voice representing clients.

The proposed Local Health System Integration Act is to be credited for its recognition in legislation of the critical role of community engagement. Our concerns then become, how are "community" and "engagement" defined in practical terms? Community must consist primarily of those citizens of Ontario whose health is at stake. In mental health and addictions, this means those who have had personal experience of these systems. It will not do to substitute the voice of others. Study after study has shown that prejudice-based beliefs and discriminatory treatment of our members is pervasive throughout society. People considered to be mentally disturbed or having addictions are frequently found to be the least wanted of any social group, be it in the general public, as employees or even in the health care system itself.

"Individuals with mental illness and addiction also face discrimination and rejection by service providers both in the mental health system and the broader health care system, and discrimination by policy-makers and the media." This is a finding of the mental health committee of the Senate that was chaired by Michael Kirby and recently toured Canada. For this reason and because the most effective health care provision is that which meets clients' self-identified needs, it is critical to have people who have personally experienced mental health issues and addictions have a substantial voice in decisions affecting our lives. There is considerable research evidence indicating the importance of meeting clients' self-identified needs rather than the needs identified by health service providers. To quote from one such study, "Outcomes were not strongly related to either the amount or types of services people received. However, good outcomes were strongly linked to consumers having their needs met.... The results also demonstrated that good outcomes were more closely linked to consumers' perspectives of needs than in their case managers' perspective."

"Good outcomes were also linked to whether consumers felt empowered—had some control over the treatment process and were involved in decisions regarding their services, medications and housing."

The same is true on a policy as well as an individual level. It will not do for the LHIN to engage only those who plan or provide services and consider that to be a legitimate process for valid decision-making. This requirement on a LHIN policy level also applies to the accountability provisions that LHINs should apply to all funded services. Each must be required to have meaningful involvement of its clients in governance and evaluation.

In the recent interim report of the standing Senate committee on social affairs, science and technology, it was noted that:

"A major criticism of mental health services and supports and addiction treatment in Canada is that it is largely organized around (and often for the convenience of) providers, not patients/clients. Rather than the system adapting to meet their needs, it seems that individuals with mental illness and addiction are expected to adapt to fit into the system and access services and supports only when and where the system can provide them.

"This rather damning observation is confirmed in several provincial reports that have acknowledged that the delivery of mental health services and supports and addiction treatment needs to be more strongly person-oriented. To improve the quality of patients'/clients' lives, safe, timely and effective treatments, services and supports should be coordinated around the needs of individuals with mental illness and addiction."

They note that their international comparative analysis has found that other countries have managed to engage in such a process.

The support that the Centre for Addiction and Mental Health offers for an independent client voice is by far the exception rather than the rule in Ontario.

The US National Council on Disability observed that "policy-making based on input from experts, and that excludes participation from people labelled with psychiatric disabilities themselves, results in wasteful and ineffective one-size-fits-all public policy that doesn't efficiently meet the needs of those it is intended to serve."

"The National Council on Disability has also concluded that one of the reasons public policy concerning psychiatric disability is so different from that concerning other disabilities is the systematic exclusion of people with psychiatric disabilities from policy-making."

The method of engaging community will predict how meaningful the community's contribution will be to health care planning and delivery.

I would like to go over the recommendations of the Empowerment Council briefly.

I'd like you to know that a previous Liberal government formed a legislative subcommittee, known as the Graham commission, that toured Ontario in the most comprehensive consultation with the people of Ontario that ever took place on mental health services. It came out with a number of recommendations, and I urge committee members to go directly to the community mental health legislation subcommittee report which details the recommendations that came directly from the consultation. I don't recommend the later reports, which reflect influences that came into play other than the direct voice of the people of Ontario.

Recommendation 12 of that committee, of that report, is one that we fully endorse: "that consumer-survivors participate fully in the mental health system—that one third of boards and committees should be consumer-survivors, chosen by consumer/survivors."

We recommend that Bill 36 more specifically describe the formal mechanism for community engagement and that health care clients be identified as integral and substantial participants in any engagement process.

We recommend that the legislation require the creation of standing committees of the LHIN board that report directly to the board.

We recommend that a standing committee on mental health and addictions be specified in legislation, at least one third of which consists of clients or former clients of addiction and mental health services nominated by clients at a consultation for this purpose. Actually I should have said "as part of a consultation process," as we later detail that. Any body representing mental health issues must also contain representatives of advocacy organizations, as the individual's experience of rights deprivation is uniquely prominent in the mental health system.

We recommend that this same requirement as described in the Graham committee's recommendation be required of all funded mental health and addiction services.

We recommend that another standing committee of the board be formed that is essential to good health care decision-making—a committee of persons with disabilities. Reflective of the percentage of need in the population and the specific quality of mental disability issues, we recommend that such a standing committee include at least two members representing people from the mental health system and two people representing people from the addictions systems. This should include some representatives of self-help initiatives for persons with disabilities, including advocacy organizations, as the well-being of the organizations that are run by and for us also affects our well-being.

The recommended process by which clients are selected to represent their community was exercised in the creation of the Advocacy Commission, an organization stemming from the work of Father Sean O'Sullivan in his report You've Got a Friend. It entailed the democratic polling of groups and organizations in order to elect representatives who, in turn, nominated commission members.

The Empowerment Council would also like to endorse the recommendations made in the submission to this committee by the Ontario Peer Development Initiative.

We commend the combined efforts of the Centre for Addiction and Mental Health, the Canadian Mental Health Association and the Ontario Federation of Community Mental Health and Addiction Programs for their support of client involvement.

I'm missing my last page. I hope no one else is missing it.

The Empowerment Council also agrees that mental health and addiction funding must be protected and enhanced, as is clearly required by all reviews of this health care sector.

This is a great opportunity to do things right, creating a health care system that enhances social as well as personal well-being. By its very structure and processes, the LHIN is poised to become a determinant of health, and we hope it will be a good one.

The Chair: Thank you. We have a minute-plus each, and I'll start with Mr. Arnott, please.

Mr. Arnott: Thank you very much for your presentation. It was very good. I want to ask you about community engagement and how you feel the LHINs should engage their communities in discussions as they move forward. Exactly how would you want that to happen?

Ms. Jennifer Chambers: I think the creation of standing committees with representatives on the committees who have been selected by the community should entail a regular feedback process between those representatives and the community. One way this has been done is to have public consultations to which members of the community are invited and particular issues are polled in the community, both initially as setting out some values and principles in which the committee can operate and then on occasion about some more specific, detailed decision-making.

The Chair: Ms. Martel.

Ms. Martel: Thank you for your presentation today. You recommended to us the report of the subcommittee that was established by the Legislature some time ago, and I appreciate the recommendation for us to read it, but I wanted to ask as well about some work that was done even more recently than that, which seems to have gone into an abyss. Those were the task forces that were established on mental health, the nine regional task force reports that were submitted to the government. I don't know where they've gone. I don't know where the recommendations are. I'm assuming that on each of those task forces there were consumer-survivors who played an active role. Maybe you can tell us what your knowledge is of where they've gone and how all of that work might actually impact on this process, because that seems to be the most recent good work that was done on what is needed for mental health reform in Ontario.

Ms. Jennifer Chambers: I would strongly recommend that there be a standing committee on mental health and addictions and that that committee review the reports you just mentioned: the Mental Health Implementation Task Force reports. A great deal of effort and consultation did go into the creation of those reports, and I think they would have a lot of value, save a lot of time and reflect a lot of community involvement if they were reviewed.

The Chair: Thanks very much for your presentation.

Ms. Wynne: Do I get to—

The Chair: Of course. Ms. Wynne wants to ask you a question.

Ms. Wynne: Thanks very much for being here. You noted on page 3 of your document, "It will not do for the LHIN to engage only those who plan or provide services and consider that to be a legitimate process," and then you reference the Ontario Peer Development Initiative. If I recall—and I don't have their presentation in front of me—they talked about the engagement of families in consultation. So I'm assuming that you'd be looking for some explicit mention of the importance of families in that community engagement process. Is that a fair assessment of what you're looking for?

Ms. Jennifer Chambers: No. I represent the clients, the people who have been clients in the mental health and addictions system, not the families. I leave it to families to best represent themselves and their wishes in this regard.

Ms. Wynne: Okay. I think the point that was being made, though, was that families and clients are often intertwined, especially in this sector, so that it's necessary to include the family. It's not that you're not supporting that; it's just that you were advocating on the client side at this point. Is that right?

Ms. Jennifer Chambers: Yes, although I'd actually say that it's not uncommon for families and clients to take opposite positions on issues, so while I would not seek to be exclusive of any group in Ontario, I wouldn't necessarily serve my community well to recommend a prominent role for every family organization that exists in the mental health sector.

Ms. Wynne: So for you it's the client groups, the individuals, who need that prominent role.

Ms. Jennifer Chambers: Yes, the people most directly affected.

The Chair: Thank you again for coming tonight.

The next presentation is not in the room yet. It's the last one. We will wait until he does attend or until 4:45, which means 13 more minutes, unless he comes before that. In the meantime, it's newspaper or BlackBerry time. Thank you.

The committee recessed from 1634 to 1646.

The Chair: It is 4:46. The person who should be speaking to us has spoken to us in other locations. Therefore, unless you disagree, I think we can bring an end to this meeting. Before doing that, unless there is any disagreement—Ms. Wynne.

Ms. Wynne: No, there's no disagreement. I just wanted to make a very brief comment. This has been a very long series of committee hearings, and I just wanted to say that I think the process of listening to the more than 200 people—individuals and representatives of groups—has been a really worthwhile one. Even though many common themes came out throughout the seven days, as the hearings went on those themes were embellished and clarified. We have a lot of material to work with in terms of coming up with amendments.

Sometimes it's easy to underestimate the public, and an experience like this really allows us to be clear on how much wisdom and information there is in the public. So I want to thank everybody who presented before us and the communities behind them that support their views. And thank you very much to the opposition members for such a civil and fruitful process.

Mr. Arnott: Mr. Chairman, I just want to express my appreciation to you, Anne Stokes and the other staff who have worked so hard over the course of these hearings. It's been an interesting process, and we certainly look forward to next week when we do the clause-by-clause.

Ms. Martel: My thanks as well to the many people who made presentations, particularly those who drove a long way to come here. It was good as well that the committee actually made some accommodation to hear from people from the northwest and the northeast in a different way than having them travel. My thanks as well to all of the staff who were involved, both those who travelled with us last week and those who were involved at Queen's Park, for making this happen.

The Chair: Thanks to you, to Ted and to everyone else for what you have done for this very important piece of legislation. It's not over yet, but I feel better hearing that there will be amendments. Hopefully, all of us will feel much better when the amendments are heard and dealt with. At the end of the day, we are going to improve the system somehow. The issue I see is how much we're going to improve it.

Thank you to all, and to staff in particular. Goodnight.

The committee adjourned at 1650.

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