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Mercredi 1er 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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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Wednesday 1 February 2006

Mercredi 1er février 2006

The committee met at 0902 in the Crowne Plaza Ottawa Hotel, Ottawa.

LOCAL HEALTH SYSTEM INTEGRATION ACT, 2006

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

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

DR. DENNIS PITT

The Chair (Mr. Mario G. Racco): Good morning. It's nice to be in Ottawa. We will start the meeting right away, with your permission. The first item on the agenda this morning is the Ontario Medical Association, Ottawa chapter, Mr. Dennis Pitt. If you would start, please, there's 15 minutes, total time. Whatever amount of time is left will be available for potential questions and/or comments from the membership. Please start any time you wish.

Dr. Dennis Pitt: Thank you very much, Mr. Chair. With me today is Dr. Steven Harrison, who's with the health policy department of the Ontario Medical Association.

I'm speaking to you from the perspective of a practising physician, as a surgeon who's been in practice in Ottawa for 25 years. I do sit on the board of the Ontario Medical Association and I'm a member of the board of the Ottawa Hospital, the Canadian Medical Association and the Canadian Association of General Surgeons, but my comments are my own as a practising surgeon and they're not necessarily a formal policy of any of the organizations that I'm associated with.

To begin with, I've looked with some admiration at how the LHINs have been brought out. I've had an opportunity to talk with my colleagues in some of the other provinces and I think the politicians and the civil servants who are behind this have learned from the other provinces. Specifically, practising physicians are much happier with this coming in at a measured pace, as an evolution rather than the revolution that took place in some of the other provinces. Hospital restructuring has already been done and the hospital boards have been left in place. I think this is much better than, specifically, Alberta, where a lot of doctors were very upset and there was massive upheaval; and, of course, there have been no massive budget cuts with this.

I understand that these are much different than the health authorities in the other provinces, and that's what we have to compare them to. Hopefully, this will work much better in looking after accountability and planning than the health authorities have elsewhere.

In this particular LHIN, I would like to compliment Michel Lalonde, the chair of the board, and Robert Cushman, the CEO, who have been around talking to groups of physicians all over this LHIN, from Pembroke to Cornwall, with a variety of physician groups within Ottawa. We're very pleased that they've communicated with everybody. They're happy to listen to everybody, and I compliment them.

What we're looking for the LHINs to accomplish: Physicians like to look after their patients. We're interested in patient care. In especially the last 10 years, every physician and surgeon I know has been doing more and more paperwork at the expense of patient care. We're also very frustrated with the amount of bureaucracy we have to deal with. I don't mean the bureaucracy at the Ministry of Health; I mean the bureaucracy of managing our patients. We're spending far too much time on the phone, organizing tests, investigations, trying to get patients seen. This is extremely frustrating to physicians. It's driving some physicians to quit medicine and some to leave the country. I've sat in on some focus groups and that is the number one source of frustration for physicians. We're looking to LHINs to improve this. We're very hopeful that they'll be able to cut through this bureaucracy and excess paperwork.

I'll give you one example that's happened recently so you'll understand what I'm talking about. Pembroke is a city just a couple of hours' drive northwest of here. They had two general surgeons. I'm a general surgeon, so this is why I'm so familiar with this. One general surgeon left last fall in November and the remaining general surgeon broke his arm. So they had no one. They sent an urgent request down to the Ottawa Hospital for a surgeon to do locums there, if we could help them out any way.

One of my colleagues who has been a general surgeon in Ottawa for more than 25 years, who trained in Ottawa, a very competent general surgeon, said, "Well, yes, I'd be interested in finding some time to help them out." He notified the Pembroke hospital that he was willing to do

what he could. The reply was that he had to go through the application process as if he was a brand new surgeon coming from who knows where. He had to get his college documentation, all the paperwork, including three references, so he could help them out. I talked to him two weeks ago and, in fact, he did all that. He was interested to see how this process would turn out. As of two weeks ago, he had still not received notification that he could work in Pembroke at that hospital. This was in response to their emergency, their crisis in November. That's the kind of problem we would very much hope LHINs will address and relieve us of.

My only concern with the LHINs that I see is the way it refers to physician input and representation to the LHIN. There's a small section that refers to a health professionals advisory committee. I've read it and I reread it again this morning. It's very vague and unclear. It's not at all specific about how physicians should have input to LHINs. I'd like to emphasize that physicians need formal input, number one, so the LHINs can take advantage of our knowledge or expertise. We're the people who directly look after patients in hospitals. Patients have a nametag on their wrists with the patient's name and the physician's name on there. That's who the responsible person is. When they look for primary care, they go their family doctor. I'm not putting down the other professions. In no way are my comments derogatory to them, but I want to emphasize where the responsibility ultimately lies for people, especially when they're in hospital. So we think we have a lot to contribute as far as advice. In no way do we want to make final decisions, but we think our advice is valuable.

Secondly, we think LHINs will be far more successful if they get the buy-in and the support of all the practising physicians. I think the way to do that is to have a formal structure that can relate to LHINs and be part of the LHIN establishments in the respective areas.

We did have a meeting before Christmas—the Ontario Medical Association organized it—between practising physicians and the Ministry of Health. I thought it was a very good meeting; some very good suggestions came out of there. I think that should be looked at very carefully with the final form of the LHIN legislation.

Thank you for this opportunity to speak to you. I'd be happy to have any discussion.

0910

The Chair: Thank you. We have about a minute and a half available for each group. I will start with Jim Wilson.

Mr. Jim Wilson (Simcoe–Grey): Thank you, Doctor, for your presentation. I'm a former health minister, and I hear you about the bureaucracy. You were very kind about it, I think, in terms of the hoops you have to go through to get your job done. Don't think the minister doesn't go through the same type of hoops at Queen's Park.

Just in terms of the OMA and yourself putting forward the suggestion that you have more input in the decision-making process at the LHINs, exactly what are you looking for—your own committee? I guess the way it is now you'll be one of 22 or 23 regulated health professions on that committee. Do you want to explain further what you mean?

Dr. Pitt: Certainly. These are not hard and fast things that we're demanding. Out of discussions with my colleagues here in Ottawa and at the OMA and out of the discussion in the meeting that I mentioned before Christmas, the principle we came up with was that an advisory committee should have representation from hospital-based physicians as well as community-based physicians, representation from specialist family doctors and also, specifically for this LHIN, representation from the city, like Ottawa, plus somebody from the smaller community.

We did say that we didn't think this committee should be too large, excessively large. Numbers were tossed around between five and 10; that sort of thing. Also, we considered whether these representatives on the committee should be elected or appointed. Most people thought, some combination; there are advantages both ways. That is the basic principle that we talked about among the physicians.

Ms. Shelley Martel (Nickel Belt): Thank you for being here this morning. The process you were referring to when you gave us the explanation of the situation in Pembroke: Is this the hospital process to provide privileges?

Dr. Pitt: That's not very clear to me as a practising surgeon here in Ottawa either. I don't know how that got derailed. I don't know the kind of bureaucracy involved. I know the message came out on the e-mail from the chair of our department looking for people to do locums there. This surgeon, a colleague of mine whom I talked to, was not clear why he had to do all this either. I did not pursue it. I didn't call the Pembroke hospital. I didn't look for details. I don't want to blame anybody; I don't think that's the point here. I brought this up because I think this is something LHINs can deal with.

I had an opportunity to go out to Alberta in 1999, and their regionalization was very rapid and upset everybody. They initially had excluded the physicians. In 1999, there was a big, huge project to re-involve physicians. They have credentialed physicians for the entire region. For instance, I have privileges at the Ottawa Hospital only; that's the only place I can work, whereas, in the regions in Alberta, for instance in Calgary, you have privileges in the entire region, so you could easily move from one hospital to the other for hospital-based docs. I would think the LHIN could facilitate something like that quite readily.

The Chair: Thank you. Ms. Wynne.

Ms. Kathleen O. Wynne (Don Valley West): Thank you, Dr. Pitt, for being here. As you acknowledged, we've heard this a number of times from some of your colleagues in Toronto and in London. As you reference, subsection 16(2) is where the health professionals advisory committee is outlined.

Our concern is that we hear from all health professionals, that all health professionals have input. If we were to start down the road of having a separate com-

mittee for each health professional group, that will be unworkable.

You've made the remark today about having the different doctor specialties represented on this committee. If we were to accommodate that notion—not talking about majority or minority, but just recognizing that there are specialists, there are family practitioners, there are different doctors who need to be represented—on this multidisciplinary committee, would that go some way to resolving the issue for you?

Dr. Pitt: That's a very good question, and I've given that some thought. The first presentation I heard, from Michel Lalonde and Robert Cushman, said that there were over 200 different health care groups and agencies within this Champlain LHIN, which really made me blink. I'm a practising physician. I'm not all that attuned to all that. I thought, "Wow, have you ever got a big job to sort all that out."

You certainly don't want to exclude the other regulated health care professions. The details are going to have to be worked out so you have them as well. I'm really not qualified to comment on how to represent them the best. I hate to hedge on your question, but I really haven't figured that out. I think it's really difficult.

The worst thing that could happen is that it's another layer of bureaucracy and it's just another layer of administration. We really don't want to see that happen. It has to be streamlined some way.

Ms. Wynne: We need the best advice. That's what we need.

Dr. Pitt: Having one physician in a room with 20 other health care representatives for a meeting: We don't see that functioning very well. We all go to meetings where you sit forever, and we're very uncomfortable with that. I think that's the best I can say at this stage.

The Chair: Thank you, Dr. Pitt, for your presentation.

SUE McSHEFFREY

The Chair: The second presentation is from Sue McSheffrey. Good morning. You can start any time you're ready, Ms. McSheffrey.

Ms. Sue McSheffrey: I'm the pink presentation, the pink lady.

The Chair: Yes, a nice colour.

Ms. McSheffrey: It won't get lost.

Good morning. Thank you so much, and welcome to Ottawa. My name is Sue McSheffrey. I'm a physiotherapist working for the community care access centre in Renfrew county. It's Ontario's largest county. It starts an hour west of here in Arnprior and ends, over two hours past there, near Mattawa.

Mr. Richard Patten (Ottawa Centre): Is that walking or running?

Ms. McSheffrey: By donkey.

Our community has serious concerns about the proposed legislation, especially the misnomer of "local." There is nothing local about a bureaucracy that extends from the edge of Montreal to just outside of North Bay. LHINs are not local. They serve populations the size of whole provinces like Nova Scotia, Manitoba or Saskatchewan. Some are the geographic size of France or Germany. So I want to know, why is the government calling them local?

Within our own true local health care community, we're concerned that staff will have no protection from being moved around within the LHIN. A good example is my situation. I've been 15 years as a physiotherapist in home care. We go from nine physios, full staff, to two. If the Cornwall area, say, is short of physios, will I be driving three hours to cover that area? No one knows. We're told that those details aren't available.

I'm here to tell you that workers like me are sick and tired of being guinea pigs for change. The health system is not so broken that it requires this level of government intervention. All of the problems we do have come from things that the LHINs will not change, like not enough doctors in rural areas. The doctors, gatekeepers of the system now more than ever, are left out. Why? Why did you not take the chance to bring doctors into the core of our health system instead of leaving them on the fringes? Our area of Renfrew county would be much better served if you put physicians on salary and controlled where they can practise. This is a key component of the British system that the McGuinty government seems to love and is so set on copying, so why ignore it?

0920

Health science professionals are in short supply. The money being wasted to rearrange the bureaucracy could be used to provide bursaries to students in these fields. It doesn't matter how you reconfigure things; if there aren't enough radiation technologists, you can't do more treatments.

There are two areas that I consider myself an expert in. One is the disaster that has become the British National Health Service. It boggles my mind that anyone in government would use the NHS as a model for health care. Rationalization resulted in my mum being sent two and a half hours north of her home in Stafford for surgery because they were the cheapest centre to bid on that surgery. This resulted in no visitors and expensive transfer costs, as mum had to pay a driver to get her there.

Rationalization in Renfrew county could mean the end of our local hospitals, like the Deep River and District Hospital or the Arnprior and District Memorial Hospital. Patients from our area will have to travel farther. Winter travel from Killaloe to Ottawa is not always an option. We have no public transit.

How people access services and fairness across Ontario is as important as the services themselves. The range of health services offered in a community can determine more than just access to health. Health care providers are also key employers in many towns. It's often the only place to get a good job. The removal of key services from a community can lead to other economic losses. Businesses often consider local infrastructure when they decide to locate or relocate. The loss

of a hospital or the downgrading of a hospital to a clinic could hurt or discourage business.

My second area of expertise is in health planning. I was a founding member of the Renfrew County District Health Council and the last chair before the Harris government silenced us for good. These LHINs are being implemented with no local planning. As someone who worked hard to engage our county in meaningful planning, this terrifies me. There is no plan. The government wants to set up the LHINs first, then plan the system. It should be the other way around. Since everyone at the district health councils has been fired, there has been no health care planning in the province. They stopped the planning in January 2005; the planners have all been laid off. Where are you getting your information, or are you just winging it?

We see the LHINs as government-appointed executive boards with a mandate to continually merge and transfer services somewhere within the vast LHIN region. With the ministry, there was accountability through the local MPP in question period and ultimately through the polls on election day. This removes our power to do anything through the political arena in the short term. In the long term, we'll be sure to remember this in October 2007.

The LHIN board will have no power, as the government hired the CEOs, not the board. In other words, why appoint a board that cannot select its own CEO? The board will be puppets of the government, but without public accountability.

There were seven regional offices set up at the turn of the millennium to plan, manage, fund and monitor the system of health care programs. They're being replaced by 14 unaccountable LHINs that appear to have the same mandate. The LHIN CEO will be paid about twice as much as the regional directors, and, of course, there are twice as many LHINs as regional offices. Do you honestly believe that this is giving better value for the supposedly scarce health care dollars?

Lastly, this health system of ours has undergone so much political tinkering that the surprise should be that we're still functioning at all. Ontario's health system is not seriously broken and does not need such a massive and costly reorganization of the system. In fact, the risks outweigh any potential that I can see that would emerge from the restructuring.

There's more than enough money being spent on the health care portfolio, much of it on things other than health care. For example, in my sector, home care, the shift to privatization has been a consistent cost driver. Across Canada, the sector has undergone a massive shift from not-for-profit to for-profit delivery of care. Costs have increased by 21.3% a year from 1980 to 2001; this has not been matched by service increases. When Ontario enacted a one-year funding freeze in 2001, service to patients was cut by 30%. Our clients are getting less care for more money, and it's not being spent on salaries and wages.

The legislation sets out a process whereby the CCACs will amalgamate to fit the LHIN boundaries. There is no timetable set out for this to take place, meaning the CCACs could be out of sync with the LHINs for a long time. Moving from 42 CCACs to 14 will create fresh chaos in the home care sector. Decision-making authority will be taken much farther from local communities. Health care providers will likely bid on contracts covering regions four times the size. This may particularly impact smaller providers, especially if regulations remain in place limiting the number of providers that can share a given contract.

And then, what about us? There are nine CCACs like ours with direct service providers on staff. We don't fit into a plan like this. When I met with Elinor Caplan, she argued with me that there were no direct service providers left in the CCAC system; ministry staff had told her. Maybe you can understand our levels of anxiety around this huge rearranging of health care when staff don't even know what the present system looks like.

This committee has the power to fix all of this. The LHIN concept is flawed and is being rammed in without adequate planning or consultation. For example, in human resources, my union, OPSEU, has not been consulted about the impact on its members; neither has any other health care union been involved. There is no HR strategy other than using the Conservatives' Bill 136. No legislation should go forward without a human resources plan. Without health care workers, you have no health care system.

This plan must be negotiated and include, at a minimum: layoff provisions, like layoff as a last resort; measures to avoid layoffs; voluntary exit opportunities; early retirement options; pension bridging and protection of pension funds; retraining options; and successor rights and protection of collective agreements.

I'm already involved in a class-action lawsuit against the crown after our pension plan was screwed up by the last provincial government. Why invite war when there is no need? All we want is peace and stability, so that we can focus on what we're trained to do for our patients.

Please resist the urge to dismantle and rebuild just for the sake of marking your territory, and go out and buy a Lego set instead. In the end, it'll cause less pain and frustration, and we'll still have a health system that's the envy of the world. Please put the brakes on this legislation until you've properly thought through the impact on health care workers, patients and their home communities.

Thank you.

The Chair: Thank you. There are 30 seconds each. Madame Martel, would you like to start?

Ms. Martel: Thank you very much for your presentation today. I'm glad you pointed out that the problems that we have come from things that the LHINs aren't going to fix at all, because the actual fact of the matter is that the system and the amount of money that goes in is determined by the government. Who gets access to services is a function of the policies and regulations of the government, and the LHINs have absolutely no power to change either of those two things.

I just wanted to focus on competitive bidding. You didn't touch on it directly, but I remember a previous

presentation from you a couple of years ago, I think at this same hotel. The government says that there's nothing in the legislation that says the LHINs are going to use competitive bidding to acquire services, but the legislation also doesn't specifically prohibit the use of competitive bidding. What has it been like in home care, and what do you think will happen if the LHINs use that for all of the services they are going to be acquiring?

Ms. McSheffrey: When I met Elinor Caplan, one of the things she said to us was that part of her mandate was to review competitive bidding, because it could be used as a model within the LHINs of procurement for services, which is the British system, which is why my mum ended up going where she did for her surgery.

In home care, it's been absolutely chaotic. Nobody has any stability with their job. Everybody is worried about two years down the road, three years down the road, when the contracts expire. It's meant that colleagues of mine were unable to get mortgages, because the job that they had was only good for the length of the contract. So even though health professionals are in short supply—they can walk into a job anywhere in Ontario—because they're short-term contracts, you can't get loans.

0930

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: Thank you very much for being here. Just a couple of comments. There is nothing, as you know, in this bill about competitive bidding. It's silent on that. I am sure you're aware that Leah Casselman has met with the minister on a number of occasions, so she has been in conversation. You said your union had not been consulted; in fact, there have been conversations.

I wanted to just go to the point about the lack of access to MPPs. I'm really confused about why that would be something you'd take from this bill. MPPs are going to be as accountable as they have ever been. You have access to your MPP before this bill is passed and if it's passed. So I think that misinformation is pretty problematic. People in Ontario will continue to have access to their MPPs if there are concerns about the health care system. I'd just like you to comment on that.

Ms. McSheffrey: The concern I have is, right now if the health policy comes down, questions can be asked in the House and it's a decision made by the Minister of Health.

Mr. Patten: They still can.

Ms. Wynne: They still can.

Ms. McSheffrey: Under the LHINs, the LHINs are going to be making decisions. It's one step removed. That's what I'm talking about. So the MPPs don't have the same control through the House.

Mr. Patten: They never had before.

Ms. McSheffrey: But you can raise questions from the floor.

Ms. Wynne: That's what happened—

The Chair: I believe that the lady made her position, and you also did what was proper.

I would ask Mr. Arnott—30 seconds, please.

Mr. Ted Arnott (Waterloo–Wellington): The government members are quite right that the opposition will continue to ask questions in the Legislature about health care, but I can tell you what the minister's response is going to be. The minister is going to say, "Oh, I had nothing to do with that decision. That was a decision that was made by the local health integration network. Go talk to them." So it's absolutely true that there's a political buffer that's being created by this bill, designed to protect the minister from difficult decisions, so as to remove accountability and blame to a local board. That's really what the government's agenda is all about with Bill 36.

The Chair: Thank you for your presentation.

HOPEWELL EATING DISORDERS SUPPORT CENTRE OF OTTAWA

The Chair: The next group will be the Hopewell Eating Disorders Support Centre of Ottawa.

Ms. Joanne Curran: Good morning. Thank you very much for inviting me here today. My name is Joanne Curran.

I've asked to speak with you because I think that I am able to give you multiple perspectives as to why it is so critical that this government recognize eating disorders as a special provincial program rather than have these disorders managed by the LHINs.

What makes me qualified to comment? For starters, I am the mother of a young woman who, at the age of 12, began a cycle of release, relapse and readmission; where anorexia crippled her once athletic body, crushed the joie de vivre that she had as a child and nearly claimed her life.

As president and co-founder of Hopewell, an eating disorder support centre in Ottawa, as well as a charity, I hear all too often from sufferers who, time and again, face barriers to treatment and from parents of children who they fear will lose their lives because of having to wait, sometimes for months, for assessments.

As a representative of Hopewell, I am also actively involved with a provincial network of peer support groups and, therefore, am very aware of what treatment is or is not available in places like Sault Ste. Marie, London, Burlington, Toronto and Ottawa.

Lastly, I am a nurse by profession who has spent the past 30 years in health promotion and disease prevention.

I know that some members of this committee are well informed about eating disorders and understand the serious nature of them. For those of you who are not as familiar about this serious public health problem, let me begin by saying that eating disorders are not about food, nor are they about vanity, nor are they about a 15-year-old who is looking for attention; rather, they're a means to control a life that otherwise feels out of control. They are a mental illness with serious physical consequences.

What brings one bright, ambitious youth to an eating disorder is often completely different for someone else. What is similar, however, are the devastating social

consequences of anorexia and bulimia. Not only do they derail someone's school, work and family life, they also seriously compromise peer relationships and lead to serious health problems that can be carried into adulthood.

Children as young as nine are now being admitted to hospitals with anorexia. These kids are younger, they're sicker, both medically and mentally, and harder to treat, leading to repeat hospitalizations for medical stabilization.

The unanticipated increase in the prevalence and severity of eating disorders has created an urgent demand for expert resources within each region of this province. By expert resources, I don't mean family physicians, who themselves have admitted to lacking the necessary expertise to treat the high and complex demands of a severe and chronic illness.

Regrettably, many regions across this province have neither intensive eating disorder services nor the experts needed to deliver them. In those regions where there are these services and these experts, nowhere is there the full spectrum of services for eating disorders that best practices have shown to be absolutely essential for successful treatment of these very chronic illnesses. Indeed, staff and services have had to be cut to balance hospital budgets; this in spite of the fact that the services were limited to begin with.

The provincial eating disorder network of providers has responded to the current cuts by directing patients from underserviced regions to already strained specialized adult and pediatric programs like those in Ottawa and Toronto. This has led to unacceptably long waiting lists for intensive treatment of clients who are often young and extremely ill. The current health system deficiencies have taxed professionals to the point where they are finding it harder and harder to be effective practitioners in the care and treatment of the growing number of sufferers.

Anorexia has the highest mortality of any mental illness. Several of those clients who have been waiting for treatment have died while waiting. Others have travelled to treatment programs in the United States and, upon their return to Ontario, experienced an interruption in their follow-up care because of the same long waiting lists that drove them south of the border. This leaves them vulnerable to relapse and subsequent readmission to treatment programs here and in the United States.

Clearly, it is not just the patients' conditions that are unstable; the health system is also in crisis. By making eating disorders a special provincial program, there is a far greater chance that appropriate capacity-building to deliver evidence-based care can take place in a more efficient and responsible manner. If the responsibility for eating disorder treatment is delegated to the LHINs, I fear that the existing, albeit limited, specialized services that are presently being offered within a provincial network of eating disorder providers will be lost. In my opinion, a provincial program would be the best health care structure to deliver timely and uniform access to treatment to those nine-year-olds up to 50-year-olds from across the province who present with eating disorders. I would appreciate hearing from this committee as to whether a provincial structure for eating disorder service delivery is being considered.

I'd also like to know how peer groups, like Hopewell, that have been shown to provide a valuable and necessary service to our communities—and given that those groups are not provincially funded and, therefore, do not come under the umbrella of the LHINs—will be included in discussions around local health system planning.

My parting comment is that our daughter Bridget, who is now 20, is physically healthy and learning to live with her obsessive-compulsive disorder and her learning disabilities. She's one of the lucky ones. There are far too many women out there who continue to struggle on a daily basis. Eight years ago, at the age of 12, when she was diagnosed with anorexia, there were no specialized services in Ottawa. As a result, she had numerous, lengthy—and by "lengthy" I mean six- to eight-month admissions over a three-year period. She lost a year of school, most of her friends and all of her confidence. With the assistance of many skilled and committed professionals she is finally, at the age of 20, eight years later, reclaiming her life.

As I said at the outset, eating disorders are complex and require the intervention and expertise of specialized multi-disciplinary treatment teams. To ensure that every child, youth, young adult and adult has access to this type of care, I believe that eating disorders must come under a special provincial program.

0940

The Chair: Thank you. We have 30 seconds each. I'll ask Ms. Wynne.

Ms. Wynne: Thank you very much for being here this morning. I certainly share your concern about the need for a coordinated approach to this disorder. Do you feel, though, that with at least having the beginnings of coordination with the development of the LHINs, there's the possibility that there will be a discussion about some of these issues that doesn't happen now? Because there really isn't coordination within the health system. I'm not aware of a special eating disorder program that's in the works, but it seems to me that the development of the LHINs is a good step towards having a more coordinated approach. If we don't know what's going on in our local areas or our regions, we're not going to be able to coordinate what's going on around the province. So do you think that the LHINs are a good step in terms of physicians and other health practitioners being aware of what the gaps are in their own areas on issues like this and on others?

Ms. Curran: Perhaps the best way of responding to this is to describe to you what has happened over the past year and a half. In 2004, a proposal was submitted by this provincial network of eating disorder service providers to the ministry. The ministry came back and asked for an emergency proposal. At that time, all of these programs that are involved in this provincial network—all of them—required funding, but they set aside their personal needs and looked at the benefits to the province at large

and developed a proposal where certain programs would be beefed up, for want of a better word, recognizing full well that their own local programs would not be getting the funding by supporting the investment of dollars in these other programs. That provincial network of service providers that is an informal group has been very effective, I believe, in addressing the needs of the province as a whole.

The Chair: Thank you. Mr. Wilson.

Mr. Wilson: Thank you, Ms. Curran, for your presentation. In terms of the group you're talking about, are they providing direct services?

Ms. Curran: They're providing direct services. I'm not talking about the network of peer support groups.

Mr. Wilson: That's what I was going to ask you. The front page, that's the peer support groups?

Ms. Curran: This group is different from what I mentioned, yes.

The Chair: Thank you. Ms. Martel.

Ms. Martel: It's nice to meet you in person. Let me just follow up where you were ending off, which is that the provincial eating disorders network is highly organized; there is no duplication. The application that went in to the ministry that long time ago has yet to be funded, despite me raising two questions in the Legislature this fall about it. What the provincial disorders organization needs is money, cash, so that we have a full continuum of services. There is nothing in the LHIN legislation that's going to fix that and there's no need for more coordination or a look at duplication because there isn't any duplication and the system is highly coordinated. What it requires is approval of the application.

If this doesn't get dealt with quickly, in terms of approval, what's going to happen to the services, albeit very limited, that are now in place, particularly for women, who have such desperate needs?

Ms. Curran: They will be cut back, as they already have been. And they are limited to begin with.

The Chair: Thank you very much for your presentation.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 479

The Chair: The next presentation is from the Ontario Public Service Employees Union, Local 479, Royal Ottawa Hospital. Good morning.

Ms. Marlene Rivier: Good morning. My name is Marlene Rivier. I'm a health professional working in mental health.

OPSEU Local 479 represents the nearly 200 health professionals at the Royal Ottawa Hospital. We are among the 30,000 health care workers represented by OPSEU in this province. The facility in which we work is also one of the first P3 hospitals to be constructed in Ontario, but that's a discussion for another day.

We are grateful for the opportunity to participate in this public consultation with respect to a bill we believe has the potential to fundamentally transform the health care system in a manner undermining of the principles of the Canada Health Act. Publicly funded health care services as set out in the Canada Health Act reflect fundamental Canadian values, and the preservation of these principles is essential for the health of Ontarians now and in the future.

Who pays the price for health services restructuring? Let's start with patients. Ontario, like the rest of Canada, is experiencing increasing income disparity; the rich are getting richer and the poor poorer, the gap between them ever widening. This is a disturbing trend in a prosperous province, the economic engine of Canada. Poverty, specifically income inequality, is the most powerful determinant of health, and the negative consequences for population health in this province are inescapable.

In the absence of income equality, social programs are the great equalizers, mitigating some of the negative impacts of poverty. Chief among these is our public health care system. When this system is weakened, population health suffers and the economic consequences are costly, though not necessarily immediately apparent. The human toll is impossible to measure. Middle- and especially low-income Ontarians have borne the brunt of health services restructuring, and they will continue to carry the burden of the LHINs.

This is not the first time patients in our community have had to deal with the impact of major health system restructuring. During the Harris government the HSRC directed sweeping changes to take place in our community. Two hospitals were closed and a third sought recourse to the courts in order to assure its continued survival.

The Salvation Army Grace Hospital served a community which included many low-income families. Its loss has been deeply felt. Promised community investment, which was to precede hospital closures, never materialized, but the closures went ahead, leaving residents in this community with reduced access to needed health care.

The Montfort, a unique cultural institution within the health care system, was slated for closure, despite the fact that it met the unique needs of the francophone community. In an apparent effort to reduce duplication, the kind of large-scale restructuring carried out by the Harris government and provided for in Bill 36 threatens a form of health care homogenization which fails to recognize the unique needs of linguistic and cultural groups, inner-city communities, women, aboriginal people, etc. These are needs which must be taken into account in providing effective health care.

The concentration of services in particular facilities which are deemed to provide a service at an acceptable cost has the effect of denying local communities comprehensive care and transfers the cost of health care from the public system to the individual, regardless of the ability to shoulder those costs, producing a two-tier system with regard to access to reduced services. Low-income Ontarians will not be surfing the net to find the facility in another community that can offer a needed service in a more timely fashion—they simply can't

afford it. This reduced access to services will be hard felt by middle- and low-income Ontarians, who will either experience financial hardship or simply go without needed services.

The directives of the HSRC have not been fully implemented in our community, and the prospect of further restructuring is quite daunting. Under the HSRC, the decision was made to centralize all mental heath emergency services in the remaining general hospitals, resulting in the closure of the psychiatric emergency service at the Royal Ottawa Hospital. The unique character of this service was not recognized, nor the seamless service provided to ROH patients, who now must present at a general hospital for emergency admission. This has been experienced as a great loss by patients and families. Again, the promised dedicated services at the general hospitals have never been fully realized in favour of a homogenized approach to mental health emergencies.

Another group that's affected, of course, is workers. In order to be maximally efficient, workers need to be free of the worry as to whether they will have a job from day to day or who their employer will be. The loss of productivity, not to mention the toll on the health of workers associated with continuous instability, cannot be underestimated. Instability appears to be much of what Bill 36 has to offer with its continuous restructuring of the health care system. The chronic shortage of health care professionals is exacerbated by this threat to employment, which will only aggravate current challenges in attracting workers to these professions. Remote communities, as always, will be hardest hit by these recruitment and retention problems. The province needs to commit to develop through negotiation and to fund human resource labour adjustment plans that will include, at a minimum—and I won't read them out to you.

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An integrated system without physicians? Of all the perplexing omissions from this plan to integrate the health system, such as ambulance services and public health, none is more perplexing than the exclusion of the gatekeepers of the system: physicians. Much of the inefficiency in the system can be traced to cumbersome mechanisms between physicians and other health care providers and institutions. More efficient and integrated services for patients is a value for all health care providers and cannot be accomplished without the involvement of key providers such as physicians.

Disintegration in mental health: The inclusion of some aspects of mental health service provision and the exclusion of others—i.e. the psychiatric hospitals under direct control of the MOHLTC—precludes true integration of mental health services, whose uniqueness is again not recognized by Bill 36.

What about the real cost drivers in health care? Surely, a significant interest in putting forward this legislation is the control of health care costs, and yet the chief cost drivers are not addressed. Drugs are the fastest-growing cost in the system. This industry stands outside the system and is driven entirely by market forces, to the detriment of patients, especially low- and middle-income earners. Clearly, no relief is in sight.

Privatization, another chief cost driver, is conspicuous in its absence. In fact, there is considerable concern that this bill favours privatization and facilitates it. The problems faced by our system, such as wait times and shortages, will be exacerbated by further privatization. As an example, the availability of home care to patients in our community has been severely undermined by the privatization of this key service and particularly by competitive bidding.

So what is needed? What is missing? First of all, transparent language. There is little that is local in the LHINs: vast geographic regions increasingly remote from the communities they serve, with inadequate or non-existent mechanisms for local control and input; lack of accountability; centralized exercise of expanded powers on the part of the minister; and minimal public consultation.

We need to know what the plan is. We need an articulated vision of the system. We need to address the revenue-generating problems inherited from the Harris government's ideologically-driven tax cuts, which robbed government coffers of $13 billion, to support our public services and spare an already efficient health care system from further efficiencies. We need to feed and fine-tune the system, not dismantle it for sale to the private sector. That is something low- and middle-income Ontarians cannot afford. More importantly, we need to look beyond the budget cycle and the election cycle to set policy that will secure a health care system for the Ontarians of today as well as the Ontarians of the future.

The Chair: Thank you, madam, for your presentation. We have a minute-plus each. Mr. Arnott?

Mr. Arnott: Thank you very much for your presentation. You've outlined a number of concerns about the bill and also a number of your organization's concerns about health care in general. If the Minister of Health were here today and you were in a position to give him some direct advice as to what he should be doing in the next six months, what exactly would you tell him he should be doing?

Ms. Rivier: I would advise him to put a hold on this process, to be more transparent, to seek input from those who will be affected by it, and to rethink this plan.

The Chair: Ms. Martel?

Ms. Martel: Thank you for being here today. This community has already seen a great deal of upheaval through the restructuring orders, which would have had both an impact on workers and, ultimately, the patients they were trying to deliver service to. There is no human resources plan anywhere mentioned in this. There is going to be significant upheaval. What do you think that's going to mean, both for workers, who've already gone through one long round, and, more importantly, for the patients who are trying to get services from those same staff?

Ms. Rivier: I can't underestimate the amount of time that is lost from work when people are fretting about

whether they have a job and who their employer's going to be. You can't underestimate that.

I guess in my worst moments, I imagine that the lack of human resource planning is not accidental. We're all aware of the fact that there's at least a 20% differential between health care professionals working in the community and those working in hospitals. In my worst moments, I imagine that this is really a mechanism for degrading the economic lives of health professionals, taking away their jobs in hospitals and forcing them to accept low-paying jobs in the community.

We fought hard for what we have. We provide, I think, a very valuable service, and we deserve to be recognized for it. I don't think that we deserve to see the years that we've put into this system disregarded. We don't deserve to lose our pensions, our hard-fought wages and benefits. But really, that is the direction we're moving in. An enormous amount of energy went into constructing the human resource plan in Ottawa. I was part of that negotiating team. But it meant that we went from a projection of 2,000 layoffs in this city to a handful, and that reduced toll cannot be undervalued.

Everything eventually affects patients. If workers are distracted and distressed, that interferes with their ability to give the high-quality service they want to give to patients.

The Chair: Mr. Ramal.

Mr. Khalil Ramal (London–Fanshawe): It's nice to see you again.

About what you said in your committee presentation—just quick questions. What has led you to believe that this bill will be against, or doesn't speak of, the unique needs of linguistic people, cultural groups, aboriginals, the francophone community etc., since the ministry and the minister himself had an open dialogue with the francophone community, with aboriginal people, with many different stakeholders across the province of Ontario? That's my first point.

The second part: I wonder if you listened to the opening statement of the minister on Monday, when he said clearly, to all the people of the province of Ontario, in front of this committee, "No privatizations, no hospital closures, no two-tier health care." What's your answer to that?

Ms. Rivier: First, if you can remind me of your first question. With two questions, it's hard to remember it all.

Mr. Ramal: We had open dialogue with the aboriginal and francophone communities.

Ms. Rivier: Yes; thank you. The reason I have concerns about that is because, first of all, we saw it in the round that Harris carried out. Secondly, when the focus is on consolidating services and avoiding duplication of services, there is a great danger that the unique value provided by small providers, who are tailored to individual communities, will be lost. I am really concerned about something as simple as, say, cataract surgery. We have this hospital here who can do it very, very efficiently. But if there are people from particular communities who don't feel the relationship to that institution and that institution does not understand their special cultural needs, they won't get that service; they won't go there. That's a reality that needs to be addressed. We cannot simply homogenize the system in an effort to save money. Sometimes there are multiple providers for a service because they provide it in a unique way that is essential for those communities and is essential to them actually getting the health care they need.

In terms of privatization, unless I see explicit language that says that there won't be two-tier, there won't be privatization, I am not reassured. When we see that we are moving towards a model—

Mr. Ramal: The minister, in his opening statement before this committee, gave all the people—

Ms. Rivier: I've also heard the minister—

Interjections.

The Chair: Madam, you have the floor.

Ms. Rivier: The minister has said that he doesn't see a difference between sweeping floors in a hotel and sweeping floors in a hospital. To me, that demonstrates a fundamental misunderstanding of the uniqueness of the health care sector, that cleaners who work in hospitals have unique and complex responsibilities that people in hotels do not have. I see a race to the bottom implied in that; that we're all going to be brought down to the bottom, because the specialness of what is offered in hospitals is not recognized.

The Chair: Thank you very much for your presentation.

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ROYAL OTTAWA HEALTH CARE GROUP

The Chair: Next is the Royal Ottawa Health Care Group and the Royal Ottawa Hospital—Bruce Swan and John Scott, please. Good morning. You have 15 minutes total for your presentation and potential questions or comments. You can start any time you're ready.

Mr. John Scott: Thank you, Mr. Chair. My name is John Scott. I'm chair of the Royal Ottawa Health Care Group. I'm accompanied by Bruce Swan, our president and chief executive officer, and also Kathryn Hendrick, who is behind me, our vice-president of communications and public affairs. Thank you very much for the opportunity to meet with you as members of the committee reviewing the legislation. We've handed out some material, which we will leave with you, but I'd like to provide a quick overview on that and then turn it over to Bruce to talk about some positive suggestions that we would like to put forward to the committee.

The Royal Ottawa Health Care Group comprises two teaching hospitals in Ottawa and Brockville associated with the University of Ottawa and Queen's University. We are unique in a way because we span two LHINs, the Champlain LHIN and the South East LHIN. A fact that so many people don't realize is that 60% of our care is already given in outpatient or community-based support. We also have within our system the Institute of Mental Health Research, which is the third-largest mental health research institute in Canada.

With respect to LHINs, we've taken the opportunity already to meet with Michel Lalonde, the chair of the Champlain LHIN, and Rob Cushman, the CEO, as well as Paul Auras, the chief executive officer of the South East LHIN. We've extended an invitation to Michel and to Rob to attend an upcoming board meeting to meet not only with our board of directors, but we will be inviting the senior representatives of all the stakeholders within the mental health care field so that we all have an opportunity to dialogue and to better understand the potential that is available to us within the LHIN system.

On that note, our approach as a board of directors is that LHINs provide us with an opportunity. Mental health, unfortunately, is the very poor cousin within the mental health care sphere, but it is pervasive. You heard earlier about eating disorder difficulties and whatever, but it is pervasive and is linked to most other medical problems that people face in their daily lives. So there is a need for very, very strong community support, but also support within the community.

We have gone through significant transition as the Royal Ottawa Health Care Group, and our mandate has changed in the last five to six years to move toward a tertiary care facility, so there has been significant upheaval. But we have progressed as best we can and in the most transparent way, and we look at the LHINs opportunity as an ability for us to better connect with the community and, most importantly, because of the legislation, to address the needs of our patients.

I want to say quite openly that we support this legislation fully. The reason for this support of the legislation is, first and foremost, that the patient is at the centre of the intention of this legislation. It promotes proactive, systemic change; it encourages and breaks down barriers to integration and partnership-building; it focuses on the full continuum of care for patients; and, by being community-anchored, it opens up the opportunities for education and support at the primary care or family physician level. Again, that was one of the comments that was made by one of the earlier presenters. We look at this as the opportunity for us to be able to be involved in the system at an earlier stage and hopefully enhance the betterment of the patients within our system.

We do have some suggestions for your consideration, Mr. Chair. With that point, I'd like to turn over to our chief executive officer. There are four points that we would like to briefly address: One is removing what we consider a perceived potential barrier for partnership integration; the second is looking at the provincial planning forum within the LHINs; the third is cross-LHIN service delivery needs—as I mentioned a few moments ago, we span two LHINs; the fourth is the role of multiple ministries involved in delivery of health care.

Mr. Bruce Swan: The proposed LHIN legislation promotes systemic changes and will advance the collapse of silos in the health care sector. For mental health services, it means that the hospital role—that of the Royal Ottawa Hospital and the Brockville Psychiatric Hospital—has an opportunity to change from an institutional facility for mentally ill persons to a health care centre which advances research in behavioural and neurosciences, program evaluation, the education of future mental health clinicians, and a continuum of care that reduces duplicity of service and fills in the cracks.

LHIN legislation ensures that the hospital is but one player in a system of mental health providers. It is our position that the term "hospital" for psychiatric facilities should be changed to "mental health centres." This better reflects the role of the facility within a LHIN and allows for a level playing field for all partners in the continuum of care to link service deliveries in a network.

The critical mass of specialists in mental health will need to provide resources across more than one LHIN. There are efficiencies to gain in having LHINs work collaboratively in mental health so that specialized but limited resources are available more broadly. The Champlain Mental Health Network and the South, East Mental Health Alliance are working now on systemic changes that will create a mental health system that provides patients with an array of services that meet their needs. The goal is to provide the right care, in the right place, at the right time.

The LHIN legislation calls for an approval process that imposes potential barriers for the expedient integration of partners. A request to integrate with a partner will be replied to within 60 days by the LHIN, and an opportunity to appeal the LHIN decision is open for an additional 30 days. We believe this is too prescriptive. Legislation should impact health providers who are not willing to integrate, not impose timelines on those who are. This approval process should be removed from the legislation.

Through the LHIN infrastructure, a provincial planning body for mental health services representing all 14 LHINs should be established to ensure that primary, secondary and tertiary programs are defined, accessible and resourced for the residents of Ontario. Primary mental health care needs to be supported and linked to the specialized or tertiary providers to access training and provide opportunities for research that advances therapies and service delivery. The majority of mental health diagnoses present in primary care. An integrated system, and LHIN legislation, should ensure that the tertiary providers work to support the needs of the primary health care providers.

Accountability agreements should be standardized for the delivery of mental health systems for the province of Ontario and for each of the 14 LHINs. Decisions on resource allocation, system planning, and referral and discharge planning should be done in multi-LHIN districts, with highly specialized programs such as forensic psychiatry, dual-diagnosed disabled and mentally ill, and children and adolescent mental health, viewed as provincial programs.

The mental health system requires the determined collaboration of multiple ministries, including the Ministry of Health and Long-Term Care, the Ministry of Community and Social Services, and corrections. If the

mental health system is to integrate successfully, the province requires integration as well. The mental health agenda should be formalized within these ministries and partnered with a provincial LHIN planning group. Thank you.

The Chair: We have about six minutes left—two minutes each. We'll start with Mr. Wilson.

Mr. Wilson: Thank you for your presentation. You spoke on the last page here about section 28, the integration by the minister. I'm just giving my bias here; I'm the one who set up the Health Services Restructuring Commission as Minister of Health. This is 14 health services restructuring commissions. This is more power than I had. In fact, I had no power under that; that was given to the independent commission. The minister has 14 health services restructuring commissions, with more power than Bill 26 ever gave. The only safeguard is this 30-day debate period, although that will depend on the mood of the minister, I guess, as to whether he's going to debate. Do you want to comment on what you meant there?

Mr. Scott: Yes, I can comment. I am referring specifically to section 27, not section 28. Section 27 deals with the health provider who is coming forward with an integration plan that's already been agreed to with another partner. The legislation at this point imposes a 90-day hold period on that process. Now, when you've got willing providers in the community who want to go forward, then the issue here is, is 90 days a fair and reasonable period? Perhaps it is, but we're suggesting that there may be opportunities for that period to be reduced, because in the health care sector it may be important to move forward with a very positive and pro-active community-based integration plan that's agreed to by the health providers within the LHIN environment.

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Mr. Wilson: Well, if it's voluntary integration, why do you need legislation? Why don't you just do it now if it's the right thing to do?

Mr. Scott: But under this, it requires that if we're provided with health care funding, then we have to give notification to the LHIN and allow them the 60-day period to decide whether or not they're going to prevent us from doing it. It would be wonderful, for example, if the LHIN would provide the support within two weeks or 30 days or something, but we anticipate that they're going to be very busy, so there is that 60-day period. Then you have to wait for a further 30-day period to see whether or not there is any other objection that comes forward. So I'm not talking about the minister or the LHIN's ability to do things with respect to other sections under the act. It's geared at where it's a voluntary, proactive, community-based suggestion with respect to integration.

The Chair: Thank you. Madame Martel.

Ms. Martel: Thank you for being here today. I want to focus on your comments that the LHIN legislation, with respect to mental health services, is going to mean that the hospital role, that of ROH and BPH, is going to have an opportunity to change, and you listed the change as moving from an institutional facility to a health centre that advances research, etc. What's the barrier now for you to do that? Why do you need LHIN legislation?

Mr. Scott: Well, if I may, Bruce—and you may have some comments—I'm talking as the volunteer chair and not as the chief executive officer. I think that it's probably recognized that there are currently silos within the system, unfortunately. Notwithstanding the best interests of the hospitals, the community providers and whatever, in terms of the requirement for us to get on with what we're doing, it doesn't allow us to lift up our eyes and to look more at the collective community support that we can give. This legislation, the way we interpret it, is effectively encouraging, promoting, is giving us that mandate to work in a better continuum-of-care environment, as I said before. We look at it as a complement, a supplement and a direction

Ms. Martel: But what are the concrete barriers now that stop you from doing what you want to do that will be changed with the LHIN legislation?

Mr. Scott: Good point. The concrete barrier is the direction that we're getting. One of the key issues right now is, we're working with the Ministry of Health and Long-Term Care as a centralized body. The intention of this legislation is also to bring it to the LHIN environment, which allows us the opportunity within our community to deal directly with the LHIN—as I said, the chair, the LHIN board and the CEO—and talk about the things that are very specific and related to us within our community. The comment was made by Mr. Wilson that this is 14 ministries of health, if you want to call it that. Yes, it is, to a certain extent, but they allow us to deal with it at the community base, a much more localized environment, and be able to have a better forum to be able to have these discussions, we feel.

Ms. Martel: Okay, but if it's—

The Chair: Thank you. Mr. Patten.

Mr. Patten: Thank you very much for coming today. I've seen the evolution of your organization over time, from being an institution in which people spent a lot of time to looking at your whole role in the community. I'm quite familiar with the development of the ACTT teams and the role that the health centre plays throughout eastern Ontario. So it would seem to me that there is potentially here a convergence of encouraging a culture of sharing, co-operating and integrating that should help the rural area in particular, where, in the past, the services tended to be centred in the urban centres and people in the rural areas were—I have a two-point question. One is, if we talk across ministry boundaries or with other community organizations, who would you see as some logical partners that you would look forward to talking to in terms of your role? Secondly, do you see the LHINs as being supportive of what I think is your intent: to strengthen your role on a regional basis, not just on a city basis?

Mr. Swan: First of all, I think the forming of the LHINs forces us to look at the population we serve. We do serve eastern Ontario, and as to your comment about maybe being more urban-focused, I think that has been

the tradition for mental health, particularly the old provincial hospitals.

As far as the legislation is concerned, I think it enables us to integrate with our partners and pay close attention to the population we're here to serve. Within health, our partners outside of hospitals are those like the Canadian Mental Health Association, Salus, some of the housing support organizations. Across ministries, it's child and family services. There are issues with child and family services; they actually do a lot of mental health, as we do. We are the tertiary or the more complex part of the mental health system. With corrections, about 50% of our work comes through corrections, so we have a partnership with them in Brockville. We operate a 100-bed jail that's a schedule 1 hospital.

Basically, there has to be dialogue across ministries, and what we have found with some of the work we've been doing is that there are barriers within each of our ministries that need to be eroded. We see the LHIN legislation and the forming of the LHINs as an enabling body that helps us keep our mind on integration. In mental health's case, it goes beyond health, because there are so many other ministries that are involved that are also providing mental health service.

Mr. Patten: Just a very quick follow-up: What about the Ministry of Education, the implementation with high schools and elementary school programs through the school system, where of course many—

Mr. Swan: Actually, in a full continuum of service, we would be linked with education as well. When we refer to the continuum, that's the supports that would go into the education system.

The Chair: Thank you very much for your presentation.

ONTARIO COMMUNITY SUPPORT ASSOCIATION, OTTAWA

The Chair: We'll move to the next presentation, from the Ontario Community Support Association, Ottawa, Valerie Bishop-de Young. Good morning. Bonjour.

Ms. Valerie Bishop-de Young: Good morning, Mr. Chair and members of the standing committee. Thank you for the opportunity to speak with you today. My name is Valerie Bishop-de Young. I'm here representing the Ontario Community Support Association—the acronym is OCSA—and I sit currently as president of the board of directors.

A bit of background: OCSA supports, promotes and represents the common goals of its member organizations, of which there are approximately 360. Member agencies provide not-for-profit health and social services that help people live at home in their own communities. Our vision is that Ontarians will be served with a well-funded continuum of quality community support services delivered by the not-for-profit sector.

Our members span across the fulsome heart of the province. They are community-based. Our members provide demonstrated economic value added to the health care system. The University of Toronto supports this and has provided data, evidence, to say that $1 of public investment is equal to $1.50 of product; that is, service. We represent 25,000 staff and over 100,000 volunteers who work to help adults, seniors and people with disabilities to remain independent in their local communities.

Staff and volunteers work together to provide services such as Meals on Wheels, personal support and homemaking services. As much as other parts of the health care sector will attest to being the unsung heroes and underfunded and unknown, community support services virtually represent that reality. We are the band-aid of the health care system. Meals on Wheels allows people to stay at home in their own homes. Respite services to family and caregivers—those numbers aren't represented in a hospital environment. Many of our members also provide services through the purchased service contracts associated with community care access centres, CCACs.

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Page 4 of my presentation gives you an overview of OCSA's position with respect to LHINs, and that is that we support reform of the Ontario health care system and that the needs of patients—in our sector we refer to them as clients—and local communities come first. We look forward to working with our health care partners to move towards an integrated system that emphasizes self-care, prevention and accessibility to services at the right time in the right place. Our member agencies have many values in common with the transformation agenda: equitable access to service, a client-centred approach that preserves client choice, results-driven outcomes that are rooted in a provincial strategic business planning process, and transparent accountability.

We believe there are some keys to success for Bill 36. Those include a strong, overarching foundation and the principles of ensuring accessibility, transparent accountability, service comprehensiveness and public administration, elements that are reflected in the Canada Health Act and Ontario's Commitment to the Future of Medicare Act.

Consultation provides for constructive exchange of opinions and information, and it is critical for buy-in of the key components of the health care system. Meaningful dialogue must be realistic in its assessment of the facts. Critical targeted investment is required to ensure the health care system has the fuel—that is, the skilled human resources—to do the job that's necessary. No structure, LHIN or any other, will be successful without the necessary support of key players and the necessary resources.

Comprehensive dialogue looks beyond traditional system silos; that is, how are other scarce resources such as volunteers and unregulated care providers accounted for and supported? Critical investment is needed to ensure recruitment, training and active engagement of the value-added volunteers and of the unregulated care providers who increasingly, given the shortage of regulated providers—that is, nurses and therapists specifically—are providing the care that our aging population demands.

We ask that the LHIN legislation have due consideration for the value of volunteers, that the legislation recognize and encourage volunteerism. In order to be true to the philosophy of system thinking, the community support sector in each LHIN must be part of the decision-making process regarding integration and the development of the local integrated health service plan. Recognizing the value of volunteers is more than just good politics. In health and community support services, it's good economic value.

A broad culture of integration can only be driven by a clear provincial plan. A provincial plan needs to include processes and practices that can be measured and that support the smooth transition of clients within and across sectors. System navigation is not a job description in its own right; it is the job function of every health care worker.

At OCSA, we believe that every door is the right door. Our vision for LHINs is based on the adoption of the broad determinants of health where people are supported at the first point of access, wherever they enter the health care system. Comprehensive primary health care includes community support services as key participants, and it is key to transformation. The community support sector is very often the first point of contact for clients. Personal support services, community services and home care are the key to preventing unnecessary and more costly interventions, such as visits to the emergency room and unnecessary hospital stays. Supporting a client through the system smoothly, following the most direct route and reducing bureaucracy is just good integration practice.

Effective and efficient management at the local level of LHINs: Community support services help keep clients out of those ER rooms. Events like a fall that bring people to the ER can be avoided with adequate supports in the community. We see ourselves as very clear partners with hospitals in every LHIN, that we work together to ensure that everybody gets the care they need, where they need it, effectively. Countries with the best health outcomes and the lowest expenditures of GDP have strong primary health care systems, and that includes home and community care.

Community support services are a good investment, and they can help the system live within its means. There are many studies and much evidence that speaks to that, most notably the research by Dr. Marcus Hollander here in Canada. Community support services can provide care for much less than any other part of the system. I've given you the data on page 11 of my presentation.

Our concerns and our recommendations with respect to Bill 36: Number one is with respect to the local health advisory committees. While the legislation—Bill 36; the act itself—focuses on breaking down silos, local health care advisories that are limited to regulated professionals in fact reinforce silo existence, and do so at the highest level by providing advice to the decision-making body of the LHIN. We ask that consideration be given to expanding local health advisory committee membership to include representation of the community support sector at the table.

With respect to accountability agreements, the essence of LHINs is local responsiveness based on province-wide strategic goals. We recommend that the LHIN legislation speak clearly to the development of outcome indicators, and that those goals are articulated in a clear—established, first and foremost, before outcomes—provincial strategic plan, and that the plan understands and appreciates that "local knows best" solutions often respect local strengths and facilitate health system effectiveness.

In terms of effective and efficient services, we ask for clarity of language, please. We recommend that "efficient" and "effective" be defined in the legislation, but that they recognize the value of quality outcomes—the numbers game doesn't always represent the full picture; that the components of innovation and flexibility are recognized; and community responsiveness, including the degree of community involvement and support inherent in service provider operations. Clarity of the language will reduce ambiguity and remove opportunity for selective application.

With respect to part V, section 28, the discretion of the minister to force integration, the legislation specifically proposes the option of forced integration for not-for-profit organizations. We feel that that authority should be extended to all funded health care providers who receive public funds, or to none at all. We are unclear as to why the not-for-profit sector has been targeted in this fashion. It certainly seems to make sweeping assumptions with respect to the governance of not-for-profits, and it makes equal assumptions with respect to the governance of for-profit organizations. We would suggest that local accountability and funding accountability follow the dollars and not governance.

With respect to system navigation—system navigation, again, is not a job description in its own right. Every client has a unique set of needs, a different point of access into the system and a different path of processes and relationships to transition through. All health care providers have a role to play in helping the client or the patient through the system.

CCACs are broker organizations that purchase services on behalf of clients. We believe that there are unintended consequences of role expansion, up to and including overlaying of an expensive competitive model on top of effective, timely service delivery. We recommend that the bill limit the role of CCACs to their current position in terms of brokering for services such as nursing, personal support, therapies and medical supplies—that which they already do.

The Chair: Thank you very much. We did use the 15 minutes. We thank you for your presentation.

1030

ONTARIO PUBLIC SERVICE
EMPLOYEES UNION, LOCAL 460

The Chair: The next one is a teleconference from the Ontario Public Service Employees Union, Local 460, Kingston. Is Gavin Anderson on the line?

Mr. Gavin Anderson: Hello. Good morning from Kingston.

The Chair: Good morning, Mr. Anderson. You have 15 minutes total for your presentation. If there is any time left, we will allow some questions and/or comments. Please start any time.

Mr. Anderson: Thank you. My name is Gavin Anderson, and I'm the vice-president of OPSEU Local 460. Local 460 represents 85 front-line clinicians and clerical staff who work for Pathways for Children and Youth. Pathways is a children's mental health agency that serves children and families in Kingston, Frontenac and Lennox and Addington counties.

I will speak about the relevance of the local health integration networks to children's mental health in a moment, but first I want to thank the standing committee on social policy for hearing my submission. I had hoped that the committee would convene for at least one day in Kingston, but I appreciate the opportunity to participate by speakerphone, and I trust that the transmission is clear.

I realize that most of the submissions you will hear will be delivered by individuals and organizations that are directly involved in the delivery of health care services or groups that advocate for patients or the Canadian medicare system. I know that my own union president, Leah Casselman, as well as many other elected union leaders have met with the committee and spoken with passion and conviction about the problems associated with Bill 36 and the LHINs initiative. The Ontario Health Coalition and local community health coalitions have also weighed in. It is not my intention to repackage their submissions, other than to reiterate that the unions and the health care coalitions make a convincing argument against the LHINs.

I agree with those who maintain that the LHINs have been poorly planned, without adequate consultation. I share the concern that physicians have been inexplicably left out of the equation. I believe that the LHINs are neither democratic nor accountable and stretch the boundaries of the term "local" beyond reason. These are serious challenges, and I certainly hope that the committee takes them to heart. It would be a grave error to proceed with the LHINs as presently contemplated.

I began by identifying myself as the vice-president of OPSEU Local 460. That is the credential that I used to request standing, but you should also know that I am a registered social worker at Pathways with a full caseload. I have arranged my schedule today so that I could call on my break. I have worked in children's mental health for over 25 years, the last 18 in southeast Ontario with Pathways and its predecessor agency. When my colleagues and I speak about children's mental health, we do so with the credibility and the authority that is earned through years of direct, dedicated service.

Many of you may be wondering about the connection between children's mental health and the LHINs, since children's mental health agencies, including Pathways, receive their funding from the Ministry of Children and Youth Services and not the Ministry of Health and Long-Term Care. George Smitherman confirmed the connection on November 29 when speaking about Bill 36. He said, as reported in Hansard:

"We also believe that there are opportunities to move forward and create a broader role for community care access centres. Other government ministries have wondered—and we will work on this as a government; we will seek input on this—whether it might not be possible to use community care access centres not just as a place that's branded, if you will, related to the Ministry of Health, but with a broader service role. Taking a look at other community programs that are delivered by sister ministries, like the Ministry of Children and Youth Services, the Ministry of Community and Social Services and even the Ministry of Education...."

Clearly, the government of Ontario is contemplating moving children's mental health and other community services into the CCAC model, which to my thinking will place these non-medical agencies squarely under the authority of the LHINs. Let me explain why that is threatening to my members and to the families that depend on our services.

Mental health remains poorly understood and chronically underfunded. Our colleagues who work in the adult mental health sector, including OPSEU members who work in psychiatric hospitals and psychiatric wards, have testified in this and many other venues about the bleeding of resources away from mental health services towards more easily measured and more easily understood medical procedures. In the LHINs model of allocating resources, adult mental health workers, patients and advocates will be competing for recognition and funding in 14 jurisdictions. Historically, the needs of children with mental health issues are even less well supported.

Children's Mental Health Ontario has estimated that as many as 558,000 children under the age of 19 have a diagnosable mental health disorder; that's 18%, or nearly one child in five. More than 300,000 are living with multiple disorders. Our experience is that it is difficult to get and keep the attention of even our own ministry. Our capacity to meet the needs of children with emotional and behavioural problems is shrinking when measured against the expanding demand for services.

We are also aware of the problems in home care, which under the CCAC model has degenerated into a fragmented sector of competing service providers that have disrupted continuity, eroded service standards and depressed wages. We do not want to see children's mental services going to the lowest bidder. We do not want to have to follow our work from employer to employer, as contracts are terminated and reissued to the cheapest alternative.

The children and families of Ontario need to have confidence that their government will provide access to adequately funded children's mental health services. This is a commitment that only a central government can guarantee. We do not believe that 14 LHINs will independently accept the same obligation, especially in the face of competition from services that historically have enjoyed far more political and community sympathy than

the services that support the types of misbehaving children and dysfunctional families that rely on our services.

The LHINs initiative is bad policy that has failed in other jurisdictions. The LHINs represent poor planning and incomplete consultation and deserve to be derailed on their own merit. Minister Smitherman's musings that the LHINs of the future will potentially swallow more agencies, including the one I work for, are just piling on. Please put the brakes on this potential train wreck before our health care system is thrown into further disarray.

I believe there is some time available, and I would be pleased to clarify any part of my presentation or answer any questions that anybody might have. Thank you for your attention and your consideration.

The Chair: Thank you. We have at least two minutes for each group. I will start with Madame Martel, please.

Ms. Martel: Thank you, Mr. Anderson, for joining us this morning and for taking the time to do so. I want to focus specifically on your concern around children's mental health somehow being taken up by CCACs, particularly in light of the chaos in CCACs with respect to competitive or cutthroat bidding. The government has tried to say, and the minister tried to say in his opening remarks on Monday, that there's nothing in the bill that says that LHINs will use the competitive bidding model to purchase or acquire services. I've pointed out to the committee on numerous occasions that there isn't anything in the bill that stops that, either. It's not explicitly written into the bill that this will not be the mechanism that is used for LHINs to acquire or purchase services.

Further, we heard from one of your colleagues earlier this morning, Ms. McSheffrey, who said that when she made a presentation before Elinor Caplan about competitive bidding, Ms. Caplan made a point of saying that she was looking at competitive bidding because it might well be the model used in the LHINs for the purchase of services. I remain very concerned that in fact this will be exactly the model that LHINs will use to purchase services, and the chaos that we've seen in home care will then be expanded across all of the other sectors that LHINs are responsible for.

Given your intimate work with children who have very severe needs and with their families who are trying to support them, if that model is applied and if you essentially are incorporated or attached to CCACs in a way that you aren't now, what is your fear both for the services that you're trying to provide and for the very vulnerable clients you're trying to give services to?

Mr. Anderson: I think you've phrased our concerns very well. We work with individual children, but it's always in the context of families. The work can go on for extended periods of time, sometimes continuously, sometimes addressing particular developmental stages or times in the family's evolution. It's critically important that there be continuity and stability within the service providers. We need to attract individuals to this type of work who can be confident that their loyalty to the field will result in their having a career in the field, not like home care.

1040

I have friends in Kingston who worked for All-Care Health Services, who saw their contract lost. Many of them had to sign on again with new agencies and learn new protocols. That's exactly what will happen in children's mental health. That's the CCAC model now. So for the government to issue assurances that it won't happen—I think the best predictor of the future is the past. Unless the government renounces the competitive bidding process, which they had an opportunity to do when Elinor Caplan was doing her work and didn't do, then my members are afraid that that's our future.

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: Thank you, Mr. Anderson, for joining us. I just wanted to make a couple of comments. I wanted to draw your attention to the front of the Globe and Mail today—just in terms of the model that we're trying to develop—that BC is being seen as the best health care system in the country, and we're trying to improve on that. That's the model we're trying to put in place.

I just want to make a comment about the Ministry of Children and Youth Services. The fact that our government has set up a ministry specifically to focus on children speaks to our commitment not to derail that focus, not to move children's services out of that coordinated area—

Mr. Anderson: If I could just interrupt and ask you then how you reconcile that with Mr. Smitherman's comments on November 29.

Ms. Wynne: Mr. Anderson, I have a question. One of the jobs I have is that I'm the parliamentary assistant to the Minister of Education. I've been very involved in a review of special education recently. I just wonder if you could comment on the crying need that I hear from people in the education sector, people working with children in special education, the need for more coordination among ministries around meeting those needs. It seems to me that having a LHIN in place that coordinates local health services and, I agree with you, is then able to help ministries work together—MCYS, education and health—will be a good thing for children with special needs and the children you deal with. Could you comment on that?

Mr. Anderson: Yes. Coordination would be a good thing. I'm not here to criticize anybody who wants to integrate or coordinate services. The gist of my presentation is that there's a hierarchy in terms of what services get funded. We need a province-wide central government commitment to children's mental health and the issues that challenge the families with children with mental health issues. Integration is fine, but my worry is that in 14 jurisdictions, children's mental health—and adult mental health, for that basis—will be a low priority. So coordination without adequate funding really isn't helping the situation.

Our anxiety is that the minister is suggesting that the CCAC model will come into children's mental health.

Regardless of the integration possibilities, the threat is much larger than the opportunity.

Ms. Wynne: But, Mr. Anderson, there's nothing in the bill that says that. So thank you very much—

Mr. Anderson: There's nothing in the bill that allays our fears.

The Chair: Thank you. Mr. Wilson.

Mr. Wilson: Thank you, Mr. Anderson, for your comments. Just following up on what my colleague from across the way has been saying: First of all, I just want to say, don't anyone be fooled by the Globe and Mail article today saying that BC's the best health care system. Ontario and BC aren't even comparable in terms of complexity and the volumes we do. Also, keep in mind that OHIP's the largest single insurer on the North American continent. I don't think much is comparable. We're even bigger than all of the US insurance companies.

I would say that your point's well taken, that children's mental health services have often been the poor cousin in health care. Because you have these fears—and there certainly are a number of sections in the act, about seven of them, that deal with getting rid of not-for-profit organizations and so-called integrating them; they seem to be singled out—will you or OPSEU or children's mental health services people be putting forward amendments to give you some safeguards that there'll be, for example, as you make the point, a province-wide mental health program in place before these integrations start?

Mr. Anderson: I would hope that OPSEU and the unions are doing that. It's my understanding that we have written submissions as a central union that are following these presentations. I'm afraid my purview's limited to my little local in Kingston and to let you know the anxiety that some of the community agencies are feeling.

Mr. Wilson: Don't hesitate to think up an amendment. We'll help you with the legalese of it.

Mr. Anderson: Okay. I appreciate that.

The Chair: Thank you, Mr. Anderson.

OTTAWA HOSPITAL

The Chair: We'll move to the next presentation, which is from Ottawa Hospital. There are a number of individuals speaking. Good morning.

Ms. Peggy Taillon: Good morning.

The Chair: You can start any time you are ready. You have 15 minutes.

Ms. Taillon: Great. Thank you very much. Thank you all for having us here today. My name is Peggy Taillon and I'm the vice-president at the Ottawa Hospital. I'm here today with our chief of medical staff, Dr. Chris Carruthers, who is also representing our board of governors today.

We certainly do appreciate the opportunity to speak with you. We'll declare our bias right from the get-go so that you get a sense of the thrust of our presentation today. Dr. Carruthers and I and the Ottawa Hospital are extremely supportive of the transformation agenda and the direction this government is taking with respect to local health integration.

We put together some material in your package. A lot of it is for your perusal and some background. We wanted you to understand who the Ottawa Hospital is. So in the package you'll have a backgrounder and our strategic directions, which actually do speak to our commitment and contribution to the LHIN in the Champlain district.

In the presentation "Bill 36 and LHINs," page 3, slide 5 really sets out the Ottawa Hospital's perspective on Bill 36. Of course, we are very supportive of the transformation agenda. The position we take is that this is not just health care transformation; this is actually major social transformation in Ontario. One of the points that we'd like to emphasize with you today is that community engagement and engagement of the broader citizens in Ontario and awareness of this wide-sweeping social transformation need to be enhanced. We're going to talk a little bit about some ways in which we believe we can strengthen this transformation agenda, strengthen the LHINs and strengthen Bill 36.

Page 7, slide 14 really emphasizes the point. Any regional structure, any local governance: One of the key pillars to it is being local, being close to the citizens, the patients. We believe that Bill 36 needs to be strengthened in that the only true reflection of community engagement embedded in Bill 36 is a public board meeting. We believe that meaningful consultation, engagement and dialogue with your community so that plans actually reflect the unique needs of every community across the province—consultation and engagement need to be strengthened and the LHINs need to look at very practical ways to engage local communities and reflect the uniqueness of communities across Ontario.

We also think that the definition of "community" in Bill 36 needs to be expanded. We need to reflect, really, the diverse heritage of Ontario. By that, we mean linguistic, rural, northern, aboriginal, new Ontarians. We'd like to ask you to reflect on how the LHINs will improve the patient experience for those populations. Our previous speaker spoke to special populations, people requiring mental health services; we all know the demographics around the aging population. I think we need to think in practical terms about what LHINs will do to change their experience as patients, as citizens on the ground. We believe there are tremendous opportunities to do that through implementing this transformation.

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The legislation could be strengthened in the sense that it really doesn't define the health care system per se. It talks about it in very broad terms. I think this is an opportunity to clarify roles and responsibilities across the health care system. All of us in the health care system couldn't possibly even define all of our partners in care because there are literally hundreds. There are over 250 providers just here in the Champlain district.

I believe that the opportunity is to define in this legislation the four levels of care and very clearly articulate them: what is first-line care, acute, tertiary and quarter-

nary, and who are the providers—not specifically, but what are the types of providers that are found under each level of care and what are their roles and responsibilities respectively to provide care, so that we can create meaningful accountability so that people can understand which door they enter to get what types of service in the province. I think this is a real opportunity to do that, and I was disappointed to see that that was missing in the legislation.

Another piece that's key, and I'm sure you've heard it reflected in your consultations across the province, is that Bill 36 is silent on two key pillars of the health care system: health research, and that would include basic science research that's done in laboratories and clinical research that's done in our clinics and ORs, and education of future health professionals.

Research and education are truly the lifeblood of the health care system and are key to sustainability. Academic health science centres are the primary conduit for research and education and are not even mentioned in this bill, and we really would urge you to revisit and reflect that in this legislation.

The other point that I'd like to emphasize—and it was reflected, I believe, in the last speaker's presentation—is that health is really one pillar of Ontario's human services network. While the Ministry of Health and Long-Term Care embarks on this needed transformation, other ministries such as social services, children's services, justice, corrections and education are going to continue to work in their historical and traditional silos. I believe that this will weaken the gains that can be made through local health integrated networks. I would strongly urge the government to look at how to better integrate social services, and children's services in particular, with the local health integrated network strategy.

If there's any message that I could leave with you today: We need to keep this simple; we need to focus on people. Health care is all about people—the people who provide service, the people who receive service, and the people who are supporting the vulnerable people in our province. The focus to date has really been about organizations and structures, and I think we need to focus on the patient journey and what this change is actually going to do for citizens across Ontario. My neighbours don't even know that this major social change is occurring in Ontario, and I think that's something that all of us could improve on and really, truly engage them in a meaningful way.

With that, I'm going to ask Dr. Carruthers to speak on his points.

Dr. Chris Carruthers: I think you've got the handout. Just quickly on my background: I'm chief of staff at the Ottawa Hospital. I've been in practice for 30-plus years; an orthopaedic surgeon.

I want to focus on one issue. I recognize that there are a multitude of issues. I recognize that there are other issues to be addressed, but I think it's best to leave you with one message. Number one, I strongly support the direction of LHINs. I've supported it in the past; I've written about it in the Ottawa newspapers and editorials. You're going in the right direction. As a matter of fact, we're behind. You need champions, and I want to show you how we can create more champions and make it successful.

I think there are key success factors, and one of the key success factors is having the physicians on board. I've learned an awful lot in a hospital where I have 1,200 physicians to deal with on a daily basis. If they're not on board, I'm not going to be successful in implementing what I want to do. I need them there.

Prior to this, we in eastern Ontario were ahead of the curve of several other districts. We already had a regional chiefs of staff association. This was a loose group of the chiefs of staff from all the hospitals from Pembroke to Cornwall who met on a regular basis and talked about issues, talked about the challenges in delivering health care, how we could do it. It was an informal relationship but it was a very beneficial structure.

What I see missing in the legislation is such a structure as we go forward. I think it should be embedded generically in all of the LHINs. Our group met successfully two to four times a year and talked about issues related to the delivery and integration of health care—not specifically physician issues.

I think one of the weaknesses—and I'll put a caveat on my remarks by saying I recognize that there are other important issues—is that there is no formal structure other than the PAC for physician input. Already, without such an inclusion, it risks indicating that the government has limited interest in physician involvement or participation. Such a formal structure is a critical success factor for the LHIN. Today, prior to the LHIN, there does not exist a formal structure where hospitals and other providers sit at a table and talk about how to best integrate the system. We do not sit down at a formal table and talk, particularly with the physicians, as to how to integrate the services. There is a professional advisory committee, but I don't think it is sufficient. Failure to engage physicians will lead to a potential failure, particularly of the implementation of integrated service plans.

So what would I recommend? Look seriously at creating a regional medical advisory committee. Don't forget that in the present structure the existing hospitals' MACs continue. So it's only natural that there is a roll-up of that over the LHINs. Such a structure was recommended when you look at Tom Closson's report on the integrated service plan for northwestern Ontario. They did a study. They looked at it and suggested that. It must be a meaningful structure with direct input to the LHIN board. A token structure will lead to physician apathy and non-collaboration.

Membership has not been decided, but it could be by both appointed and elected. It must be there to make the LHIN successful, not there as an obstacle or to obstruct the LHIN. This is the way to go. It would address other issues, though, that are important as we look at a regional

LHIN structure, such as medical human resource planning, and the advantages and risks of integration of clinical services. One of the key issues is looking regionally at the quality of patient care, looking at utilization management, common clinical pathways—so when you enter one hospital with a disease, it will be similar to the other—and provide communication, which is key.

So a LHIN-based MAC would provide the opportunity for LHIN physician leadership, the champions, for the benefit of the public and the medical community. Such a structure should be part of the LHIN legislation.

Those are my comments.

The Chair: Thank you. We have 30 seconds each. Mr. Patten.

Mr. Patten: Thank you for coming today. It's interesting. First of all, you're seen as the giant in the community, this powerful, huge hospital. So it's heartening to hear you talking about supporting something that is intended to be a leveller.

As I've been listening to some of the presentations this morning, I'm tempted to ask, how much money do people spend going back and forth to Toronto? MPPs have to do that, but how many people from hospitals, from health care centres and one thing or another, fighting for more resources: "You don't understand our area. The system is too centralized"? This is an attempt to say we've got to push some of that decision-making, responsibility and power back down to the region.

Now, I acknowledge that the region is pretty darned big, and that's going to be one heck of a challenge, but one question I would ask you is—and Dr. Carruthers, I appreciate your comment as well, and Ms. Taillon, you work on sort of the organization side of things and building systems—is there not room in this particular system for doctors to have an advisory role in and of themselves? I don't see anything precluding that, except formally, and this is an attempt to try and break down the traditional structures that have gone where, quite frankly, doctors have dominated the whole system. Well, it's a health care system; it's not just a medical system. I think this is the intent here. I'm being very blunt, but that's taking nothing away from my respect for doctors, believe me.

Ms. Taillon: Richard, I think that Chris reflects on the fact that in the Champlain district we've worked under tremendous goodwill, and the Ottawa Hospital has been committed to working with and enabling our partners in the district. We have a number of regional initiatives. We have lots of regional programs. We've moved out a number of services, created satellite programs in other smaller hospitals, and Chris has brought together a group out of goodwill in a very informal way. I think what he's seeking is formalization. There are all kinds of those groups out there, and I think that the LHINs need to think about what core advisory groups they need to give them meaningful advice on the ground above and beyond—again ensuring meaningful citizen engagement, which I think is critical and missing.

The Chair: Thank you. Mr. Wilson.

1100

Mr. Wilson: Thank you very much for your presentation. The regional medical advisory committee—I guess it's the first time, as my colleague Mr. Arnott, who's been attending all of these hearings, says, that we've got a label for what you're looking for. Certainly, we support that. I don't see why it's any sweat off the government's back—I think Mr. Patten was saying the same thing—to include an advisory committee; in fact, it's probably a very positive step.

I just wanted to say, since I was the fellow who brought in the Health Services Restructuring Commission and gave it independent but sunset powers—it went away after a while—with the exception of it, the only levers the Minister of Health has in the system are funding levers. This bill is a fundamental change in terms of the powers of the minister, who really brings upon himself or herself in the future tremendous new powers. You're away from funding levers to direct integration orders. Does that not concern you? You didn't mention anything, really, about the powers of the minister. It used to concern the OMA when I was minister, I can tell you that.

Dr. Carruthers: I'm not going to speak as a physician; I'm going to speak as a citizen. The direction this is going, the devolution of power, is very important. If you knew and understood the Champlain district, you would understand that this is one of the most collaborative districts that ever existed. The Ottawa Hospital may be a giant, but we work collaboratively with Pembroke, Arnprior and Almonte. So this can be a success. I think it's heading in the right direction. The other reason is, we have the key people in place to make this LHIN a very successful one.

The Chair: Thank you. Madame Martel.

Ms. Martel: Very briefly, you heard the concerns expressed by the previous speaker about where our mental health, particularly children's mental health, ranks in terms of priority. So how do you see the LHINs dealing with those very concerns?

Ms. Taillon: I was involved with mental health reform, actually under your government, heading up the mental health task forces in the province. So this is an area that's very close to me. The task forces actually recommended regional mental health authorities. We felt very strongly that health services needed to be reorganized. Mental health does not have a profile. There is tremendous stigma. There is a lot of misunderstanding and a lack of resources. We thought that having some local authority to start looking at how to best expend resources that are actually going to meet the needs, so we're planning for people instead of planning based only on policy that's very centralized, was something that was really needed. And we looked at evidence from the UK and right across Canada. We thought this was the structure that needed to happen to fill the gaps, for vulnerable people particularly, in the mental health system.

The Chair: Thank you very much for your presentation.

OTTAWA FRANCOPHONE COMMUNITY LEADERS

LEADERS DE LA COMMUNAUTÉ FRANCOPHONE

The Chair: The next presentation is from the Ottawa Francophone Community Leaders. There are five and we only have four microphones, if you can keep that in mind. Please have a seat. There is a total of 15 minutes for your presentation. Any time left will allow for members to ask questions or make any comments.

Mr. Gilles Morin: Did you say 15 minutes?

The Chair: In total, yes. That is what has been agreed. I would suggest that you may want to start your presentation quickly.

Mr. Morin: Before we start, I'd like to ask you—we came here as a group and we will be continuing with our presentation, so if the questions can be reserved for the end.

The Chair: Excuse me. We have already decided on the matter. Unless I hear from the membership otherwise, please start so you have more time for your presentation.

Mr. Morin: Monsieur le Président, members of the committee, it is crucial that there be no misunderstanding about what we have to share with you today. This is an extremely important issue for all Ontarians, but it is vitally important to the Franco-Ontarian community. Our health depends on it; so does our future as a vibrant culture that has flourished in Ontario for more than 300 years.

As some of you may know, I had the great opportunity to sit as a member of the Ontario Legislature for 14 years. And, like my friend Mr. Grandmaître, I had the pleasure of being part of Premier David Peterson's cabinet. I was also a member of the opposition, and it was obvious to me that you do not have to be in government to be useful to society.

This is one issue where we all have to work together to come together. Franco-Ontarians have had more than their share of battles over the last century to have their rights respected. We do not wish to battle over this. We ask simply that you try to understand what it's like to be a Franco-Ontarian and to be deprived of the health care services in French you are entitled to, and that you act on it.

Furthermore, we ask that you think of Franco-Ontarians not as an interest group, not as a group that wants and needs services in their language, but as one of the founding peoples of this country. Francophones were signatories of the 1867 constitutional pact that created Canada, and they would never have signed the Constitution if they had believed that their culture and language would not be protected throughout this new country. We're not saying it; the courts are saying it. This is what the Court of Appeal for Ontario wrote in the Montfort judgment: "The protections accorded linguistic and religious minorities are an essential feature of the original 1867 Constitution without which Confederation would not have occurred ... The protection of linguistic minorities is essential to our country."

This is what the Supreme Court wrote in the secession reference: The Consitution Act of 1867 "guarantees to protect French language and culture" in Canada as a whole. You certainly do not protect French language and culture if Franco-Ontarians have no or little access to health care in their own language. At present, health care services in French are far from adequate. I will let other speakers address this issue more specifically.

During the 20th century the notion of a minority of francophones in Canada being a founding people, with all its significance and implications, was lost, and decision-makers, especially at the provincial level, governed as if the minority did not have rights equal to those enjoyed by the majority. But times have changed; things have changed: Franco-Ontarians now have their own schools and the governance of their school system; French is an official language in our courts of justice, where it is used routinely now; the French Language Services Act of Ontario was passed 20 years ago; and the Franco-Ontarian community applauds positive initiatives in health care such as the expansion of the Montfort Hospital, the investments in teaching for francophones and the development of family health teams.

However, practically everywhere else in the province, health care services in French have in fact deteriorated. The Franco-Ontarian community has not been protected. There is no doubt at all that this deterioration has had two dire consequences. First, Franco-Ontarians have been offered health care services of a quality inferior to those offered to the majority since they can't communicate in their own language. That is not best practice in health care. Second, the lack of health care services in French has increased assimilation, and government policies that have such an impact are squarely against the Constitution of Canada and the intent of the French Language Services Act. Ontario can do better.

Dear colleagues, more than half a million francophones live in Ontario. That's equal to the population of Newfoundland and almost four times the population of Prince Edward Island. It is also more than half of the one million francophones who live outside Quebec. Ontario must take the lead in providing adequate health care to its linguistic minority. If we can't do it here, it cannot and will not be done anywhere else in this country, and Canada will be lesser for it. In fact, Canada as we know it, with the richness of its linguistic and cultural duality, will eventually cease to exist; it is only a matter of time.

But if we all think of the francophone minority as a founding people and act accordingly, a lot of things should be givens. The government should actively seek to improve health care services in French. For all these good reasons, it is time to act. Let's make sure this law, this transformation of our health care system, treats the minority as it should be.

Merci. Je demande maintenant à ma collègue Mme Michelle de Courville Nicol, présidente sortante du Conseil d'administration de l'Hôpital Montfort, de prendre la parole.

Mme Michelle de Courville Nicol: Monsieur le Président, membres du comité, j'aimerais vous parler d'une question essentielle au succès de la transformation du système des soins de santé et au développement des services de santé adéquats en français pour la communauté franco-ontarienne de toute la province.

Laissez-moi vous dire clairement que chaque Franco-Ontarien possède autant le droit d'avoir accès à des services de soins de santé dans sa langue que chaque membre de la majorité. Évidemment, ce n'est pas la réalité présentement.

Il n'y a qu'une façon d'assurer l'atteinte de cet objectif que nous devrions tous avoir : fournir l'accès aux services de soins de santé en français à chaque membre de la minorité.

1110

Toutes les décisions touchant les francophones dans la planification et la prestation des services de soins de santé en français doivent être prises par des représentants de la communauté franco-ontarienne. Non seulement est-ce que c'est la meilleure pratique, c'est la loi.

Le gouvernement et le ministre de la Santé et des Soins de longue durée ont démontré une volonté de réaliser cet objectif, mais pour le moment, le cadre des réseaux locaux d'intégration des services de santé est profondément défectueux, et structuré de manière à échouer en ce qui a trait à l'élaboration et au maintien de services de soins de santé en français.

Chaque fois que cette question a été soulevée lors des ateliers sur les réseaux locaux d'intégration qui ont lancé cette initiative du gouvernement il y a plus d'un an, la responsable de l'intégration du système, Mme Gail Paech, a dit à plusieurs reprises qu'un groupe de travail présidé par M. Gérald Savoie examinait cette question et allait résoudre le problème.

En fait, nous comprenons que le groupe de travail sur les services de soins de santé en français présidé par Gérald Savoie a eu le mandat d'examiner précisément comment les décisions en matière de soins de santé touchant les francophones pouvaient être prises par des francophones, y compris la question de la gouvernance.

Nous savons qu'après neuf mois de délibérations, le comité de travail sur les services de soins de santé en français a déposé son rapport final en octobre, mais que la communauté franco-ontarienne ne l'a pas encore vu parce qu'il n'a pas été rendu public par le ministère. Nous attendons sa publication avec impatience.

Cependant, la position de la communauté franco-ontarienne sur la question de la gouvernance est claire. Il n'y a aucune manière d'arrêter la tendance à la détérioration des services de soins de santé en français si les Franco-Ontariens ne jouent pas un rôle central dans les décisions touchant ces services.

C'est un principe qui a été énoncé et répété dans plusieurs jugements de la Cour suprême du Canada. Voici ce que la cour disait dans le jugement Mahé en 1990 :

« … les minorités linguistiques ne peuvent pas être toujours certaines que la majorité tiendra compte de toutes leurs préoccupations linguistiques et culturelles. Cette carence n'est pas nécessairement intentionnelle: on ne peut attendre de la majorité qu'elle comprenne et évalue les diverses façons dont les méthodes d'instruction peuvent influer sur la langue et la culture de la minorité. Commentant les différents revers subis par la minorité francophone de l'Ontario, la cour d'appel de cette province a souligné que 'ces événements ont été rendus possibles par l'absence de participation valable à la gestion et au contrôle des conseils scolaires locaux par la minorité francophone'. »

Cette citation porte sur l'éducation, mais le même principe s'applique aux soins de santé.

La majorité, et ce n'est pas de sa faute, est incapable de prendre les meilleures décisions pour la minorité. D'une certaine façon, il s'agit de l'ordre naturel des choses. Les membres de la majorité ne se réveillent pas chaque matin en se demandant ce qu'ils peuvent faire pour la minorité, tandis que les Franco-Ontariens se réveillent chaque matin en se demandant ce qu'ils devront faire pour survivre comme francophones.

Nous ne devrions pas avoir peur d'accorder aux Franco-Ontariens les moyens de prendre des décisions en matière de services de soins de santé pour la communauté franco-ontarienne.

Je ne suis pas venue ici pour vous parler au nom de l'Hôpital Montfort ou à son sujet, mais Montfort demeure un brillant exemple de la manière dont un important établissement de soins de santé francophone, dont la langue de travail est le français et la gouvernance francophone, fournit des services dans les deux langues officielles 24 heures par jour, sept jours par semaine, à titre de partenaire à part entière dans le système de soins de santé à Ottawa et en Ontario. C'est un hôpital très efficient qui fournit d'excellents soins de santé personnalisés.

Montfort est un partenaire à part entière parce que les rôles de chaque établissement dans notre région sont clairs. Peut-être qu'il a fallu cinq ans de chaos pour s'y rendre, mais c'est fait, et plus nous avançons avec des rôles bien établis, plus il y a de gens dans le système qui sont convaincus que les choses fonctionnent mieux qu'avant.

Vous devez comprendre que nous ne demandons pas un système de soins de santé en français séparé. Tous les services de soins de santé doivent être élaborés en les intégrant dans l'ensemble du système, et il doit exister une coopération et un échange d'information constants entre la majorité et la minorité en soins de santé.

Nous devons féliciter le ministre de la Santé et des Soins de longue durée d'avoir nommé quatre francophones au réseau local d'intégration des services de santé Champlain. C'est même plus que ce qu'il avait promis. Mais il y a 13 autres réseaux locaux, et il y a des francophones dans toutes ces régions. Plusieurs d'entre eux n'ont absolument aucun autre accès à des services de soins de santé. En fait, des études ont montré qu'une proportion ahurissante de Franco-Ontariens, 74 %, a peu ou aucun accès à des services de soins de santé en français. Seulement 12 % d'entre eux déclare avoir un

accès en tout temps à des services hospitaliers en français, et peu importe le nombre de francophones qui siègent présentement au réseau Champlain ou aux autres réseaux d'intégration, les gouvernements changent et les ministres changent.

Peu importe les directives du ministre, s'il n'y a pas une volonté au niveau local de tenter activement de fournir des services de santé adéquats en français, il n'y en aura pas. Nous avons entendu toutes les excuses pour tenter de justifier pourquoi certains fournisseurs sont incapables d'offrir des services de soins de santé en français. Aucune ne tient debout. Les mêmes excuses seront utilisées pour expliquer pourquoi les mêmes fournisseurs ne peuvent pas respecter les politiques du gouvernement. La communauté franco-ontarienne a les connaissances et le savoir-faire pour ne pas avoir à s'excuser.

Pour la première fois de notre histoire, le ministère de la Santé a consulté les Franco-Ontariens sérieusement en tant que groupe pour réaliser une importante initiative gouvernementale. Ce dialogue doit continuer afin que, dans une période de temps raisonnable, nous puissions avoir un système de soins de santé où les décisions touchant les francophones sont prises par les représentants de la communauté franco-ontarienne. Si nous ne le faisons pas dans le cadre de cette loi, il faut le faire spécifiquement et précisément dans les règlements.

Merci. M. Bernard Grandmaître, ancien ministre des Affaires municipales et ancien ministre délégué aux Affaires francophones, prendra maintenant la parole.

M. Bernard Grandmaître: Monsieur le Président, membres du comité, le préambule du projet de loi 36 déclare : « La population de l'Ontario et son gouvernement croient que le système de santé devrait être guidé par un engagement à l'égard de l'équité et un respect de la diversité des collectivités lorsqu'il dessert la population de l'Ontario et respecte les exigences de la Loi sur les services en français, lorsqu'il dessert les collectivités francophones. » Ça, monsieur le Président, c'est une première. Finalement, un ministre qui reconnaît pleinement l'importance de la Loi sur les services en français. De mémoire d'homme, aucune autre loi n'a jamais énoncé ce qui est une obligation légale importante pour le gouvernement de l'Ontario dans son préambule ou ailleurs dans le texte. Personne ne devrait faire l'erreur de penser que cette mention n'a pas force de loi parce qu'elle apparaît seulement dans le préambule. En fait, c'est précisément le sujet aujourd'hui de mon intervention en ce qui a trait à la Loi sur les services en français.

Vous savez peut-être que j'ai eu l'honneur de déposer ce projet de loi à l'Assemblée législative en 1986, à titre de ministre des Affaires francophones. J'ai été encore plus heureux d'être témoin d'un vote unanime des membres des trois partis de la législature et d'y participer pour approuver la Loi sur les services en français en troisième lecture. Une question qui aurait pu nous diviser profondément et diviser les citoyens de l'Ontario a fini par nous unir parce que c'était la bonne chose à faire au nom de la justice et des valeurs sur lesquelles est fondé le Canada. Nous avons cru que c'était le début d'une nouvelle ère dans les relations entre la minorité et la majorité.

Le véritable changement prend du temps, et 16 ans se sont écoulés avant que la Loi sur les services en français prenne tout son sens, avec tout ce que cela implique, lors du jugement de la Cour d'appel de l'Ontario dans le cas Montfort en 2001. La cour, avec l'assentiment des avocats du procureur général, a déclaré que la Loi sur les services en français était une loi quasi-constitutionnelle. Cela signifie qu'elle passe avant toute autre loi, mais ce n'est pas tout.

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Le jugement Montfort est le premier en Ontario où les droits linguistiques, y compris la Loi sur les services en français, étaient interprétés d'une manière généreuse plutôt que restrictive—restrictive parce que la Cour suprême du Canada, dans le jugement Beaulac de 1999, a changé ses directives en matière d'interprétation des droits linguistiques.

Voici ce que la Cour d'appel de l'Ontario a déclaré dans la décision Montfort, et je cite :

« À une certaine époque, la Cour suprême du Canada interprétait les droits linguistiques dans une optique restrictive... Il est maintenant évident, toutefois, que cette approche étroite et restrictive a été abandonnée et que les droits linguistiques doivent être traités comme des droits fondamentaux de la personne et interprétés libéralement par les tribunaux. »

I'll speed it up.

En faire le moins possible—non, je ne peux pas me hâter, monsieur le Président, parce que ça joint.

« Au cours des 20 dernières années, ce n'est certainement pas la manière dont le ministère de la Santé et des Soins de longue durée a interprété les obligations découlant de la Loi sur les services en français. Il aurait pu être généreux et proactif dans la prestation de services de santé à la communauté franco-ontarienne sans l'intervention des tribunaux. Mais le ministère a choisi une attitude minimaliste, pour ne pas dire réductionniste. »

Mais la communauté franco-ontarienne a maintenant une raison d'avoir espoir. Nous voyons un gouvernement et un ministre qui semblent avoir décidé de changer radicalement la manière dont le ministère de la Santé et des Soins de longue durée perçoit la Loi sur les services en français. Ce gouvernement et ce ministre agissent avec fermeté en vue d'élaborer des services de soins de santé adéquats et insistent sur l'importance de rendre des comptes partout en province.

Cette loi doit être claire dans les intentions de promouvoir et de protéger activement les services de santé en français. Vous voudrez peut-être examiner des amendements qui pourraient atteindre cet objectif. Les règlements aussi doivent être clairs sur cette question.

Maintenant, monsieur le Président, pour hâter le processus, je vais céder la parole à Mme Lalonde, qui est bien connue dans la cause de Montfort.

The Chair: Merci pour votre présentation, in particular our ex-colleagues Monsieur Morin and Monsieur

Grandmaître. We thank you for making the presentation. There is about 30 seconds each that we will allow for questions or comments. Can I start with Mr. Arnott, please.

Mr. Grandmaître: Mr. Chair, instead of questions, we prefer that Mrs. Lalonde address the committee.

The Chair: For a minute and a half? Okay. Go ahead, Madame.

Mrs. Gisèle Lalonde: Can I give you at least one message? Ontario can certainly do better. Ontario must do better. The current LHIN makeup and framework is very troubling, because all it tells us is that we are going to get more of the same, which means, in time, our disappearance. If you look at the document we presented to you and if you read it, you will see that what I say is very, very true. We refuse to live as second-class citizens, unable to get adequate health care services in the country we founded.

As Mr. Morin said, we are not second-class citizens. We have been here since the very beginning, and we should be respected, at least in the report—we are not even there—when you are speaking about other founding nations. We are one of the founding nations. The last thing we want is to have to resort to the courts once again. We don't want to go to court. We had to go to court for education; we had to go to court to keep our hospital open. We don't want to go to court for these LHINs. This is the message I want to give to the actual government. Thank you.

The Chair: Thank you very much again for the presentations.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, HOSPITAL PROFESSIONALS DIVISION

The Chair: The next presentation is from the Ontario Public Service Employees Union, hospital professionals division, Brendan Kilcline. Sir, you can start any time you are ready. There is a total of 15 minutes.

Mr. Brendan Kilcline: Thank you. Good morning. My name is Brendan Kilcline. I work at the Kingston General Hospital as a laboratory assistant. I'm very proud of the work that I do. I'm also with OPSEU. I'm very proud of my union. I'm on the hospital professionals division executive.

I'd like to make an initial remark. It's not that we are against the stated aims of having truly locally accountable, integrated, networked health systems; it's just that we don't think this bill achieves that particularly well. In fact, we have grave concerns that it actually might be counterproductive to those aims. I'd like to have a few comments, if I might, on the structure of the bill, the issue of labour stability and efficiency.

First, I'd like to highlight who we are and what we do. We represent an incredibly diverse group of highly trained hospital professional practitioners in diagnostic, therapeutic and support services. These are essential to the positive outcome of any medical intervention. There's a lot more to a successful treatment outcome than the interventions of just our valued colleagues, physicians and nurses, but ours is a continuing struggle, as it were, to raise awareness within the public and within our members of government as to the nature and value of the services we provide. We perform the backbone of recovery in a patient-centred, interdisciplinary approach to treatment. This is the best and most cost-effective approach to patient care.

Unfortunately, this is the approach that would be dismantled if we end up going down the road of boutique medical clinics, of moving services out of hospitals inappropriately, and of increasing centralization or so-called rationalization of delivery, those models, and we feel that they are predictable consequences of this bill as it stands.

We've heard a number of things about the government's and Minister Smitherman's good intentions. We've even heard remarks that unions tend to be alarmist. Despite these good intentions, the bill, as it stands, sets up a framework that promotes the outcomes that we fear. It's somewhat like if I park a heavy truck on a hill without brakes. It may not be my intention to let the thing careen out of control down the hill, but the legislative framework—i.e., the laws of gravity—takes precedence, and that is the unintended consequence. So we have concerns about this bill overall.

I particularly want to talk about labour instability. It seems to us that the bill, as it stands, enshrines instability in the labour pool. Its structural, never-ending reform, rationalization, amalgamations, mergers are hardwired into the act, or the bill, as it is now. There's an indisputable fact that employment stability ensures the best patient care. We have had experience with home care which has been particularly disastrous, in our opinion, in the Kingston area. The experience of the workers and the patients in that kind of purchaser-provider split competitive bidding environment has just been awful. Elinor Caplan touches on just those things in her report. Again, despite what we're told about intentions, we believe that the structure of the bill itself leads to a certain inevitability about going down that road. It's not good for the workers and it's not good for the patients, and it doesn't get any more local than that. The front-line caregiver and the patient are as local as it gets, and we feel that this bill pays pretty much an afterthought to that relationship.

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We have considerable experience already with restructuring. We've had the Mike Harris Sinclair commission restructuring, so we're quite well aware about what happens in restructuring and its problems. We are actually still recovering from that. One of the effects of those restructuring exercises is that when people get moved around, they don't necessarily find themselves in employment positions where the skills and experience they spent many years obtaining are deployed as they were previously. Staff end up getting moved out of their particular areas of expertise and get placed back on the learning curve.

Remember, we have an extremely diverse group of professionals. The learning curve is long and steep, and it just doesn't make sense to take people at the height of their expertise and reassign them in areas where they might have to reacquaint themselves with other sub-specialties within their profession. They're all professional, they're all capable of doing that, they're all licensed to do that, but the truth is, the degree of sub-specialization in our professions is extremely high. We feel that it's folly to institutionalize that kind of constant moving and restructuring and relocation of services. At least with the Sinclair restructuring, there was an end point, and we are on the way to recovering from that. Workers are tired of endless amalgamations, mergers and privatization. They want to stay focused on their job, which is looking after the public.

If we look at the demographics in our professions—I take this information, actually, from the ministry's educational website; it's got lots of good information on there—our professions are 80% female. A very high percentage are approaching retirement age, and we have relatively few younger workers in the system. Women are still primary caregivers in the home to children and elderly relatives. They are much more likely than men to put their careers on hold to address their responsibilities, and they do not have the degree of labour mobility that perhaps men have, as a whole. What this bill does, we feel, is institutionalize the moving of services from one place to another.

Many will not transfer with service. They're close to retirement, so they will choose to change careers or retire, and that will be a huge loss of skills. Many will stay in their homes and commute greater distances. This presents a number of problems, one of which we experienced during the ice storm. Because our workforce generally tends to locate close to the place of work, most of our workforce was able to come in to work despite the ice storm or other similar disasters. When you start moving people around on a fairly frequent basis and relocate services through the district, workers invariably end up commuting longer distances, and fewer of them would be able to respond in that kind of circumstance.

It gives rise to great recruitment and retention issues. How can we attract young women to our professions when they have this degree of instability in their working lives? There are already severe shortages in our professions.

The other thing is, as service alignments are constantly being reviewed—the location of the service, where the service will be, in a very large geographic area—self-fulfilling prophecies occur. When relocation of a service is contemplated, people don't wait. They start seeking positions elsewhere. These are highly trained professionals. When they get another position elsewhere, because they don't want to wait for an impending change or they feel their job is insecure, programs actually fail because the staff move. They get appointments elsewhere, possibly in the United States, and the program vanishes because the staff aren't there to deliver it.

There has to be a sensible and fair human resources strategy as a prerequisite to this and not as an afterthought. The number one priority should be labour stability. We have to negotiate a fair human resources adjustment plan with labour before attempting anything else, not as an afterthought. We don't deserve less. We demand no less.

On efficiency: Our hospitals are the most efficient in Canada. Our hospital public labs are the most efficient in Canada; in Kingston, the most efficient on the continent. What we are very concerned about is that this bill will cause hyperconcentration of services. This is an all-your-eggs-in-one-basket approach. It is a dangerous approach. There is a plateau curve on efficiencies. What happens is that your increase in efficiency is very minor but your risks increase. The services are farther away from the point of delivery, from the communities. Disasters do happen. Structures burn down, diseases sweep through workforces. You end up with a hyperconcentrated delivery model, and there is no reserve capacity.

The Chair: One minute left, sir.

Mr. Kilcline: Okay. We're very concerned about that. The structure of this legislation guides delivery in that way. It's dangerous to rush into poorly-thought-out structures. The bill does not address the major cost escalators but attempts to squeeze the last drop out of already extremely efficient sectors, at great risk to the capacity of the system. The public and workers will not stand by and watch the province's most cherished program be mismanaged by ministers who seek to act first, plan later and leave the public and the front-line workers to pick up the broken bits.

The Chair: Thanks very much. There are 30 seconds if somebody wants to ask a question. Madame Martel, any questions?

Ms. Martel: Thanks.

The Chair: Do you have one?

Ms. Martel: No. I said, "Thanks."

The Chair: Okay, thanks. That's fine.

Thank you for your presentation.

PERLEY AND RIDEAU VETERANS' HEALTH CENTRE

The Chair: The next presentation is from the Perley and Rideau Veterans' Health Centre, Greg Fougère and Peter Strum. Welcome. Good morning to both of you gentlemen. You can start whenever you're ready.

Mr. Peter Strum: Good morning. We appreciate the opportunity of presenting our thoughts on Bill 36. My name is Peter Strum, and I am a member of the board of directors at the Perley and Rideau Veterans' Health Centre. I chair a special task force that deals with the LHIN legislation. With me today is our chief executive officer of the health centre, Mr. Greg Fougère.

I'm going to say a few words just to position who we are and from what perspective we're making our comments. In particular, I think you'll see that we demonstrate a leadership role in long-term care in this part of

the province. You will hear from the remarks of Mr. Fougère that we are very supportive of your legislation. We think it has many fine attributes. There are a few minor points that we would suggest you look at, and there is one major point that we think actually taints what is otherwise a good piece of legislation.

The Perley and Rideau Veterans' Health Centre is a non-profit long-term-care facility operated under the Charitable Institutions Act. We have a resident population of 450. Our operating budget is supported two thirds by the Ontario government and the other one third from Veterans Affairs Canada. About half—that is to say, 250 beds—are for the veterans. This being the Year of the Veteran, it's perhaps appropriate that we speak to that.

You will hear from my remarks that we have a leadership role at both the local and the provincial levels in the area of health care for our seniors. In particular, I draw to your attention that Mr. Fougère, who's with us today, has served as chair of the Ontario Association of Non-Profit Homes and Services for Seniors for over three years.

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If you were to come to our facility, you would find that the Health Services Restructuring Commission has its offices in our building, and our staff are often at various tables dealing with issues related to the Champlain Dementia Care Network.

We have already had the chair of the LHIN speak with us, as well as the CEO. We very much appreciate their efforts to meet with us and discuss the issues. We actually would commend the government, and we think we're very lucky, in the selection of those two gentlemen because of the vast experience they bring to the issues in this community and their knowledge of hospital administration, public health, long-term care and community-based health care. In this LHIN, we think we're off to a good start.

Our board has been adamant that it intends to work with the LHIN in advancing the goals and objectives as stated by the Minister of Health. We believe in, and we think we can show by example, how non-profit, long-term-care homes can step out of the traditional box to serve a broader range of health care needs for our seniors. For example, at our facility you would find that we house the Alzheimer Society of Ottawa to provide instant access, support and information for families and staff of residents in our home as well as for the broader community. Veterans Affairs has an office with us. The Victorian Order of Nurses manages our dementia respite day program for 64 community-based clinics each and every week of the year.

We have six clinics at our facility, again showing our leadership and our thinking about the kind of care that has to be developed for long-term care. Those kinds of clinics include audiology, chiropody, dental services, occupational therapy, a pharmacy and physiotherapy.

Our facility was one of only two homes in Ontario to pilot a 13-bed convalescent care program, in co-operation with the ministry, the Ottawa Community Care Access Centre and local hospitals. The purpose? To free up badly needed spaces in our hospitals, to free up those acute care beds. We think it's the kind of integration that has to be looked at. That pilot which we worked on is now being rolled out across the province.

Out latest project is an endeavour between the Victorian Order of Nurses, the Alzheimer Society and our facility, the Perley Rideau, to build and operate a first-of-its-kind respite bungalow in this area. A guest house or a home away from home is located on our grounds and will offer respite to 12 men and women in early to mid-stages of Alzheimer's disease and other dementias. It really offers care, and extended care, if you like, to help caregivers deal with that kind of a health problem.

That's the kind of facility we have. That's our organization and our perspective in this community. I think you can understand, therefore, that we have a huge vested interest in what the LHIN is doing.

As I said earlier, Mr. Fougère will now speak to the fact that we have a couple of suggestions, but there is one area in particular that we are concerned about.

Mr. Greg Fougère: The Perley Rideau supports the enactment of Bill 36 to provide a legislative framework for local health integration networks. While supporting the objects of LHINs in part II and section 5, and being ready and eager to assist in their achievement, we caution that achieving efficient health services, as promoted in clauses 5(a) and (j), should never be exclusively defined as promoting the lowest-cost service. Often, especially in the non-profit sector, health services may be offered to people with special needs who may not receive care from some health service providers due to their higher needs and therefore higher cost.

We support health service providers entering into agreements to achieve performance standards, in clause 5(l), and service accountability agreements, in part IV, section 20. In fact, long-term-care homes already enter into service agreements with the Ministry of Health and Long-Term Care, and must annually comply with standards set out in the Charitable Institutions Act.

We're also very encouraged by part III, related to planning and community engagement. We will provide input to help shape the provincial strategic plan and will actively participate in the development of the local integrated health service plan for the Champlain LHIN.

However, there are two areas of serious concern that we would like to bring to the standing committee's attention and request that further work be done on before completion of Bill 36 prior to moving to the next legislative step. These two areas of concern relate to the limited and discriminatory scope of the integration powers of the minister under section 28 and sections throughout the bill that deal with matters of compensation and liability and the lack of protection of boards of directors of health service providers.

Section 28 is our more serious concern. This section would give the Minister of Health and Long-Term Care powers to force mergers and shut down health service providers—but only in the not-for-profit sector. It is not

in the public interest to have discriminatory and prejudicial legislation which allows the minister to only issue integration orders against not-for-profit organizations. This is particularly worrisome in the long-term-care home and community services sector, where many for-profit corporations receive public funds to provide health services. For example, more than 50% of long-term-care beds in Ontario are operated by for-profit corporations who receive public funds and are considered health service providers under Bill 36.

We do not understand and consider it bad public policy, and certainly not in the public interest, to exclude the for-profit sector from the powers of the minister to cease operations, amalgamate or transfer operations. This section of the legislation could have the unintended consequence of increasing private, for-profit care in the long-term-care sector. This would certainly be contrary to the McGuinty's government's vocal opposition to private, for-profit health care. We fully support our provincial association, the Ontario Association of Non-Profit Homes and Services for Seniors, in calling for section 28 to be either removed from the bill or revised to apply to all health services.

The second area of concern relates to the area of liability and compensation and the lack of protection of boards of directors of health service providers. Local health integration networks were introduced by the McGuinty government as a made-in-Ontario solution to a regionalized and decentralized approach to health care, a laudable initiative which we fully support. As a made-in-Ontario model of locally planned and funded health care, different from other provinces, the government has kept the boards of directors of health service providers intact. Bill 36 indemnifies and saves harmless the minister, the LHIN boards and the executives, but does not do the same for the boards, directors and executives of health service providers, and we feel that this issue needs to be dealt with before the bill moves forward.

In closing, thank you for this opportunity.

The Chair: Thank you very much for your presentations. There's no time for questioning, but thank you very much.

ASSOCIATION OF FUNDRAISING PROFESSIONALS

The Chair: The next presentation is from the Association of Fundraising Professionals, Tami Mallette.

Mr. Boyd McBride: Good morning. My name is Boyd McBride and not Tami Mallette. I'm sorry.

The Chair: Sorry. That's not the one I have here. But welcome and good morning.

Mr. McBride: Thank you for having me here as a representative of the Association of Fundraising Professionals. I serve as the national director of SOS Children's Villages, an international children's charity, but I'm here today testifying as chair of the government relations committee of the Association of Fundraising Professionals.

I'm here to address just one issue covered by the proposed act: the power it gives the minister and local health integration networks to transfer charitable property as part of changes to the system of health care delivery. But let me back up for just a moment and explain why AFP has an interest in this.

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We're a 27,000-member association with 175 chapters around the world and a good representation here in Ontario, members who raise funds for charitable organizations, including many health care institutions in the province. We have over 2,700 members across Canada and over 1,000 members in Toronto alone. I just cite this as background to emphasize that AFP brings expertise and background on issues relating to charitable donations, stewardship and the voluntary sector to this discussion and to many others we've had with government at various levels over the years.

Much of our energy and effort as an association is spent educating and training members in ethical fundraising practices and working with federal and provincial governments, regulators, to improve the regulations and the regulatory framework which supports and sustains the philanthropic process in Canada. We have supported many initiatives on the part of federal and provincial governments to enhance appropriate regulation of charities and fundraising, and in each case we try to help regulators understand the balance between their need to regulate and the need of the sector to be able to raise funds effectively for critical programs like health care programs, which I think you've heard a lot about this morning.

We would like to register our concern that the proposed power to transfer charitable property in this legislation is unprecedented and, we feel, may be unnecessary and could in fact be detrimental to all the parties involved. Bill 36 includes a measure which would enable the minister and local health care integration networks to order a health service provider—including hospitals, psychiatric facilities, seniors or nursing homes, and such—to transfer charitable property to another health service provider. We have never seen a regulatory entity given this type of power over charitable property, and it's unclear to us that what we feel is kind of a drastic step is necessary.

The proposed provision covers decisions which are, in a sense, already generally taken by the courts. Under the cy-près doctrine, the courts may alter the terms of a charitable trust where the maintenance of those terms is no longer practicable. So if somebody leaves an endowment to an organization like the one that just testified and that organization goes away, the courts typically will intervene to find a way to transfer those resources to another organization doing the kind of work that the donor originally intended to support.

In exercising this kind of jurisdiction, the courts attempt to preserve the overall intent behind the charitable donation in circumstances where it's no longer possible for the trustee—the charity—to comply with the

trust's exact terms. We believe that the courts are in fact better placed than the LHINs or the minister to make decisions regarding transfer of charitable property like this. The courts are impartial, transparent, have the expertise and experience in making such decisions, and provide a forum for all the interested parties, including donors and health service providers, to provide input into how or where the charitable property should be transferred. So donors can take some comfort in the fact that the courts will preserve, as much as possible, the intent behind their charitable donations.

We're actually a bit curious—and this is a dialogue that we're quite happy to continue participating in—as to how the minister or a LHIN could compel a transfer when most gifts are a legally binding contract between the donor and the recipient health service provider. We're also troubled by the fact that donors and health service providers have no voice in the proposed process and feel that if the measures advance as described in the legislation, we could find ourselves in a situation where there's a loss of confidence among donors in their ability to make a gift to a health care institution and know that it will in fact do what they want it to do.

It's our experience that people generally donate charitable property to specific groups for very specific purposes. We find that donors take the time and effort to make those kinds of informed choices when they bestow their gifts. To most donors, one non-profit doesn't necessarily equal another. They're making choices as they make the gift. There may be all kinds of good reasons why a donor chooses to support one particular health service provider over another. We just believe that donors' gifts are not interchangeable, and they're very often quite personal to the donor.

A couple more comments and then, if there's time, I'm happy to try to field questions. We understand that if donors feel they're losing their voice over the use of their gifts to health service providers, it's possible that they'll donate their property to organizations completely unrelated to health care where they can be confident that their gifts to the library or to a community service organization will be retained in that institution and used in the intended way. I don't think anyone at this table wants us to see donations to health care institutions diverted because there's a loss of confidence in the ability of those funds to stay with the institution. We think it's possible that this provision will have a chilling affect on charitable giving and weaken the health service providers that rely on donations of charitable property, particularly legacy gifts.

We're wondering if a compromise could be fashioned that would allow the ministry to meet its goal of creating a better-integrated health system without undermining the best interests of the donors and the health service providers. We just feel that the Ontario government should be doing everything it can in this to enhance rather than impede the role of the voluntary sector in delivery of these critical services.

Based on this kind of reasoning, AFP urges the committee to remove the problematic provision that would enable the minister or the local health integration network to order a health service provider to transfer charitable property to another health service provider. With more information and background regarding the rationale for the provision, we at AFP would be willing to bring some of our resources to the committee to perhaps fashion a compromise provision that would achieve a similar goal for the ministry without undermining donors and their gifts to health service providers.

Perhaps on that point, I'll just say that we look forward to working with the committee, if that's your wish. Thank you for time.

The Chair: We have 30 seconds each. Mr. Wilson can start with some questions.

Mr. Wilson: You've raise an excellent point, sir, in terms of section 30. I don't know what it's in there for. The only example we have that research gave was that if they close a hospital and the foundation had held money for the construction of a surgical wing, then the money has to go to whoever's taking over the amalgamated entity, I guess; something like that.

The fact of the matter is, these are 14 health service restructuring commissions that are being set up. They'll have, between themselves and the minister all the power they need to close whatever they want. I think this is to keep those transfers of property out of the courts, to try and simplify it. You raised the point that maybe it won't work that way.

Mr. McBride: I'm suspicious that if a donor's intent is somehow compromised, it will end up in the courts in any event. We just feel that we don't want to have donors lose confidence in their ability to have their views, their wishes, followed as much as possible, and that's generally a decision of the courts.

The Chair: Madame Martel.

Ms. Martel: Thank you for being here this morning. I take it you didn't see this in the legislation before it was introduced; I don't think you were consulted about it. Since you have seen it, since the legislation has been introduced, have you made an effort to talk to ministry folks about this, and where have you gotten with that?

Mr. McBride: To my knowledge, we have not. But I will check on that and get back to you.

Ms. Martel: So from the committee's perspective, this is the first time it's been raised by the association in a forum, either public or otherwise, to bring to the attention of the ministry your concerns.

Mr. McBride: I believe that's correct.

Ms. Martel: So we'll wait to see if the government's going to do that.

The Chair: The final word to the local MPP, Mr. Patten—before lunch, that is.

Mr. Patten: Hi, Boyd. How are you? Good to see you.

Mr. McBride: Good to see you, sir.

Mr. Patten: By the way, I think you raised an excellent point. I would ask you if you could put that down in letter form for us.

To respond to you, I think the intent was that the government isn't going to pay twice to purchase property

that was already deemed to be serving the general public and that kind of thing. However, as you know, I worked in the voluntary sector for many years and I have great sensitivity to the growing government impact on the voluntary sector, which can sometimes have negative effects and unintended consequences. This may be one of them. I'm thinking there are some fuzzy areas in here, and you raise a good point.

I understand the intent of the legislation, and it says what they would not do and would not force organizations to do etc. But it identifies only health care providers, and some organizations are multifaceted. I'm thinking of the YMCA, which has health services, counselling services, recreational services, development services and all kinds of different things. It could be fuzzy in that particular area.

But if I might ask you if you could put it in a letter form and send it to us. That would be very helpful.

Mr. McBride: To the committee?

Mr. Patten: Yes.

Mr. McBride: I'd be happy to do that. We've prepared a four- or five-page brief, but if you'd prefer it in a letter format—

Mr. Patten: If the brief is there—I haven't seen it.

Mr. McBride: I'm sorry. It was just delivered to me yesterday, and I'm happy to make copies and have it delivered to you today.

The Chair: So we'll all get a copy. Thanks very much. Thank you for your presentation.

We will break for an hour for lunch, and we'll be back here at 1 o'clock.

The committee recessed from 1202 to 1300.

ONTARIO NURSES' ASSOCIATION, LOCAL 84

The Chair: Bienvenue. It is 1 o'clock. We thank you for coming. You are from the Ontario Nurses' Association, Local 84, Ottawa?

Ms. Anne Clark: I am.

The Chair: You may start your presentation. There is 15 minutes total time.

Ms. Clark: Good afternoon. My name is Anne Clark. I'm a vice-president of the Ontario Nurses' Association. With me today are Jan Davidson, ONA's project manager in our response to LHINs, and Marc-André Pelletier, one of our servicing and team managers.

Currently, I am a clinical resource nurse in my hospital who has been nursing full-time since 1980 in Nepean. Due to the last round of restructuring in the mid-1990s, I had to add urology to my skills, as all specialty surgery was consolidated and beds were closed. It looks like nurses will be forced to go through it yet again.

Yes, Minister, change is hard. Nurses have already suffered through many rounds of restructuring. It may be new to this minister, but not to nurses.

Let me start by telling you that ONA has 10,000 members in the Ottawa area, what we refer to as region 2 in our structure, and the surrounding three local health integration networks, or LHINs. We have registered nurses and allied health professionals working in all sectors currently included under Bill 36—hospitals, community care access centres and long-term-care facilities—and in public health services, which are excluded from LHINs.

Nurses in the Ottawa region have had a number of experiences with restructuring in both the hospital sector and the home care sector. I want to tell you, however, that nurses are not prepared to be treated as poorly as they have been in the past. Our members in Cornwall, for example, report that they haven't heard anything yet as far as consultation with the public about LHINs. They also report that the community in Hawkesbury is expressing concern already about reduced access to services from clinics—for example, diabetic, haemodialysis and cardiac—if they are moved into the community out of the local hospital. Concerns are also being expressed over the impacts on patient care if non-clinical services, like housekeeping and dietary services, are centralized.

Today, I want to expand on issues in Bill 36 related to protecting the public interest and restricting privatization of health services as the delivery of services shifts: the failure to identify the public interest criteria on which funding and integration decisions will be made; the failure to protect medicare and to ensure adequate funding to maintain publicly funded health care as well as for the transition to the new model; the promotion of extra-billing and user fees by allowing for the transfer of services which are currently being publicly funded and delivered to delivery by for-profit providers; and contracting out of non-clinical services that are critical to patient care and to the health and safety of health care workers.

If we agree that the purpose of the bill should be to implement seamless health care for patients, then we fail to understand how this can be accomplished without a process for integration decisions to be weighed against criteria that define the public interest. It's our view that the public is entitled to know exactly what factors are being considered. Consequently, in our written submission we will be making a proposal that all funding and integration decisions should be exercised in a manner that is consistent with factors that would define the public interest.

Let's move now to how Bill 36 fails to protect medicare.

First of all, it's our view that Bill 36 fails to ensure that there will be adequate funding to maintain publicly funded health care as well as funding to ensure transition to the new model. Accordingly, we will be making a proposal that there be a legislative requirement for sufficient additional funding to achieve all the purposes of the act.

In this regard, the only provision that specifically addresses the minister's unfettered discretion around funding is the ambiguously drafted section 17. In section 17, "the minister shall consider whether to adjust the funding to take into account a portion of any savings from efficiencies ... that the network proposes to spend

on patient care." Obviously, we will be making a proposal that any and all savings identified should be reinvested in patient care.

Because LHINs are being implemented before a provincial strategic plan has been released and because there are no details regarding the criteria or model for funding each LHIN, we are concerned that regional inequalities in health care services may develop between LHINs. We are also concerned about what will happen to services if, for example, there is a deficit in one of the LHINs or in one of the health service providers. This is currently the situation, for example, at the Peterborough Regional Health Centre. We will therefore make a proposal that funding cannot result in regional disparities between LHINs.

Our final proposal related to funding will be to propose an expansion of current programs to cover the increased travel in all LHINs that will certainly result from integration and consolidation of services.

Let me turn next to our concerns in Bill 36 related to the model for purchasing services. The minister said on Monday that he wants the committee to ask the question, "Where in the bill does it say that?"

Well, first of all, LHINs do not deliver health care services. LHINs appear to be set up much like the introduction of community care access centres—CCACs—in the home care sector in the case of home care delivery, where funding flows to the CCACs, which then purchase services through a competitive bidding model. Will this competitive bidding model from CCACs be expanded to LHINs for the purchase of acute, long-term and community care? We don't know, but the structure for that to happen is certainly being put in place. The competitive bidding model may not be expressly stated in Bill 36, but neither is any other funding model. We do know that LHINs are being set up in the same fashion as CCACs: The purchaser and provider of services is split up.

If the competitive bidding model is introduced, we have grave concerns based on our experience in home care. In the home care sector, the competitive bidding model opened the door to the delivery of home care by for-profit companies and resulted in less care and a lack of continuity of care. The competitive bidding model has resulted in job loss for nurses when contracts are lost. In Kingston, for example, a for-profit company won a bid, and then once ONA negotiated a first contract, they simply closed up shop. Closing down nursing services because of lost contracts has occurred all across the province.

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Competitive bidding has meant nurses being forced to leave the home care sector because of lower terms and conditions of work in the new employer. It has also resulted in a lack of continuity of care for people receiving care in their homes. We are extremely concerned about the prospect of widespread turmoil for patients and health care staff if such a competitive funding model is introduced by LHINs.

Minister, there is a solution. Simply write it into the bill: no competitive bidding. We will propose a prohibition on the competitive bidding model for the purchase of services by LHINs.

We are also concerned about the potential for further privatization of health care services flowing from integration decisions. Of particular concern for nurses, despite the minister's reassuring words, is that the only provision that proposes to address this is subsection 25(3). LHINs may not issue integration decisions that "permit a transfer of services that results in a requirement for an individual to pay for those services, except as otherwise permitted by law." What interpretation are we to give to this language? We believe it is ambiguous, inadequate and opens the door for private clinics to set up shop. Our view is that a much more explicit and enforceable statement is required to prevent further privatization of health services. Therefore, we will make a proposal to restrict any transfer that results in a requirement for an individual to pay for services previously publicly funded.

Also of concern in this regard is why the government has limited its powers in section 28 with respect to the minister ordering only not-for-profit health service providers to cease operating. This limitation appears to favour for-profit delivery of health care, and we believe it to be inconsistent with the principles set out in the Commitment to the Future of Medicare Act.

I'd like now to move on to our concerns related to contracting out of non-clinical services that we believe to be critical for patient care and for the health and safety of health care workers. In section 33, cabinet may, by regulation, order public hospitals to cease performing any non-clinical service and to integrate the service by transferring it to another "person or entity." We are concerned that non-clinical services are separately targeted and being treated differently than all other health care services.

Our particular concern is the consequence of contracting out certain non-clinical services—for example, housekeeping and dietary—which are critical to patient care. Nurses are unable to provide quality care if we can't rely on the quality of non-clinical services. In addition, these non-clinical services are essential to a healthy workplace and for protecting the health and safety of employees.

Furthermore, the contracting out of non-clinical services such as human resources runs contrary to the whole purpose of maintaining good employee-employer relationships. Contracting out this relationship will only serve to erode morale further and to increase retention and recruitment problems. All of this will be happening at the same time as the shortage of nurses and other health professionals is growing worse as a result of upcoming retirements.

Our intention is to ensure that health reform is done right and results in a genuinely integrated health system. Specifying criteria to define the public interest, restricting further privatization and maintaining a public delivery model are key success factors to ensure that health reform is done right.

Thank you very much.

The Chair: Thank you. There's about a minute and a half total left. I'll start with Ms. Martel, please—30 seconds.

Ms. Martel: Thank you for your participation here today. Thank you very much for talking about competitive bidding, because you're right: The minister said, "I don't see it anywhere in the bill, so therefore it is not to be." The way to resolve that is to place the amendment. I'd be happy to place yours or my own and see how the government responds. With that, I think we will very quickly find out where everybody stands on this issue.

I want, though, to talk to you about section 33—you read part of it into the record—because, as I read it, I think this is the section the minister will use for privatization. I think that's very clear. My other concern is that "non-clinical services" is not defined anywhere in the bill, so while we, amongst us, talk about housekeeping and human resources, the fact is that that's open to interpretation, and I'm not sure where that's going to take us.

What are you concerned about with respect to that particular section, where there's no definition of "non-clinical services," but it's also very clear that the minister, of his own volition, can order integrations under this section, ostensibly through a wide range of public hospitals?

Ms. Clark: It's very all-encompassing and there's very little groundwork, very few rules, very little detail. There need to be specific detail and rules in place.

The Chair: Thank you. Mr. Fonseca.

Mr. Peter Fonseca (Mississauga East): Do you not feel that for the people of Ontario, when it comes to something like procurement—and I'll just take the example of an MRI machine—we would be able to get the best value for money by doing this in a large, regional way or in a provincial manner so we're able to get that at the lowest cost, and those precious health care dollars we're saving can then be used to serve our patients better?

Ms. Clark: We believe in a seamless health care system in which those things would be funded, but nowhere in LHINs does it say that's going to make that situation any better. That could be done now without this legislation.

Mr. Fonseca: But right now, things are through a hospital or through other organizations; this way, it could be provincially or it could be regionally, and it would allow us to get the best deal for the people of Ontario.

Ms. Jan Davidson: I'm just going to take about five minutes on this—no, I won't.

The Chair: Ten seconds.

Ms. Davidson: I know. It's one thing to purchase equipment on a bulk basis to get the best price—

Mr. Fonseca: I'm just asking if that was a good idea.

Ms. Davidson: —but our concern is that you may be trying to purchase the bulk staff at the best price too, and that just doesn't go with purchasing materials.

The Chair: Thank you. Mr. Wilson.

Mr. Wilson: Thank you very much for your presentation. I'm glad to see you. We don't very often agree on things, I suppose, but we certainly agree on much of this.

You mentioned some of the costs. I never really thought of it in terms of travel costs for your members. Any other costs that you think your members might have to incur as a result of this legislation?

Ms. Clark: It's not just our members; I'm talking about the general public. When somebody is enrolled and gets into the health care system, that patient's whole psychological being, the outcome for whatever the problem is, is entailed in his family. If you're in Hawkesbury and you're having to travel to somewhere else in this province, if your family's in Hawkesbury and you could be 200 miles away, that is interfering with quality patient care; it's splintering services. In our view, that's not an integrated system. Community matters.

The Chair: Thank you very much for your presentation.

KINGSTON HEALTH COALITION

The Chair: We'll have the next presentation, from the Kingston Health Coalition, Ross Sutherland. Please start whenever you're ready. There is 15 minutes total.

Mr. Ross Sutherland: Total? Thank you. I heard that. Will you tell me when 10 minutes is up so I can stop?

The Chair: At about a minute, I'll do that for you.

Mr. Sutherland: No, 10 minutes would be great. I'll appreciate the 10-minute time.

Anyway, thank you very much, committee, for allowing me to come and address some of our concerns about Bill 36, the Local Health Systems Integration Act.

Members of our coalition have voiced numerous concerns about different aspects of the legislation. We're worried about the effect of the purchaser-provider split model for developing services and the result this will have in shifting valuable health care dollars from patient care to administration, with no clear benefit. We question how the goal of integration can be met with the omission of key sectors from the LHINs' purview, specifically doctors, independent health facilities and commercial medical labs. The lack of value statements similar to those contained in the Canada Health Act and the omission of support for the non-profit character of the system have raised concerns that Bill 36 will not work to support our public health care system.

As important as each of these are, I know that others from Kingston are addressing them in detail. I would like to use this time to discuss the proposed governance of the LHINs and the impact of this centralizing structure on health care.

The preamble of Bill 36 indicates the intention of giving communities a key role in developing their health care needs and priorities and in making decisions about their local health systems. Accountability and transparency are identified as important. Section 5 talks about community engagement, and there are to be committees of health care providers and provider agencies but noticeably none for patients and the community at large.

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We would suggest that to meet these goals there needs to be the ability for open discussion and engaged dialogue in the community, which means we need equal knowledge between interested participants, accessible information, and the ability to express opinions without fear of consequences. Central to this is the ability of the LHINs to act as an independent voice for community interests, or, to put this in the negative, without communities having full information on cost alternatives—what works, what does not work—how can they participate in any meaningful dialogue or priority-setting or give considered input to decisions? Without formal community input channels that give the community a voice at the table, with an appropriate appeal process, what reason is there for the LHINs management to seriously consider concerns of the residents? Without some form of independence from the ministry, what ability is there for the LHINs to speak up for the community, instead of just becoming "Yes, Minister" organizations that cannot offer considered critical opinion without fear of losing their jobs, their salaries or violating the law if not co-operating with the ministry?

To understand the importance of these governance questions to a healthy health care system and to a functioning democracy—that is, one where there is some balance in the system and communities have rights where they can access the information they need for considered discussion and where they have the ability to speak up for their interests—we need only look at a relatively recent example in Ontario: the evolution of governance of the community care access centres.

The CCACs and home care have been a major focus of the work of our local coalition, and we feel there are many lessons from that experience with the CCACs that are germane to the current LHINs discussion. Like the LHINs, the CCACs were set up to coordinate community-level health care services. But unlike the LHINs, when they were initially constituted they were set up with locally responsible boards and CEOs who were hired by those boards. To be sure, they had to work within provincial guidelines and funding restraints, and many of the boards chose relatively restrictive engagements with their communities, but their line of responsibility ran to the community; it didn't run to the ministry. The first boards were appointed by the government; the subsequent boards were to be elected by members of the community. This was a fairly broad mandate, with most CCACs allowing most community members to participate in the process.

These structures led to some very interesting and important developments. CCAC boards around the province felt that they could stand up to the government when their waiting lists started to grow and funding restrictions meant a cutback in care, and they did this. They not only had an obligation, but they had the independence that allowed them to speak out for their communities. In Ottawa, the CCAC was able to point out the substantially increased costs of contracting out therapy services, and they had the numbers to make the argument well because they were the agency involved in doing that. Sudbury was able to voice their concerns about the splintering of services if they contracted out their support workers. Many CCACs were willing to articulate their communities' needs in the face of provincial government restructuring.

This balance in power between the community and the province allowed for a creative tension where communities were able to speak up and they had the information they needed to make their case. It increased the chances of an open dialogue and solutions that worked for the community and provincial objectives. It sometimes was a bit messy, but that's politics; that's the basis of a functioning democracy and of meaningful local input. In the end, it did not stop the government from implementing province-wide policies that they felt were needed, but the format, as with municipal governments and school boards, created a balance between central power and community needs.

These other forms of local government are good comparisons. The LHINs will be administering budgets for an essential service that are as large as or larger than those in many school boards and municipalities. This is a format for local control that we're familiar with. And in terms of community priorities and fiscal responsibility, health care compares favourably to schools and municipalities. It seems reasonable to allow a similar level of community control.

In 2001, the previous government decided that it had had enough with communities speaking up for themselves and passed Bill 130, the Community Care Access Corporations Act, 2001. This bill changed the governance structure of CCACs to mirror the structure proposed for the LHINs. As with the reformed CCACs, the LHINs are to be an agent of the crown and act on behalf of the government. LHINs are to be governed by a board of directors appointed by cabinet and paid at a level determined by the cabinet. The government will determine who will be chair and vice-chair. Each board member continues at the pleasure of the cabinet and can be removed at any time.

This structural centralization of control is reinforced by a health care strategic plan that will be largely formulated outside of public debate; translated to local plans, once again developed largely outside of public debate; and then used as strict guidelines for determining the provision of health care. Communities not only lose control of the political process but are faced with a non-negotiable financial and policy straitjacket that limits the options of local providers and communities to respond with creative community-based solutions The result of the 2001 changes to the CCAC governance was a complete silencing of the CCACs and the effective removal of the community from home care policy discussions. All the nice-sounding phrases about local control and bringing health care decisions closer to the community are essentially meaningless if they mask real power relations.

Mr. Patten: That was changed.

Mr. Sutherland: Well, I'm going to come to that, sir. I think it's a good point.

For the LHINs, the real lines of accountability run to the centre. They move power to the ministry and the minister's office rather than creating a healthy balance and the necessary tension to well-functioning democracies. As the CCAC history shows, this is not an academic concern but a real concern, with real consequences. It stopped information flow to the communities and effectively silenced voices that were concerned about local health care delivery.

The Kingston Health Coalition is concerned that if Bill 36 goes ahead as proposed, we will further undercut local control of health services just as Bill 130, the CCAC act, did to community care. We respect the importance of provincial guidelines and standards and our collective concern for prudent financial management, but we also strongly believe that communities, workers and patients need information, open channels of input and dialogue, and a local independent power centre to create a balance that allows communities to articulate and speak up for their health care needs.

We would encourage you to strongly reconsider the governance of the LHINs and allow for the direct election of the board of directors and the appointment of CEOs by those boards.

Am I at 10 minutes?

The Chair: Five.

Mr. Sutherland: That's perfect. I'm right on time.

This change would be a significant step in meeting the community control goals of the proposed legislation, as well as generally increasing the vitality of our democracy. Equally important, we'll be providing some public process for the development of the province's strategic health plan, which is the policy core of these initiatives.

We note that part VI of the proposed bill does redress some of the concerns with the CCAC governance, though it is unclear whether this is a return of the CCACs to the relatively open membership structure that was envisioned in 1966 or to the more closed model used by the hospitals. We would encourage you to make this clear in the legislation and implement the more open structure.

Once again, thank you for your time. I would be pleased to answer any questions.

The Chair: Thank you. There is a little more than one minute each. We'll start with Mr. Leal.

Mr. Jeff Leal (Peterborough): I'm from Peterborough. We share a lot of things with Kingston; we're an urban-rural mix. In my riding, I talk to seniors all the time. One of the problems for seniors, of course, is arthritic hips and knees. They want to be able to get access as quickly as possible; not months but weeks, for getting an artificial hip or knee. Do you not see it as a good thing that in these LHINs and in some hospitals within the LHIN we're able to bring together eight or nine or 10 orthopaedic surgeons to reduce wait times significantly for those seniors who are struggling with those bad hips and knees to get surgery and have them living a quality of life that they were used to many years ago?

Mr. Sutherland: If we had a community-controlled process that allowed us to integrate services for patients so they had some continuity of care and were allowed to get health care accessibility as quickly as possible, that would be a very good thing. I'm quite concerned, though, that because of the centralization of the power in the LHINs, in fact what will happen is what happened with the CCACs, where what we've actually seen is a more fragmented system and a much more administration cost-heavy system, so we actually have fewer health care dollars going to patient care and more dollars going to administration. We've actually done a fair amount of work documenting that. We think that the administrative costs in the CCACs went to about 20% just because of the purchaser-provider split structure. We think, unfortunately, your goal can't be met with this legislation. That's my concern.

The Chair: Mr. Wilson?

Mr. Wilson: I think your chronology of the past is quite accurate. What do you do, though, when you have a rogue board? That was one of the reasons cabinet did move to rein in the CCACs, as you might put it. In my area they opened five offices. They advertised in the papers all the time. Snow removal was as important as the bath. There didn't seem to be any priority-setting, and yet we had provincial guidelines. We also had people who didn't like the government, just openly hated us, and they got themselves on these boards. So what do you do when things get out of control?

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Mr. Sutherland: I think the school boards provided a really interesting example of that.

Mr. Wilson: They hated us too.

Mr. Sutherland: Well, it was nothing personal, I'm sure.

The school boards, in fact, some of them—first off, they allowed communities to have some sort of a response to the government, which allowed this tension so they could negotiate solutions. When some of the school boards, in the end, decided to really buck the government trend, they were put under trusteeship. You can actually do that with individual ones, and whether you support that or not, it was a political decision at that point in time. But the fact of the existence of the school boards as something which had local connections allowed that tension, allowed that debate, so in fact we had a good debate. The government had the ability in that situation, as you know, to take care of a few school boards they weren't happy with, but in fact we had that. With the LHINs, we don't even have that. We just skip that whole tension. We've gone right to the centralization, and I think that's a problem.

The Chair: Thank you. Madame Martel.

Ms. Martel: Thank you for coming today. I want to focus on the governance model particularly. The government will say, "Well, yes, we recognized there was a problem in the CCACs, and that's why we're going to have open boards again and elections and the whole nine yards." My question is, if it's so good to do it for the CCACs, why not for the LHINs?

Mr. Sutherland: I think that's a good question. I do hope, in fact, that you go back—and I would like to see it

in the legislation—and put the CCACs back to the open model. Hospitals—I'm happy that they are controlled by local boards, but they are in fact quite undemocratic, really, and very difficult to get access to. The CCAC model was very interesting. It was only a short time that it was there and it was evolving, and I think it would be nice to go back and let that evolve more. I can't imagine why you would want to go back to the much more restrictive structure with the LHINs. It doesn't make any sense to me.

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

RÉSEAU DES SERVICES DE SANTÉ EN FRANÇAIS DE L'EST DE L'ONTARIO

The Chair: The next presentation is from the Réseau des services de santé en français de l'Est de l'Ontario. Close enough? Thank you. I thought I'd better try a little. There are 15 minutes whenever you're ready.

Mme Nicole Robert: Monsieur le Président, committee members, bonjour. Bon après-midi. Mon nom est Nicole Robert. Je suis présidente du conseil d'administration du Réseau des services de santé en français de l'Est de l'Ontario.

Le réseau est formé de 61 établissements qui sont tenus d'offrir des services de santé en français à la population de la région de Champlain. Notre mandat est d'assurer l'accès à toute la gamme de services de santé aux quelque 250 000 francophones de l'est ontarien. Depuis huit ans, nous accomplissons ce mandat en collaboration avec nos partenaires par l'élaboration d'un plan régional des services de santé et le développement des services en français sur le territoire.

Depuis plus d'un an, nous suivons avec intérêt l'évolution des projets de transformation du système de santé du ministre de la Santé et des Soins de longue durée de la province.

Nous sommes d'avis que les principes d'imputabilité, de qualité et de soins centrés sur le patient s'appliquent aux services de santé en français et aux patients dont la langue maternelle est le français.

Nous avons bien accueilli l'idée d'un système qui tienne compte des besoins et de l'état de santé de la population francophone de la région.

Nous voyons également d'un bon oeil l'accent mis sur l'engagement des collectivités. Cela suppose une consultation et une participation de la communauté francophone aux décisions qui touchent les services en français.

Cependant, rien de cela n'est garanti dans le projet de loi 36 soumis à l'Assemblée législative.

La région compte plus de 40 % des 500 000 citoyens francophones de la province. De ce nombre, plus de 62 000 jeunes de moins de 24 ans auront recours au système de santé en français à un temps donné de leur vie. Et plus de 28 000 aînés et leur famille tentent d'avoir accès à des services de santé de qualité en français.

Par ailleurs, des milliers de professionnels de la santé francophones dans l'est ontarien cherchent à prodiguer les meilleurs soins possibles dans la langue du patient. Ils et elles le font par souci d'efficience en sachant que la communication est à la base de tout soin de qualité.

Pour tous ces francophones, les services en français n'ont rien de folklorique. Au quotidien, la communauté francophone de l'est ontarien ne demande pas si elle a des droits aux services de santé en français. Elle pose plutôt la question : comment ces droits se traduisent-ils dans le domaine de la santé?

L'occasion est belle pour l'Ontario d'accepter un rôle de leadership à l'égard de la santé en français.

Vous me ramènerez à juste titre au préambule du projet de loi, qui spécifie que « la population de l'Ontario et son gouvernement … respectent les exigences de la Loi sur les services en français lorsqu'il » —le système de santé—« dessert les collectivités francophones... » D'entrée de jeu, l'énoncé est encourageant pour notre communauté de langue officielle. Permettez-moi toutefois de témoigner de l'expérience du Réseau de l'Est quant à la Loi sur les services en français.

Une partie importante du mandat de notre réseau consiste à appuyer le développement des services de santé en français sur le territoire de Champlain. Selon le protocole d'entente avec le ministre, nous accompagnons les hôpitaux et les organismes communautaires en santé tout au long de l'élaboration de leur plan de désignation. Suite à une analyse des plans et d'une évaluation continue du niveau de prestation des services, le réseau est en mesure d'effectuer des recommandations au ministre.

Le processus de désignation est un moyen d'assurer la prestation d'une gamme donnée de services de santé en français par les organismes et établissements bénéficiant de paiements de transfert du ministère. Cette politique implique le respect de quatre critères qui sont mis en application à des degrés variables dans le système de santé actuel.

Au fil des ans, nous avons été témoins de progrès encourageants quant aux services de santé en français chez nos partenaires. Nous avons assisté à une amélioration de l'offre proactive de services de santé offerts à la population francophone. Dans tous les cas, la volonté de dirigeants déterminés a été le facteur clé de l'équation.

Tristement, nous avons aussi constaté des reculs importants dans l'accès aux services de santé par les francophones dans la région. Une partie du problème réside du côté des directives, normes et standards qui sont souvent non précis de la part du ministère. D'autre part, au-delà des ressources disponibles et affectées par les établissements et par le réseau, c'est le degré de priorité accordé aux services de santé en français qui est souvent en cause.

Ainsi, des changements au sein d'un conseil d'administration, la révision hâtive de politiques et procédures ou des modifications au chapitre des ressources humaines peuvent facilement compromettre la prestation des services de santé en français.

À l'heure actuelle, environ 30 établissements sont désignés et 40 sont identifiés pour fin de désignation dans

la région de Champlain. De par l'absence de mesures indicatives et incitatives, un trop faible pourcentage de ces établissements sont actifs, c'est-à-dire, travaillent activement à l'élaboration ou à l'amélioration de leur prestation des services de santé en français.

Au pire, une partie des services de santé en français sont aléatoires, et les fonds présentement affectés au maintien des services de santé en français ne sont pas toujours utilisés pour assurer l'offre et l'accès à ces services.

À moins d'imbriquer la responsabilisation quant aux services à même le règlement ou l'entente, les services de santé en français et l'établissement de tout continuum de soins ne reposent que sur des bases fragiles de bonne volonté, et ce, au détriment de la clientèle francophone. Pour l'heure, l'imputabilité réelle est loin d'être atteinte.

Pour qu'il y ait véritable reconnaissance de « l'apport du patrimoine culturel de la population francophone et … sauvegarde pour les générations à venir », tel que stipulé dans le préambule de la Loi sur les services en français, nous avons besoin de beaucoup plus que de la bonne volonté en santé. À elle seule, la référence à la Loi sur les services en français du projet de loi 36 ne répond ni aux attentes du ministre Smitherman ni à celles de la communauté francophone en ce qui a trait à l'imputabilité et à la qualité des services de santé offerts en français à la population de l'Ontario.

Depuis huit ans, notre réseau travaille de concert avec ses partenaires à l'amélioration de l'accès aux services de santé en français. Notre intervention aujourd'hui va dans le même sens. Nous sommes ici pour contribuer à la planification, au développement et à l'évaluation des services de santé en français dans la région Champlain.

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En égard au projet de loi, nous soulevons donc ces questions en vue d'une meilleure imputabilité du système à l'endroit des services en français :

De quelle façon le ministère de la Santé et de Soins de longue durée et le RLISS engageront-ils la communauté francophone dans le processus décisionnel?

Comment la notion d'intérêt public inclut-elle les droits des francophones de l'Ontario?

Quel sera le cadre d'imputabilité quant aux services de santé en français en province et dans la région?

Les ententes d'imputabilité du ministère et du RLISS tiendront-elles compte de la capacité des fournisseurs de services et des sous-traitants à respecter la Loi sur les services en français?

Dans le contexte d'une décision d'intégration, quels seront les mécanismes et recours en place pour assurer le maintien des services en français et des établissements qui voient à la prestation de ces services?

Quels seront les partenaires impliqués dans la planification et l'élaboration des plans régionaux de services de santé en français?

Nous avons hâte de poursuivre le dialogue en ce qui a trait à l'accès aux services de santé par la population francophone de l'est de l'Ontario.

Je vous remercie, messieurs et mesdames, de l'invitation pour comparaître devant vous aujourd'hui. Merci.

The Chair: Is that all? C'est tout? Merci. We have about less than a minute each, and I would start with Mr. Wilson.

M. Wilson: Merci pour votre présentation. That's the extent of my French that I'm competent with, anyway.

Mme Robert: Merci, monsieur Wilson.

Mr. Wilson: I think your questions are excellent, and I would ask, through the Chair, that the minister get back to us on each and every one of the questions that are listed on page 5. That's not an unusual request: to get it in writing from the government. I couldn't ask them better. You obviously understand this issue much better than most of us.

The only other thing I would add is, is there a particular wording in any of the existing health acts that gives you the French-language-service protections that you're looking for? Is there a clause you can point to that should be in this act? I know this act, just as you say, makes a reference to the French Language Services Act. Do you want to put some thought to whether there's anything in particular, legalese there, that should go in here that would help the committee?

Ms. Robert: Definitely, Mr. Wilson; we'll look at that. I know the French Language Services Act does help us with the language to use in such a mandate.

The Chair: Your request, Mr. Wilson, will go to the minister, who will respond to us and to you in writing. So it has been recorded. Thank you. Madame Martel.

Mme Martel: Merci d'être venue cet après-midi. Ce matin, nous avons eu une présentation de la part de M. Morin, M. Grandmaître, Mme Lalonde, et aussi Mme de Courville Nicol. Ils ont parlé à propos du comité de travail sur les services de soins de santé en français. Je ne suis pas sûre si vous connaissez ce comité. Ils ont dit que le rapport est fini depuis quelques mois, mais la communauté francophone ne sait pas en ce moment le résultat. Alors, je voudrais savoir si vous avez vraiment des espoirs à propos de ce comité, parce qu'on ne connaît pas les conclusions en ce moment. Est-ce qu'il y a d'autres recommandations concrètes que vous pouvez donner au comité pour améliorer le projet de loi pour qu'il puisse vraiment répondre aux « concerns » à propos des soins pour les francophones en Ontario?

Mme Robert: Absolument, madame Martel. C'est vrai que nous savons que le comité de travail pour les services en français n'a pas été dévoilé, c'est-à-dire leurs recommandations. Alors, les recommandations que nous faisons aujourd'hui sont les recommandations que nous entendons de nos membres et de nos partenaires dont vous avez le nombre d'établissements et qui siègent pour la plupart autour de notre table.

Pour des recommandations plus concrètes, je pense qu'il faudrait peut-être regarder un modèle de gouvernance. Aussi, ce qui serait important qu'on voie est que le réseau s'est bâti dans la région de Champlain une expertise sur la planification et l'évaluation des services de santé en français pour sa population francophone. Je crois que c'est important de bâtir sur cette expertise et de l'améliorer et de la rehausser, parce que je pense que l'expertise est là.

Vous allez entendre aussi bientôt la réponse par l'alliance des réseaux. Il y a quatre réseaux dans l'Ontario qui feront une présentation devant votre comité sous peu, et eux, apportant sûrement des amendements beaucoup plus concrets à la Loi 36.

Le Président: Merci. madame Wynne.

Ms. Wynne: Thank you. I apologize for speaking in English. I actually wanted to follow on that question of the report that has been given to the minister. Our understanding is that suggestions have been made, that they are being reviewed and that the minister is looking for mechanisms that would do what you are recommending, that there be a voice for the protection of francophone rights in health care in the LHIN process. So that's what we're expecting will come out of that review, and we don't have any reason to expect that that's not going to happen. I don't know if you want to comment on that, but we're certainly waiting to hear the results of the review of the report that went to the minister.

Ms. Robert: Yes, the members of the committee have been held under confidentiality, and we respect the minister's decision. We know that the report has been translated. I think we are very confident, as the francophone population, of the recommendations by that group, because the committee was formed of very knowledgeable professionals and people of the community who understood the needs of the francophone population as it relates to health issues. Therefore, I am sure that their voices were heard in that committee, that they were able to voice the words of their regional area, because they were chosen according to region. Therefore, I think the francophone population of Ontario will have been heard through that committee, and we're quite hopeful that the minister is looking favourably upon the recommendations that have been forwarded.

The Chair: Thank you for your presentation. Have a nice day.

Ms. Robert: Thank you. Merci beaucoup.

OTTAWA COMMUNITY CARE ACCESS CENTRE

The Chair: The next presentation is the Ottawa Community Care Access Centre. Sir, you have 15 minutes total for your presentation. If there is any time left, we might be able to ask some questions and/or comment.

Mr. Tim Plumptre: I'll be less than that, you'll be pleased to hear.

The Chair: Lots of questions.

Mr. Plumptre: Shall I launch right in?

The Chair: Yes, please.

Mr. Plumptre: Sure. My name is Tim Plumptre. I'm the chairman of the board of the Ottawa Community Care Access Centre. I'm also here, to some extent, in my personal capacity in that I'm the president of a non-profit organization called the Institute on Governance, whose mission is to improve governance in public-purpose organizations. We work exclusively on public organizations. So what I'm bringing to you is a brief that's based partly on my experience as chairman of the CCAC board here in Ottawa. I was previously the chairman of the board of the Hospice at May Court, which is a palliative care organization in Ottawa.

While I could have commented on lots of aspects of the legislation, I thought that you probably were going to get a lot of information from a lot of different people. So what my colleague is handing out here is just a short brief—it's only a couple of pages long—and a little bit of information on the institute.

The topic I have chosen to address you on is the question of the composition of the board of the CCAC within the new legislation. The brief says that there's a lot of things about the new legislation which we applaud. We think the government is moving in the right direction. I won't go through all of those things, because I know other CCACs have appeared before you and have said congratulatory things. So I won't repeat those.

But on the question of the composition of the board, there's a dilemma in any public organization around whether the board should be what's called "constituency-based" or whether it should be "competency-based," constituency-based meaning elected or chosen in some way to represent certain groups, geographic areas, linguistic groups, whatever, or whether the board should be selected based on some kind of capabilities that you want to have.

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From my reading of the legislation, the draft bill and also the commentary that's tabled on the website of the ministry, it wasn't entirely clear to me exactly what was intended as to how the boards should be established. It referred to the Corporations Act, and I didn't have time to review it, but I may be right in assuming that under the Corporations Act, as a non-profit corporation, it would be elected. I don't know whether you have the answer to that or not.

The Chair: Do you want a comment now or after? After. Make your presentation and we'll—

Mr. Plumptre: Anyway, you have basically those two options. The advantage of the constituency-based board is that it gives voice to different groups; it allows them to ensure that the different geographic areas, linguistic or other groups have some kind of say in the governance. The disadvantage is that you never know what you're going to get. You can get a collection of interesting people but who have no experience.

Indeed, a year or two ago I was invited to go over to Britain to address a seminar of what are called foundation trusts. These are very large hospitals with budgets in the hundreds of millions of pounds for which the British government is trying to establish new governance arrangements. They had decided in Britain that the boards of these hospitals should be elected by the community. So what you had was, to me, a somewhat paradoxical situation where you could have a £500-million corporation being run by a collection of people drawn from almost anywhere. One member of the boards of these foundation trusts said to me, "There are 71 different

ethnicities in my community, and I don't know which ones you'd suggest that we try and put on the board of the foundation trust."

Coming to the situation of the CCACs, I know there has been long debate over: Should the board members be appointed or should they be elected? I know a brief was submitted some time ago by the Ontario Association of CCACs that suggested three different approaches to the way in which the board might be comprised. What I'm doing here is coming down on the side of the approach that says a mixed board would probably make a fair amount of sense because you are running—and I'll restrict myself now to the Ottawa CCAC. If, as is intended, it would be amalgamated with the board of Eastern Counties and probably Renfrew, then you'd be looking at an organization with a budget of in excess of $150 million and offices established here and there over a large geographic area and several hundred employees. So it's a fairly substantial operation, and I think it would make sense to have a board that had both certain kinds of capabilities on it and that you would probably want to secure through an appointments process.

My brief suggests that perhaps the appointments should be put in the hands of the local health integration network rather than in the hands of the government, because those of you who know about the current appointments process would know that it's not working very well. In fact, I could use a stronger adjective. The appointments to the boards have really not been working well, and I think members of the government are well aware of that, including the minister, who, the last time he addressed CCAC chairs, bemoaned how poorly the appointments process was working.

I know that political appointments are a complicated thing, and sometimes even getting MPPs to suggest good candidates can be difficult, but be that as it may, it is possible to appoint people in a constructive way. My premise is that the appointments would be done in a constructive way, and that should be mixed with a certain number of board members who are elected. If you look at the top of page 3 of the brief, I've listed some of the kinds of capabilities that you might want to have on a board that was managing $150 million.

I'm finished.

The Chair: Thank you. We have a minute each, and I would start with Madame Martel.

Ms. Martel: Thank you very much for your presentation. We were just chuckling when you said that you knew how hard it was for MPPs to put names forward. Sometimes we're not asked; it depends on where you sit.

Mr. Plumptre: That could happen.

Ms. Martel: That's right. It sure does.

The government proposes to move to a model which—I'll give you my bias—I hope is elected from the community. What I saw with Bill 130 was a complete muzzling of the CCACs in terms of any information, discussion or community input, and I very much worry that that's going to be the exact situation with the LHINs. I hope it is democratically elected, and I'd like to see that for the LHINs. I think if you're really going to talk about community control and community input, then having people appointed by the government doesn't cut it. Those choices and those folks have to come from the community.

That's my bias, for what it's worth, and you can respond to that in terms of either your experience at the CCAC or you said you were with a not-for-profit organization. I don't know how the board there is selected, if you've got some experience from that you want to share.

Mr. Plumptre: I wouldn't allude to our board in particular because it's not a good model for what we're talking about here. I'm very sympathetic to the notion of election. I'm just saying that I don't think the board should be comprised solely on that basis. We work with boards all the time—that's the business of the Institute on Governance—and I can tell you that there are a lot of boards I've worked with who were sort of wringing their hands, saying, "We got all these people elected, but the board's too big, the members are contentious, there's factionalism, they don't get along and they don't have the capabilities we need to do the job. So what do we do?" The answer is that it's hard to make it work if you don't have the capabilities you need.

So I'm very sympathetic to community input, but I'd make one other comment with respect to community input, and that is that there's more than one way of getting community input. I think it's an area of the legislation that's not been well thought through. There's a strong bias in favour of it, which is good, but you can get community input through various forms of community consultation, and I would encourage the government to think about the question of public consultation, what role it should play and who should do it. So I'm all in favour of it, but there are other ways to do it as well.

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: I'd just like to let you know at this point what the plan is. It's to have a transitional appointment or mixed board, moving to a fully elected board for the CCACs. That is the plan. That's what's in the legislation.

Mr. Plumptre: That's what I thought.

Ms. Wynne: Having said that, the whole discussion of board governance is a long one. There are appointed boards and elected boards that are relatively dysfunctional or functional, depending on the individuals who are involved and the structures around them. So that is our plan.

Can you talk briefly about what you think some of the really important public engagement strategies might be? You just touched on there needing to be more. One of the things the minister really is interested in is how we can make that public or community engagement process more real than it might be otherwise. Have you got any specific suggestions?

Mr. Plumptre: The Chair's going to cut me off in about 30 seconds.

Ms. Wynne: I know, but just try.

Mr. Plumptre: That is the subject of a long conversation. Our institute did a little study of community engagement practices in regional health authorities in western Canada and elsewhere; in Nova Scotia too. It

was a real conundrum for these regional health authorities. They knew it was important. They had no training in it. The rural areas posed particular problems. We did a report to the ministry in which we flagged that as an issue—that and the orientation of board members, which I think is also very important.

I can't give you a quick answer to that.

Ms. Wynne: When was that report delivered to the minister?

Mr. Plumptre: That was delivered to the ministry staff about six months ago. It was the transition team: Gail Paech and those folks.

Ms. Wynne: Okay, so we'll refer back to that. There are some specific suggestions there?

Mr. Plumptre: Yes. It's suggested that it's an area of priority. Frankly, for me, personally, it's an area of particular concern. I've been thinking of going to the minister to try and tell him that the principles are great but the implementation is weak.

The Chair: Thank you. Mr Wilson.

Mr. Wilson: Thank you, sir. I think you put a lot of very thoughtful thoughts.

Mr. Plumptre: Those are the best kind.

Mr. Wilson: You should be elected for 15 years; you lose it after a while.

It's unclear in the bill, and perhaps the audience and everybody may be unclear. I ask Ms. Wynne this, I guess: Are we talking about election at large, like a municipal election, or are we talking about elections like we do for our hospital boards where people pay 10 bucks to become a member of the hospital corporation and then they're allowed to vote for their board of directors? Is it the hospital model?

Ms. Wynne: It's not general election, if that's what you're asking. It's a constituency—

Mr. Wilson: Okay, we need to clear that up.

What do you think of this? One of the boards that's controversial in my area is the Niagara Escarpment Commission. It has to tell people, "You can't build a house here. You can't add a garage here," and make some pretty tough decisions in preserving the beautiful escarpment. It has a mix of members appointed by cabinet, but the local municipalities that have a major stake are reserved seats on those boards also. Maybe some of the major health care players like the CCACs—maybe it's a conflict; I don't know—could also appoint people to the board. I know we don't want the boards to get too big, but maybe cabinet could appoint five of the nine—I know it's nine, minimum—and some of the major constituent groups, like the Ontario Hospital Association or the local CCACs or something like that could get together and appoint one member. Then you'd have constituent members as well as members at large. That's what they do with some other boards.

1400

Mr. Plumptre: Well, this could be another long conversation. I'm in favour of some process of general election from the community. Quite how it takes place, I'm not sure, because there is a problem, as happened at the Toronto East General Hospital, where you get certain factions that take over the board, get their own people on to the board, and then that causes all kinds of other problems. The previous government had to put in a supervisor.

Mr. Wilson: You get partisanship on these boards and political parties start getting in there.

Mr. Plumptre: All processes are imperfect. I'm probably a little out of step with some of the other briefs you got, who probably said that pure election is the best thing since sliced bread. But without going into the details of how it could be done, I'm not sure I would favour municipal appointment of people to the board—at least, not very many. I've lived that; I used to chair the children's aid society board here in Ottawa, and what you got from the municipal level was quite mixed and often very partisan. What I like about the election side is that usually you get people who are deeply committed to the community and want to make a difference, who feel a connection there and aren't necessarily there for political advantage.

I'm sorry I didn't leave you a brief on community consultation, because we could have gone there, and I think it's really important.

The Chair: Thank you very much for your presentation.

MADELEINE LEBRUN

The Chair: The next presentation will be from Madeleine Lebrun.

Ms. Madeleine Lebrun: Thanks for having me. I'm Madeleine Lebrun. I'm with SEIU and with Red Cross home care. I've been hurt by the bids. Please try to understand, it's very emotional for me to talk about it, because I've been with the Red Cross for 20 years. In 1998, when Harris came into power, they introduced the bid. We used to be 500 members. We used to go in in the morning and we'd stay four hours with a client. We had time to give them a decent bath. We had time to feed them. We had time to take care of their pet sometimes. We had time to do housekeeping, maybe light, but anyway, we did. The people felt special and we treated them as special, with respect and dignity. But Harris, when that government came in, took that away from them and took that away from me, because now I have to go in, sometimes at 7 o'clock, wake up that client, "Get up and go for a shower now," when she's not ready. If I try to be nice, coax and beg—sometimes I almost have to shove that person in the shower because I have to be out of there within an hour and I have another client that's waiting for me. That's the sad part.

You want to introduce bids? You want to degrade people? That's what it comes down to. Right now, we're down to 55 members in Red Cross. Is that fair? No. I gave my heart, I gave my soul, I gave my strength to help the people, but you came in and said, "Get away. I will take over"—with no heart, no feelings. That's what hurts me, because it could be your mother or your father that I'm going to take care of. Would you like them to be

treated that way or would you like to be treated that way yourself? No. Those people went to war. Those people fought for freedom and for dignity and respect, and what do we do? We take that away from them and we say, "Too bad."

Money starts talking now. You know what happened? When the bid came along, they told the old lady, "If you want more hours, pay." Don't forget, they have a pension; that's all they have, most of them. Most of them have no children. I mean, the ones I'm working with have no children. You're telling me it's fair? It's not. When I hear the LHINs coming along, I see my sisters and brothers who work in the hospital; they're going to be treated the same way. You're telling me, "We can get maybe an MRI or a hip replacement; we could do about 20, 50." How far do they have to travel? Are you thinking of the family that has to go with them, miss work? That's not fair.

Right now this generation—I'm 55; if I have to take care of everybody—I can't miss work, because I'm full-time. Most of the home care people have two jobs, three jobs, just to support. Do they have a family life? They don't. I'm talking about experience now. I'm talking to my co-worker, as a home care person, a PSW. People don't understand. We travel; do I get paid for travelling time? No. Do I make a lot of money? No; I make $12 an hour, and I'm not even sure if I have a job tomorrow. My hours could go up; my hours could go down. Why do I do it? Because I love it. I love the people and I think they deserve more than that. When people are sitting in the office—I'm talking about the heart right now—making judgements, making decisions without even walking in their shoes, that's not fair. That's not fair at all. I have to bid. Every three years I have to go up in front of a stranger again and offer my service again. I'm 55. I'm tired. I'm exhausted from selling myself to the lowest bid all the time. I don't get gas. People are not paying for my gas. Sorry, I have to apologize—I do get 22 cents a click, and sometimes I have to travel 30 minutes, 35 minutes. Is that fair? And if I don't do it, my boss is on my ass—sorry, my shoulder—and I hate that. I'm always under stress all the time. I go in to see that client: "Get moving, lady." "Sir, move it." You've got to remember, they're fragile; they're old people.

Again, I have to beg you, please don't go for the bids, because people do not understand. If my sister and brother have to go through what I went through, you won't have any more home care. You won't have anybody who wants to work for a hospital. Why? Because it's not worth it. The lowest bid all the time? I don't have benefits; I don't have a pension. I've got nothing. But I do have a heart. Is that recognized? Nobody cares. Nobody cares. That's why I'm very thankful that you guys let me talk. Finally, somebody is going to listen to us. Don't do the bid, because it's not worth it. You're losing life.

I'm going to tell you a true story. My father died, because what happened that time—in 1996, my father could do everything for himself. He didn't want a homemaker; he didn't want a nurse: "I can handle it." The CCAC came to him, and says, "Mr. Sabourin, you need somebody to help you with your medicine." He knew what to do. We'd coax him, "Come on, Dad, you need that." Finally, he agreed. Four years down the road, they took away his service. My dad was confused. He didn't know which pill belonged, because he needed the dosette. The nurse had prepared his pills. He didn't know.

I remember fighting; I went to see my MPP: "Please, do something. Have an investigation. Do something." Well, they did. Tony Clement made sure the CCAC was accountable. They came to my father's house. He had cancer, he was diabetic, he was blind—what more do you want from him? He qualified. I asked the question: "Who made the decision that he was not qualified?"

And you want me to take the bids? You want me to go for the LHINs? You guys are going to decide that my dad was not worth it? Well, when they did an investigation, it was, "Oh, we made a mistake." But it was too late: My dad passed away because he got confused with his medication.

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Are you waiting for these things to happen again? When we lose a bid, we have to give our clients to another agency. In the process of doing that, there are missed visits, up to six weeks. I know; I visit those people. Why was it not reported? They're afraid that you might take away their service. That's the sad part. Do they have a voice in this LHIN? Do we have a voice?

You guys are going to have to understand that bids are no good, because you're hurting a lot of people. It's sad. I don't have much money; I only make $12 an hour. I have to pay for my gas. I have to travel 30 minutes for one hour or work, and I found out they want to reduce that to 45 minutes. Would you like to take a shower in 45 minutes? Would you like me to give you a shower? You wouldn't like it, because I have to push you in, and that's a lot of stress on us. We get injured, and that's the sad part.

When the other bids came in, Red Cross lost the bid. Everybody cried. We didn't want to go to the other agency because we were well treated by Red Cross. The other agency didn't have an office. That lady was doing her work from the basement. I remember going in one time—they finally found an office—and they had a big box and all the clients in there. "You want to work? Pick your client up." Where's the confidentiality in there? There was none. Did somebody come and look at it? People don't care, and it's about time we start caring for people.

I'm talking about the handicapped too. Who's going to defend them? Who's going to do something about them? It's not the money. You're taking away their pride; you're taking away their dignity and their respect. I feel awful if they have to do that at the hospital. What chaos are we going to have? What tragedy are we going to have? We're going to have a lot.

That's it.

The Chair: Thank you for your presentation. We have about a minute each. I'll start with Ms. Wynne, please.

Ms. Wynne: Thank you very much for coming to tell your story. I just want to clarify that there's nothing in this bill that expands the competitive bidding process. I don't know where that information is coming from. There's nothing that says that's what we're going to do. I just want to assure you of that.

Ms. Lebrun: But could you have it in writing that it will not happen? That's my biggest concern, because I saw the disaster the bidding did. The homemakers are fighting among each other. I want our hours; I want to survive.

Ms. Wynne: I hear your issue, and we've certainly heard it from a number of folks coming to talk to us from the unions. I know this is a piece of information that is in the community. But what you need to know is that the legislation doesn't expand competitive bidding, and it's not our intention to set up a situation where competitive bidding will be expanded. That's the reality of the legislation, and it's also our intention.

The Chair: Thank you. Mr. Wilson.

Mr. Wilson: Well, it begs the question, then, how are you going to acquire services? I think that's what they want to know.

Ms. Lebrun: Yes.

Mr. Wilson: We'll take the blame for the past, but we also didn't make the promise to get rid of the competitive bidding process. The Liberal Party did, and you haven't done it. So you do have an obligation to be honest and say how you are going to acquire services in the future, and it's my job in opposition to point that out.

Ma'am, I appreciate your emotional testimony. Obviously, you've gone through it first-hand with your father. Some of what you said is a problem with the way bids are; some of it, in defence of the government, is rules that are set at Queen's Park. I'm an MPP and a former health minister, and I can't get my mother two baths a week. She won't mind me saying that publicly, because she's going to go public one of these days, and I'm her MPP. I've met with the executive director of the Simcoe county CCAC—Anne Bell, a wonderful person—but all she did was send the case manager for reassessment. At the end of the two-and-a-half-hour reassessment, she still can't get a second bath a week. So we're not all immune to what you've gone through. Yours was more serious.

Keep pushing, and maybe we can ask, through the Chair, for it in writing: How is the government going to acquire services in the future? You can stay silent in a bill, but you can't stay silent forever. Eventually, these things will be set up. If it passes in Parliament, you're going to have to tell people how you're going to do this.

The Chair: The request has been made, and the letter will certainly be coming to us. Then it's up to us to decide who to share it with.

Ms. Wynne: Except there is an answer. Accountability agreements that now exist between the service provider and the ministry will be between the LHIN and the service providers. That is the answer. I'm not sure you need a letter in order to get that.

The Chair: That's fine. He made a request, and we'll go through the normal process. Madame Martel.

Ms. Martel: Thank you very much for a very powerful presentation. It couldn't have been said any better than you have said it why cutthroat bidding has been so disastrous and why it should end.

Here's what we know: The Conservatives brought in cutthroat bidding, and the Liberals have kept cutthroat bidding in home care. They've been there for over two years now. There is nothing in Elinor Caplan's report that will end it. We see no evidence that Minister Smitherman will end it. It will continue in home care, and it will continue to be just as chaotic as it was under the Conservatives.

The second thing we know is that there is nothing in this bill that says competitive bidding will be used. There's nothing in this bill that says it won't. If the Liberal government means what it says, that LHINs will not acquire or purchase services through competitive bidding, then put it in the bill. I plan to find a way to move an amendment that will do just that, and then we will see how the Liberals vote and then we will see what the real intentions are of the government. If you don't want competitive bidding, move an amendment, put it in the bill, and make it clear that cutthroat bidding will not be used by the LHINs to purchase services.

The Chair: I wanted to say thank you for your presentation. I thought it was a very good presentation.

Ms. Lebrun: Thank you for hearing me.

EASTERN ONTARIO COMMUNITY HEALTH CENTRE NETWORK

The Chair: We'll move to the next one, which is from the Eastern Ontario Community Health Centre Network, David Gibson. Please have a seat, Mr. Gibson. You can start any time you're ready, for a total of 15 minutes.

Mr. David Gibson: Thank you very much for this opportunity. My name is David Gibson. I'm the executive director for Sandy Hill Community Health Centre, one of the oldest community health centres in Ontario, with over 33 years. I'm representing today the eastern region: both LHIN 10 and LHIN 11—that is, South East and Champlain—comprising 12 CHCs and one aboriginal health access centre.

The submission I have handed out will go into detail around some of the recommendations. For this brief presentation, I wanted to highlight some of the key principles.

With regard to Bill 36, the proposed Local Health System Integration Act, the Association of Ontario Health Centres and the Eastern Ontario Community Health Centre members have expressed support for the stated objectives of this health transformation strategy.

In communities across eastern Ontario—and that includes Tweed, Lanark, Kingston, Cornwall, Ottawa, Killaloe, Eganville, Beachburg, Portland—CHCs already play a very critical role in fostering health system transformation. They deliver cutting-edge interdisciplinary

primary health care, illness prevention and health promotion services to thousands of eastern region Ontarians. These services are combined with many complementary health promotion and disease prevention group programs, as well as primary care services. These health promotion messages and supports are extended into the community, building what we term overall community capacity.

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The Eastern Ontario Community Health Centre Network sees four overarching principles as critical to the success of the LHINs and would ask the committee to consider Bill 36 through the lens they provide.

The first principle is that Ontario requires a culture of health service integration and coordination, not merely a system navigation mechanism, as stated. Every door is the right door to services. LHINs should facilitate ongoing dialogue among all levels of care provision through opportunities such as, but not limited to, health service providers. A multisector approach is preferable and is grounded in a focus on the broad social determinants of health, which means more than just physical health but things like housing, education and food security. Integration also needs to be properly resourced. CHCs are interdisciplinary and have for many years been working in that system, and there is a cost, obviously, that needs to be appropriately resourced.

We feel strongly that health care providers in various sectors assisting a client to receive the appropriate care they need is the outcome of an effectively coordinated system, not the role of an individual sector, organization or individual. Each has a role to play in achieving a positive outcome. A culture of system integration and coordination is needed, not any single system navigator.

It is also imperative that this committee recognize and make accommodation for the health service providers who are not included within Bill 36. System integration and coordination must be inclusive of public health authorities and all primary care models and providers. This critical link will facilitate a true integrated and coordinated approach to patient care follow-up in and out of various health access points.

Principle 2: Ongoing and broadly defined community engagement by LHINs is key to achieving true local integration. The words of Margaret Mead were, "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has." We need to support community governance as a method of ensuring rich client and community engagement processes. Community governance cannot mean governance of all health services by a regional board. We do not support the model of community governance whereby all health services in a health region, including hospitals, long-term care and CHCs, are managed by a single board.

"Community" should not exclusively be defined as health service providers. It should include client and client group engagement and should ensure that as a basic tenet. Integration orders and institutional changes in services should be undertaken through a filter that would ensure that clients will be able to access services and that resources follow those clients to new service locations.

Challenges to any integration order should also allow a 90-day period and not a 30-day period, for this is too little to allow many community-based organizations to respond effectively.

In addition, I would like to highlight another key recommendation. I would like to propose an addition to part V, subsection 25(3), of a clause stating, in effect, "No integration decision shall permit the elimination of community governance structures except on a case-by-case basis where a single health service provider is party to an integration order with another single health service provider."

Community governance is a fundamental cornerstone to the success of CHCs and many other community partners. Community governance encourages and promotes local action and responsibility. It is perhaps the truest form of community engagement and provides an accessible and equitable mechanism through which accountability to recipients of the health care services—those persons who in effect own the health system—is achieved. Community-governed organizations are able to transmit political pressure and social change upward to promote higher-level policy change. Controlling hep C and HIV requires epidemiology, health service providers and citizen engagement. This form of governance and accountability cannot be replaced by one that defines community narrowly as the community of health providers.

Principle 3: A continuum of care approach for health service coordination and integration is critical to ensuring that services reach all clients, particularly those facing barriers in accessing services.

It is important to note that proximity of services does not necessarily mean duplication. Community health centres, for example, in Ottawa and across Ontario represent geographic and specific community needs. Barriers to access need to be borne in mind to ensure that services reach diverse target populations. One-way-valve provisions are needed. It is not responsible nor respectful to organizations to take money that has been deemed "community" and transfer it into institutional acute care or long-term-care settings. Similarly, the provision of protecting community groups from hospital deficits is also needed. It is not fair to have a hospital download a community service without those funds sufficiently providing for that community service.

Principle 4: Provincial health system standards, including standards for all primary health care models, are necessary to ensure equity in the system and effective planning at the LHIN level and across LHINs.

The Eastern Ontario CHC Network recognizes that there are certain HR anomalies with the LHIN scope of authority. For example, community health care physicians are the only primary care model included within LHINs, but all other primary care models are currently outside of LHINs. The development of an HR planning tool that ensures equity across models and for all providers needs to be in place. Physician compensation

agreements, as an example, should also pertain to all providers of all models. LHIN integration health service plans should also be informed by a provincial plan and developed in partnership with all health sectors, whether they are inside or outside of the LHIN. The other point is that health professional advisory groups should have representation from different models and not just expressly within the LHIN.

In conclusion, the Eastern Ontario CHC Network supports the intention behind the Local Health System Integration Act. We hope that this legislation will ensure that the broad determinants of health are taken into consideration in its consultation processes. The fact is, every door should be the right door to service. This means that the process for community engagement needs to be broadly defined and inclusive of more than just health service providers and organizations. It also means that all models of primary health care and public health authorities need to be included in the planning process, as well as the communities that they serve. The planning process also needs a continuum-of-care approach for health service coordination and integration.

The Chair: Thank you. We have 30 seconds each.

Mr. Arnott: Thank you very much for your presentation. I think you've informed the committee with some very good advice, defining four key principles that you think need to be covered in the approach to the legislation. We appreciate your sincere interest in being here.

Ms. Martel: I don't have questions. I just want to say that we've heard a similar presentation, and I appreciate particularly the actual wording for the proposed amendments. I'll take a look at those, because I think they would go some way to dealing with what you want to have dealt with. I just wanted to say that I appreciate the work that has been done by the association to bring forward the amendments through the presentations.

Ms. Wynne: Thanks very much for your recommendations. What do you see as the practical potential for improvement? Can you give, in 20 seconds, I guess—

Mr. Gibson: The improvement?

Ms. Wynne: Well, the CHCs work very well. You're a model, obviously, that we really support. So when you look at the LHINs and you see the potential, what's the thing that you think can—

Mr. Gibson: My recommendation is to include all primary health care models—CHCs are a founder—and public health in terms of that. I think that's the improvement if you're going to have cross-sectoral planning.

Ms. Wynne: Okay. Thanks.

The Chair: Thank you again for your presentation.

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ONTARIO NURSES' ASSOCIATION, LOCAL 83

The Chair: Next, we have the Ontario Nurses' Association, Local 83, Ottawa Hospital, Frances Smith and Éric Drouin. Welcome. You can start any time.

Ms. Frances Smith: Thank you. My name is Frances Smith, as you heard. I work as a registered nurse in the intensive care unit at the Ottawa Hospital, and I'm here to speak on behalf of Local 83.

The impact of LHINs and Bill 36 is only a concept at this point, but already individuals and organizations are identifying potential hazards in this legislation associated with the lack of a human resources strategy, the potential privatization of health care, and the disruption of health care services.

ONA Local 83 represents approximately 3,500 nurses at the Ottawa Hospital. This gives us the distinction of being the largest local in Ontario, with multiple sites across the city servicing the greater Ottawa region and western Quebec. Through the amalgamation process in 2000, nurses and patients have adapted to a complex organization which delivers highly specialized health care. The Ottawa Hospital also includes the University of Ottawa Heart Institute, the Ottawa Hospital Regional Cancer Centre, the Rehabilitation Centre, plus the Ottawa Hospital Research Institute.

Our primary concern is patient-accessible health care in our region. As nurses, we struggle every day to ensure that members of our community receive excellent nursing care. The transfer of non-acute services will impact all within our community. The Ottawa Hospital has already seen the privatization of the in vitro fertilization clinic, and the Children's Hospital of Eastern Ontario has lost its poison control centre to Toronto. These are just two examples of health care services that are either for-profit or are being outsourced to other communities outside our living environment.

LHINs cover large geographic boundaries. Smaller community hospitals may be forced to close because of unfair competition from larger urban hospitals. Our patients may have to leave their communities and families in order to obtain health care. Mr. Smitherman has publicly stated that there will be no competitive bidding process, but the legislation in Bill 36 does not affirm that position.

The outsourcing of services will be a burden to an aging population, in time, travel and financially, if they are expected to visit multiple locations for services—a blood test here, across town for an X-ray, and then a visit to the physician somewhere else—increasing frustration in an already complex health care process.

The amalgamation of the Ottawa Hospital was a painful experience for many of our employees. Bigger is not always better, and the potential that LHINs could once again disrupt their workplace is frightening and discouraging to many of our members. The proposed integration will cut costs by cutting and merging services, not by controlling the real health care costs such as pharmaceutical drugs and medical equipment.

The potential fractioning of the health care worker will reduce access to resources, education and the interaction necessary to maintain a vibrant, knowledgeable and excellent health care workforce. The environment we work in is just as important to learning as for academics and educators.

Unelected LHIN boards appointed by the government will get control of more than $21 billion to fund health care. Communities will have little opportunity to challenge decisions made regarding mergers or cuts from local hospitals and agencies. There are no checks and balances, but there is liability protection for the LHIN boards. So what recourse does the public have, should they disagree with a decision?

LHINs will determine the health care priorities and services required in local communities, yet the legislation does not reflect this. It remains silent and is not proactive in protecting community rights to participate in the decision-making process. The Ontario government is creating another level of bureaucracy that will increase costs and reduce efficiency.

We encourage the members of this panel to seriously review and correct some of the deficiencies which have been identified by many of the participating speakers across Ontario. The government has not done the necessary groundwork to protect the public or the front-line health care workers. This legislation requires further review and answers to questions necessary to protect the public. We, as health care workers, must prevent the escalation of private health care and honour the Canadian principle that health care is a fundamental right. We have an obligation to all of our patients to participate in the review of Bill 36 and ensure accessible health care for all our citizens.

Thank you, ladies and gentlemen.

M. Éric Drouin: Bonjour, délégués distingués. Mon nom est Éric Drouin. J'habite à Orléans depuis plus de 30 ans. Je viens ici aujourd'hui comme électeur public. Je suis un infirmier autorisé dans un hôpital, et je travaille dans le département d'urgence depuis plus de 10 ans.

Les RLISS, réseaux locaux d'intégration des services de santé, et le passage de la Loi 36 affecteront la qualité des soins directs et indirects dans ma communauté. Comme infirmier à l'urgence, les changements, les modifications de pratique et l'adaptation de mon travail font partie de mon quotidien.

Ma langue maternelle est le français. La Loi 36 ne prend pas en considération l'importance et l'impact qu'une restructuration des services de santé pourrait avoir sur l'accès des services de santé en français.

Une restructuration des services de santé ouvre la porte à des entreprises et entrepreneurs à continuer à éroder notre droit à être servi en français. Ceci affectera directement la qualité des soins de santé en français. Où est la responsabilité gouvernementale? Les services de santé publique ne sont pas à vendre.

Les services privés/semi-privés vont seulement voler, oui voler le personnel déjà établi dans les services publics. Ceci va seulement contribuer encore plus à augmenter la pénurie des ressources humaines des services publics. Et pour quoi? Pour un profit. Un bon exemple : la nouvelle clinique privée Copeman, qui dit pouvoir augmenter les services de santé. Où va-t-elle aller prendre les ressources humaines, les infirmières, les médecins, les technologues pour être en position d'ouvrir ses portes? Où est la responsabilité gouvernementale? Les services de santé publique ne sont pas à vendre.

En réalité, ceci est un déjà-vécu dans d'autres pays qui ont déjà installé un système privé/semi-privé de santé. Mais regardons un endroit comme Ottawa, qui a—ressource disponible—présentement le personnel pour faire 100 chirurgies de genoux par mois—un chiffre arbitraire comme exemple. Tout à coup, avec le pouvoir de la Loi 36, on centralise, déplace les services qui ouvrent la porte au côté privé. Un entrepreneur, souvent un groupe de médecins et chirurgiens, pourra ouvrir un établissement privé pour offrir des chirurgies de genoux. Ces mêmes chirurgiens viendront du service public, et on sait bien qu'il y a déjà un manque de chirurgiens spécialisés dans les os. Cet établissement privé ouvrira les portes et aura une capacité de faire 50 chirurgies par mois. Mais c'est le même chirurgien qui faisait les 50 chirurgies par mois dans les services publics. Ce chirurgien ne peut pas être à deux salles d'opération en même temps. Qui fera ces 50 chirurgies de genoux dans les services publics?

La liste d'attente ne changera pas avec la privatisation des services. La région d'Ottawa fera encore 100 chirurgies—50 dans les services publics et 50 dans les services privés. Ce qui changera, c'est que le public avec de l'argent, les riches, pourra payer pour les services privés et couper devant la ligne, avec aucune réduction dans le temps d'attente pour ce même service de chirurgie de genoux. Rendus à la fin, les riches profiteront et les moins fortunés souffriront. Où est la responsabilité gouvernementale? Les services de santé publique ne sont pas à vendre.

Aujourd'hui, les cliniques privés ou semi-privés utilisent la carte de santé. Une visite d'un patient pourra comprendre des tests sanguins et des rayons X. Ensuite, on ferme la clinique car les heures de bureau sont seulement de 8 heures à 21 heures, du lundi au vendredi. Alors, ce même patient peut se retrouver à l'urgence de l'hôpital. Puisque l'hôpital n'aura pas accès aux tests sanguins et aux rayons X faits dans la clinique privée, il devra tout recommencer à nouveau. Évidemment, il passera encore par le système de carte de santé, et les coûts seront encourus en double. Un système électronique sauvera beaucoup d'argent au service de santé, de l'argent qui pourra être réinvesti pour continuer à améliorer les services de santé publique.

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Le RLISS pourrait plutôt concentrer ses efforts à assurer une collaboration des services de santé en utilisant un service électronique central qui utiliserait la carte de santé comme mode de contrôle et paiement aux institutions utilisées. Ce système électronique pourrait contenir tous les rapports de sang, rayons X, rapports de spécialiste—neurologue, orthopédiste, chirurgien—rapports de congé d'un séjour à l'hôpital et toutes prescriptions de médicament. Où est la responsabilité gouvernementale? Les services de santé publique ne sont pas à vendre.

En fermeture, le RLISS va-t-il regarder et prendre charge de tous les services de santé, et non exclure les

médecins, agences de santé publique, services ambulanciers, laboratoires et les médicaments de prescription? Diminuer la duplication et même le quadruple de tests sanguins, rayons X? Va-t-il limiter les duplications de visite chez un spécialiste? Va-t-il apporter un contrôle sur les prescriptions médicales lorsqu'un patient visite une clinique privée une journée, ensuite un médecin de famille, ensuite un spécialiste, et à la fin l'hôpital? Quatre visites pour le même problème médical, quatre tests sanguins, un à trois rayons X et certains tests plus spécialisés doublés, multiples prescriptions.

La privatisation est un mot très alarmant. Les autres pays qui ont adopté ce système le regrettent aujourd'hui. Le RLISS a le privilège d'apprendre des erreurs des autres pays et de continuer de suivre conformément la Loi 8 et de respecter les principes des services de santé publique et non privés. Pourquoi investir notre argent des taxes pour le donner au côté privé pour y en faire des profits, le côté privé qui va seulement diviser en deux les ressources humaines précieuses—infirmiers, docteurs, techniciens et services de support—déjà en pénurie?

Une personne peut devenir malade 24 heures sur 24, sept jours par semaine. Si on a l'idée de continuer à dépendre sur des services privés seulement ouverts lundi au vendredi, les services de santé ne seront jamais arrangés. Pour ceux qui pensent que le système privé arrangera les services de santé, un mot d'avis : ne devenez pas malade vendredi soir vers 21 h 30. Il n'y aura pas de service privé pour vous aider. Il y aura seulement des services publics qui vous seront toujours disponibles. Où est la responsabilité gouvernementale? Les services de santé publique ne sont pas à vendre. Merci beaucoup.

The Chair: Thank you. There is about a minute and a half total. Mr. Ramal: 30 seconds, please.

Mr. Ramal: First, thank you for your presentation. I want to ask you two questions, basically. First, what do you think when we have unelected, appointed people working from Toronto, controlling all the health across the province of Ontario? What if an appointed body looked after the LHINs across the province? We have similar situations. Even better now, we have local people appointed by the ministry instead of a body appointed by the minister who sits in Toronto.

For the French questions: C'est plus important pour notre gouvernement, pour notre ministère d'avoir des services en français, parce que notre ministre a parlé avec la communauté francophone de l'Ontario et a écouté chaque recommandation.

Ms. Smith: I guess one of the concerns I would have, speaking to your first question, is that I believe that the LHIN boards will just set up a distancing of the government from the responsibility they hold in administering health care, the health care dollar. I think that, as a result of the decisions the LHIN boards will be forced to make within their different communities and regions, the minister will be able to enact things within health care that the communities don't want to be and should not have to be responsible for.

Mr. Ramal: He can do that now from Toronto if he wants to.

Ms. Smith: Well, we can also do something about it in four years' time, when it comes to a vote.

Mr. Ramal: I'm talking about technical stuff. You're talking about technicalities. When you have a board or a ministry controlling the whole province from Toronto—now you have local control for team units in Ontario—same things.

M. Drouin: Pour la deuxième question sur les services en français, en lisant la Loi 36, et je ne suis pas un expert, définir dans la loi et référer que les services bilingues en français soient reconnus—le dire, c'est tout bien, mais l'avoir écrit dans la loi peut offrir un peu de respect de la langue française.

The Chair: Merci. Mr. Wilson, please.

Mr. Wilson: I would just say thank you very much. As I said to the nurses' association this morning, we don't always agree, but there's much we agree on in terms of opposing parts of this bill.

As a former health minister, I know when I've met my match, so I'll just say thanks again.

The Chair: Madame Martel.

Ms. Martel: Merci pour votre présentation.

I want to focus on section 33 of the bill. It's the section that allows for integration by regulation. I'm going to focus on it because you represent nurses at the Ottawa Heart Institute, and that's referred to directly in this section. It says, "The Lieutenant Governor in Council"—that's going to be cabinet or the minister—"may, by regulation, order one or more persons or entities that operate a public hospital within the meaning of the Public Hospitals Act and the University of Ottawa Heart Institute ... to cease performing any prescribed non-clinical service and to integrate the service by transferring it to the prescribed person or entity"—we don't know who that is—"on the prescribed date," and we don't know when that is.

That's the section that allows the minister to contract out non-clinical services, which also aren't defined. Given that the University of Ottawa Heart Institute is specifically referenced in that context, does that give you some cause for concern?

Ms. Smith: Oh, yes, definitely. It gives us all a lot of cause for concern. You have to remember, I'm an intensive care unit nurse. I love what I do. I want to be able to continue to do it. You have absolutely no idea how difficult it was for us when they amalgamated the hospitals. We see so much pain and suffering today in our jobs with the people that we look after. We certainly do not need anything to make it any worse for the people who are trying to get the health care they require, in making them travel all over the region in order to obtain that health care. We want to ensure that we can give the care that we know people need as our patients.

The Chair: Thank you very much for your presentation.

ONTARIO COUNCIL OF HOSPITAL UNIONS

The Chair: The next presentation is the Canadian Union of Public Employees, CUPE, Cornwall; Ontario Council of Hospital Unions. Helen Fetterly will be speaking to us. Welcome.

Ms. Helen Fetterly: Thank you.

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

Ms. Fetterly: Good afternoon. I'd like to thank the committee for the opportunity of presenting this afternoon. My name is Helen Fetterly. I'm the secretary-treasurer of the Ontario Council of Hospital Unions, CUPE, and I've also been a health care provider in Ontario in the community of Cornwall for the last 35 years. With me this afternoon is Doug Allan from CUPE.

The Ontario Council of Hospital Unions, OCHU, is the hospital bargaining council for CUPE in Ontario. We bargain a central collective agreement with the Ontario Hospital Association. OCHU represents approximately 25,000 hospital employees in service and office hospital bargaining units from one end of the province to the other. We represent cleaners, registered practical nurses, dietary workers, operating engineers, secretaries, ward clerks, porters, carpenters, cooks, personal support workers, lab assistants and many, many others. Most OCHU members are women.

We note that, while hospital spending on certain other areas—for example, pharmaceutical drugs and supplies—has risen, spending on Canadian hospital support services has shrunk as a percentage of total hospital spending. In recent years, support spending has even shrunk in terms of total dollars spent.

OCHU, the Ontario Council of Hospital Unions, takes great pride in our long-standing campaigns in favour of universal, accessible, comprehensive, publicly funded and publicly delivered health care. We are very concerned about the impact of Bill 36 on many of these principles, and so have taken some pains in bringing our concerns to the community. Our written submission discusses a variety of issues connected to the bill, and we ask that you read it carefully, as we can only discuss a limited number of issues in our oral presentation.

1450

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. 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.

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 services. In fact, the government's reform borrows problem areas from health care regionalization in other provinces and combines them with problem areas of health care restructuring in England. It would create a new layer of bureaucracy that would (1) be unaccountable to local communities, (2) reduce provincial government accountability for the largest part of the budget, and (3) create a purchaser-provider split that will undermine health care and social services.

The LHINs cover very vast and diverse areas. The LHIN boundaries override municipal, provincial and social boundaries. The 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, so it will be very difficult for the people living within a LHIN to have a significant voice over the direction of that LHIN.

The autonomy of the LHINs from the government is very modest. The government will control LHIN funding, and each LHIN will be required to sign an accountability agreement with the government. Indeed, the government may unilaterally impose this even if the LHIN does not agree to the agreement. So LHIN boards will be responsible to the provincial government rather than local communities.

This model is similar to changes made to community care access centre governance in 2001. The key there was to replace community boards with government-controlled boards. CCACs were taken over by the provincial government in 2001 and they immediately ceased pointing out to the public their need for adequate funding. The result? Their funding was flatlined for years and home care services were cut back dramatically. Tens of thousands of frail elderly and disabled lost their home support services. In total, the effect was a reduction of 115,000 patients served from April 1, 2001, to April 1, 2003, and a cut of six million hours in services, a 30% drop. Needless to say, this is a very poor model for LHINs to follow.

LHINs will also insulate government from decisions to cut back or privatize services by creating another level of bureaucracy that will catch much of the flak. The government will control the LHINs, but the LHINs will actually implement the decisions. They will be the first targets for popular discontent, even if their actual autonomy from government is more imaginary than real.

Bill 36 also gives LHINs and the government a wide range of tools for restructuring public health care organizations.

First of all, the LHINs have their funding powers to facilitate consolidation: section 25 of the bill. They also have accountability agreements with health service providers. While these powers may appear sufficient, much more powerful tools have been given to the LHINs, the Minister of Health and cabinet to force consolidation.

LHINs are given the power to issue compulsory integration decisions requiring health care providers to cease providing a service or to transfer a service: subsection 26(1) of the act.

The minister may order not-for-profit health service providers to cease operating, amalgamate, or transfer all of their operations: section 28. Notably, for-profit pro-

viders are exempted from this threat, creating an imbalance between for-profit and not-for-profit.

The bill allows cabinet to order any public hospital to cease performing any non-clinical service and to transfer it to another organization: subsection 33(1). The bill gives cabinet the authority to contract out these services despite the wishes of the hospital. There is no definition in the act of "non-clinical service," and so this definition may be a matter of considerable controversy.

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

With service cuts, there is a real threat to local health services. At first, the government talked only of integrating support services. But cutting support services is dangerous—hospital-acquired infections have already killed thousands in Canada every year—and inefficient, as it often requires more highly paid staff to take over the functions formerly done by support staff.

An early example of support services consolidation is HBS—Hospital Business Services. With government support, 14 hospitals in the greater Toronto area planned to regionalize supply chain and office services by turning the work over to another new organization. HBS indicated to us that it would take approximately 1,000 employees out of the hospitals, turn over a significant portion of the work to for-profit corporations, and sever 20% to 25% of employees. One participating hospital has just told our members they are only waiting for Bill 36 to pass for this large-scale contracting out of our work to begin. This is just the beginning of a major change across the province that will have far-ranging consequences for workers and local communities. Many more such plans are in the works.

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

As well, clinical services are threatened. When the government pushed for cost containment in late 2004, the hospitals insisted that an exclusive focus on support services would not satisfy the cost savings demanded by the government; the savings would also require clinical cuts. The battle over the cuts has proceeded for some time, usually in secret. By April 2005, the government as much as admitted that clinical services would be consolidated or cut, with the health minister publicly calling for the centralization of hospital surgeries: "We don't need to do hip and knee surgery in 57 different hospitals." Instead, he suggested that about 20 might be appropriate. That is about a 60% cut. The minister went on to indicate that hospital specialization is coming: "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 to multiple sites for health care services.

With respect to protection of local services and access to care, integration will remove jobs and services from local communities, hampering access. Support services are likely the first target, but direct clinical care is also under attack. Reductions in community control and provincial government accountability through the LHINs will make it easier for government to implement these threats.

As well, a new form of health care privatization: Bill 36 provisions do not ensure that the LHINs, the minister or cabinet will preserve the public, not-for-profit character of our health care system. Indeed, these bodies would now be armed with the legal authority to privatize large parts of our publicly delivered health care system. Moreover, LHINs will create a split between the purchaser of health care services and the provider.

I'm just going to finish up and take the one minute I have left.

I also want to talk a bit about stopping privatization in health and social services and building co-operation. Privatization and decreased co-operation between providers are major threats of this reform. Instead of integration, privatization will bring "disintegration" with the various providers in competition to win contracts. Above all, competitive bidding and privatization should be specifically excluded in the legislation, based on the disastrous results they have already brought in Ontario health care.

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For all these concerns, we believe this bill and the government's attempt to restructure health care need to be rethought. We have made some suggestions of how health care reform could unfold, but we urge the government to take a considered and consultative approach. The public was not informed before the last election that the government would embark on the form of health care reform it has taken. We believe that a better approach would be to consult with local communities, health care workers and the public about how health care should be reformed. That would be a much more satisfactory and a much more democratic process.

Thank you.

The Chair: Thank you for your presentation.

OTTAWA COUNCIL OF WOMEN

The Chair: The next presentation will be from the Ottawa Council of Women. We have Luba Podolsky and Marianne Wilkinson. Ladies, you can start whenever you're ready. There is a total of 15 minutes available.

Ms. Marianne Wilkinson: Thank you. I'll just introduce our organization and then Luba will talk about the health aspects.

The Ottawa Council of Women is a federation of organizations of women, or of women and men, and of some individual members; it is itself a federate of the Ontario council of women and of the National Council of Women, which is in turn a federate of the International Council of Women. The Ottawa Council of Women is primarily an advocacy group. It's a non-governmental organization, democratic and non-partisan. It is funded by donations and by modest membership fees. It was founded in 1894.

The council provides a platform for members' concerns to be heard, discussed and presented to a wide audience, and to the appropriate level of government. Policy for the council is established through a resolution process. Issues of concern become subjects for resolutions which are sent to national or provincial councils and brought to a vote at their annual general meetings. Accepted resolutions become policy and form the basis for our annual briefs submitted to the federal and provincial governments. This grassroots participation has served us well for more than 100 years.

Ms. Luba Podolsky: The health committee of the Ottawa Council of Women has been actively involved in gathering information, informing our members and contributing to policy formation for both the provincial and national councils on matters pertaining to health. Our representatives attend board meetings of the Ottawa Community Care Access Centre as observers and participate in the community advisory committee of the Ottawa Hospital. In the 2001 brief presented to the government of Ontario by the provincial council, there is a resolution advocating "integrated funding, management and delivery of health services" which proposes a LHIN-like development. We also have policy supporting both local accountability for health care and the need for health promotion. We are therefore pleased that the Ministry of Health and Long-Term Care of Ontario is moving in these directions.

We want the LHINs to work and to help keep OHIP as a strong public system under the Canada Health Act. Bill 36 is the proposed legislative framework for the LHINs, and therefore it must be written correctly as changes would take a lot of time and be difficult. The preamble to Bill 36 is most encouraging. It states:

"The people of Ontario and their government

"(a) acknowledge that a community's health needs and priorities are best developed by the community, health care providers and the people they serve; ....

"(f) believe in public accountability and transparency," and also that there will be committees established to reflect this vision. The promise that there will be no restriction on patient mobility we interpret as a promise that patients can expect service as close to home as possible.

Now our concerns about Bill 36: The primary one is local accountability. This is a major concern. The proposed Bill 36 spells out accountability by LHINs to the minister and by the ministry to LHINs, but there is no accountability required by the LHIN to the community. This has been stressed by several other people today already. The public may have access to some meetings and may receive reports, but that is far from accountability. There is no representative from local levels of government on the LHIN board. All are appointed at the pleasure of the minister in far-off Queen's Park. We request inclusion in Bill 36 of a means to empower municipalities or local governments to have full participation in LHINs decisions.

There is also no provision in Bill 36 for a voice for patients. It seems that the Ontario government could run a perfectly good health care system if it didn't really have to worry about patients. There is no provision for the voice of patients. Part II, clauses 5(c) and 5(d), outlining the objects of the LHINs are welcome and appropriate but need to be expanded. What formal channels for community input are envisioned? How must patient concerns about services be dealt with? These questions should not be answered in the regulations, which can be changed easily by a different government. We need more detail in the bill to ensure that the stated objectives are met. We think that if it's not in the bill, it's not going to happen.

Part III, planning and community engagement: We wonder about the meaning of the term "engagement." Clause 16(1) implies, but does not spell out, who is within the community of persons and entities that shall be engaged while the LHIN is setting priorities. Clauses 16(2) and (3) are quite specific. We request the addition of a 16(4), to be something like: "Each LHIN shall establish a consumers' advisory committee consisting of representatives of community groups registered as such, which will be consulted when plans are being developed and priorities are being set for the delivery of health services."

Our Champlain district LHIN covers a very large geographic area. There must be clauses within the bill to ensure that local needs are met, that consumers throughout the area feel they have a stake in their health care delivery. How will the Champlain district LHIN be truly local? How will patients navigate such a complex system?

The scope of LHINs: Bill 36 deals with management of disease, but says very little about the management of health. What is the connection of the Ministry of Health Promotion to the LHINs? The community health centres in Ottawa have developed programs to deal with many aspects of health. Perhaps our LHIN could benefit from their example.

Privatization: Another concern of ours is the possibility that hospitals may lose control of staffing to a competitive bidding process by which agencies contract to supply staff. Hospitals could be ordered to do this to try to save a few dollars, even though the staff of a hospital determines its success. This would impact quality of service and flexibility of action of the hospital, and the stability and loyalty of its staff. We request a

guarantee written into the bill that hospital staffing will remain an internal matter under the control of the hospitals.

In part V, the minister may, in sections 28 and 29, amalgamate, merge or close non-profit groups that receive funding from the government. Why are non-profit groups specified? Surely the same rules should apply to for-profit groups, or are they not eligible for government funding? Perhaps they have been written right out of the bill. We support integration of services, but would like some clarification on this point.

We look forward to the successful implementation of a LHIN that will be responsive to the needs of its communities and supportive of a public health system within the Canada Health Act. Thank you.

The Chair: Thank you. There is about two and a half minutes each, and we'll start with Mr. Arnott.

Mr. Arnott: I want to thank you very much for your presentation, and if you could pass along our appreciation to your colleagues at the Ottawa Council of Women for the thoughtfulness that's gone into this presentation and the ideas that you've put forward, some of which I would venture to say we have not yet heard.

First of all, the whole idea of, what is the role of the Minister of Health Promotion in this thing? I think that's something that hasn't come up so far, and of course the Minister of Health Promotion would want to ensure that his ministry has a role in all this.

Secondly, you raise the issue of local accountability and you suggest that there is no assurance that representatives of a local community or a local municipality will be included in the LHIN board. Do you think municipal government should be given the opportunity to appoint a person to represent the community on the LHIN board, in some cases?

1510

Ms. Podolsky: I think so, personally, but it's going to be difficult because it's such a huge area. How do you choose a representative from that huge area? Perhaps there have to be representatives chosen for each committee meeting, when the committee meeting is in a specific locality. There has to be some kind of mechanism for making this local. We envision the LHIN as being a problem-solving agency, not as much a controlling agency, and in order to solve problems you have to get people together and discuss these problems. We really can't see that written into the bill.

Mr. Arnott: Some groups have suggested that there should be some sort of an appeal mechanism, so that if groups or individuals are dissatisfied with a decision of a LHIN board, there would be an independent appeal board that they could make their case to. Do you think that needs to be included in the legislation as well?

Ms. Podolsky: Yes. But even before that, before you make an appeal, you have to have some input into what the rules are and what the process is. The consumers of health care have to have some kind of an input into this whole process, and there's nothing in Bill 36 that guarantees such an input. You've been hearing mostly from health care providers, and their input is very valuable, but there isn't very much said from the point of view of the consumer. I think Madeleine came the closest to that, and we think that's a sad omission.

The Chair: Thank you. Madame Martel.

Ms. Martel: Thank you, both of you, for the presentation and for the long, long history of service to the community. I appreciate that.

You said your major concern is local accountability. It is very clear that the accountability is all about accountability to the minister, not to the local community. I just want to reinforce some of this again, because it's cabinet or the minister that creates or dissolves any LHIN. They are appointed by the government. Their remuneration is set by the minister. The chair and the vice-chair are appointed by the minister, not by the board. The LHIN is explicitly defined as an agent of the crown right in the legislation, not an agent of the community. The LHIN enters into accountability agreements with the ministry and service providers, but there's nothing with respect to their accountability back to the community. They are funded by the government on the terms and conditions that the minister considers appropriate. They can fund health service providers, but that has to be in accordance with government requirements. Also, each LHIN has to develop an integrated service plan, but that plan has to be in accordance with the plan that's put forward provincially, and we haven't heard anything about the details of how that plan is being developed right now—who's involved, whose input is being considered etc. So the sad reality is, while the government would like to say that this is about bringing control closer to the folks so you get better health care close to home, this bill centralizes power in the hands of the minister and cabinet more than any other health bill ever has.

If you were writing a bill that actually talked about accountability back to the community, what might be some of the changes that you would see would be necessary to actually ensure that the LHINs have some accountability to the community, not all of their accountability back to the minister?

Ms. Wilkinson: We think that there should be appointment through community consultation. The community itself should be involved in selecting the people to be on the LHIN, so that they are in fact from the community and responsible to the community. In the largest LHIN like this, every small community should have an advisory committee that is an integral part of the whole system, that is involved in all of the discussion, so that the community is involved all the way through. The funding has to come from the province somewhere along the line, but once the bulk funding is there, then the distribution of it should be done with a very major consultation process that involves not just the health care providers, but also the users and just general members of the community who want to see good health care provided in their communities.

The Chair: Thank you. Mr. Fonseca.

Mr. Fonseca: The local health integration system is really about the sustainability of our health care system. I have to say that I'm very excited about this particular

LHIN, the Champlain district, because the CEO of this LHIN was the medical officer of health, Robert Cushman, and he's done great work in terms of public health, population health, your anti-smoking or stop smoking initiatives here in this area.

Being the parliamentary assistant to the Minister of Health Promotion, Jim Watson, who was the mayor of Ottawa, I have to say that these are the type of initiatives that we need. I know that somebody like Rob Cushman here in this LHIN will be able to provide those best practices that are happening here and take those so that in Thunder Bay or in Toronto or in North Bay, they will also be able to adopt those practices. So that is what we are looking at, because part of the sustainability of our health care system is to really keep people healthy before they get sick, and that's where health promotion comes in.

I know that my colleague Kathleen also just wanted to mention a few things.

Ms. Wynne: I just wanted to thank you very much. On the issue of public engagement, community engagement, as opposed to "consultation" or "participation", the words that you used, the reason we've used "engagement" is that it could involve both of those, participation and consultation. I know that in some areas of the province already, there's work being done on what kinds of public engagement or community engagement should take place. So if you have specific suggestions about the kinds of things you think need to happen, that would be great, but the reason we've used the word "engagement" is that it's going to mean a variety of things in the different parts of the province.

Ms. Podolsky: But I think we would really like to see this written into the bill. If it's not in the bill, it doesn't get done. If somebody loses an election, chaos results.

Ms. Wynne: You want some specificity, and I hear what you're saying. Certainly I understand that that's something that we need to look at, but I think that we also have to be careful that we don't constrain what we mean by "public engagement," by "community engagement," because it's not going to look the same in every part of the province. So that's the balance we have to strike: being specific enough but not constraining people by outlining exactly what they should do.

Ms. Wilkinson: Our worry is that there's no requirement to really have it done at all. Our view is that the LHIN itself is really a small bureaucracy of the Ministry of Health. It is not a community group. If you then say that is a decentralization of the Ministry of Health into smaller areas, then underneath that you have to have the whole system that involves the public. That's what we see missing.

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

PATTY PLAETSCHKE

The Chair: The next presentation is from Patty Plaetschke. You are from CUPE Local 1559?

Ms. Patty Plaetschke: That's correct.

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

Ms. Plaetschke: My name is Patty Plaetschke and I am 36 years old. I'm here on behalf of CUPE Local 1559, and I hold the recording secretary position in the union. I live in Athens, Ontario, a small town with a population of 1,000 people. The closest town to me is Brockville. Brockville General is my closest hospital, and in the last three years, it has had a huge renovation done to the facility.

I'm going to first tell you about a situation I found myself in; this was at least eight years ago now. I get kidney stones, and the first one I had actually got stuck in the tract from my kidneys and wouldn't move. My left kidney was twice its normal size before I realized that something was wrong. There is a process that involves a sonar pulse machine. It's a lithotripsy procedure whereby it pulverizes the stone with sonar pulses to break it up and get it moving.

At the time I needed this procedure, there was no such machine in Ottawa, where I lived at the time, and I had to go to the London hospital. I got no compensation, because I did not live in the northern part of Ontario, and therefore had to foot the whole bill. Along the way, my car broke down, and I needed to rent a car to get to London. Once I was there, I had to wait for my procedure because I had a fever by the time I got there.

The rest of the story is that I had to choose at that time whether to stay for the procedure or leave and wait with my kidney twice the size it should be and come back again when they had the next available time. I decided to wait overnight, and I was lucky enough that someone missed their appointment the following morning.

Once again, I had to foot the whole bill to get down to London, six hours away from where I lived, to get a procedure done, and there was no compensation for me. I can't imagine being 65 or 70 years old and having to go this far to get a procedure done. Even an hour away would have been uncomfortable. I was lucky enough and I was young enough that I had enough money to cover a rental, but when you're on a fixed income and disabled, where does that come from?

1520

There's now a machine in Ottawa, after the fundraising was done by the hospital to get the machine. It then took the government another two years to say, "Yes, we will finally pay for the machine to be put into operation." I'm really afraid that this is what's going to happen after hearing the LHINs interview that the minister made.

I work for the Access Centre for Community Care in Lanark, Leeds and Grenville and have been there for the last six years, in the position of an accounting clerk at the moment. At this time, I wish to read to you the CCAC mission statement and values, and ask that you pay close attention to this, as I think this will point out some major issues that need to be addressed in the LHINs.

Their mission is: "To provide information, referral, access and coordination of services in partnership with other health and social service organizations in the

community to improve and maintain health, independence and quality of life for people of all ages."

The values: "In all our actions with clients, caregivers, staff, providers, volunteers, partners and the community, we will be:

"—fair and equitable in the provision of timely and consistent service;

"—respectful of individuals and supportive of their right to make choices"; I see the LHINs taking choices away from people in the homes;

"—sensitive to the rural nature and diversity of the community we serve"; I haven't heard until this last week of any community involvement in the decisions for the LHINs;

"—open and honest in all communications while ensuring confidentiality"; a big part of the LHINs right now is saying that they're going to enhance the system of the access centres, and they don't tell us how;

"—responsible and accountable"; if we can't get accountability within the LHINs act, how can we be responsible and accountable to our clients as well?

"—committed to excellence and continuous improvement;

"—active in encouraging learning opportunities; and

"—active in enhancing community partnerships."

I will now tell you what I experienced and what I have witnessed while working at the access centre. In the beginning, the CCAC's role in the community was to assist hospitals from having people stay to recuperate, and to prevent people from being admitted to nursing or retirement homes, because there were not enough spaces available to accommodate everybody.

In the beginning, I also got to see what the access centre did in the community when it came to nursing and therapy in people's homes. It was very satisfying to be working in a place like this. After a while, I realized what the homemaking aspect of our service did for our clients and the effects we had on their lives. We would go into the home and help these people to bathe, and clean their living quarters enough that they could still entertain people and feel good about themselves. We would assist in making meals and in doing the everyday things that are easy that we all take for granted, like grocery shopping and banking.

These people were able to stay in the community and feel that they were still living a normal life, and in response, they were healthier. They were less likely to need to be placed in nursing homes, long-term-care facilities and retirement homes. They had their dignity and pride and still felt they were in control of their lives. They could choose for themselves how they wished to live. On top of all this, we had a relationship built between the caregiver and the client that is unlike any other relationship.

Once the bidding process was started within the CCAC, we saw a freeze on funding as well. We were given the same amount of money but had increased numbers of clients. We were being used more than ever by the hospitals for recuperations at home. The money could only go so far, and something had to give. The homemaking was then reduced, and people managed to get by with less housework and perhaps used more of the Meals on Wheels program.

The following year, our funding was still not increased and our client numbers still went up. The homemaking was then stopped altogether, and this is where I think what the government did was reprehensible, cold and callous. We first show these people how we can help keep them in their homes, and then slowly take that right away from them. They stop having friends and family over due to the lack of housekeeping, and they feel less like a part of society that is valued. We strip them of their dignity because we now say that they can only get help with a bath if they need us for some other service, like nursing or therapy to recuperate from an injury.

Eventually, the worst occurs, and it is discovered that these people cannot stay in their homes and keep the life they created because we are not there to help them prepare meals. They become frail and are susceptible to infection and colds, thus causing the reverse of what we set out to do. We take away these people's self-worth, because now they once again are looking for placement in facilities to help them survive. Even worse yet, I believe that in a few cases this has caused earlier deaths.

I find it very hard to believe that the executives and the service providers in this industry associated with the CCACs did not try to voice their concerns and prove to the government that what was being done was causing such damage in the community. It appears the health minister and the government were not listening, as far as I'm concerned.

First, we need to know what role the CCAC will have in the future with the LHINs. The minister continues to state that the CCACs will have an enhanced role in the community. I wonder, with all the cutbacks and closures in the mental health industry, is there a proposed plan to add this to the CCAC blanket of health and, if so, is this the minister's way of opening up the bidding process in the mental health realm? They have done all the damage they can do in the home care sector; now let's see what can be done in mental health.

What weighs on my mind the most is the regional boundaries of the LHINs and the fact that they are not conducive to open speech about specific communities and the problems they face. As a taxpaying citizen, I want to see changes to this bill which will ensure that we get heard, that services can stay local, and that the people who pay for the service can get the service needed, which is our right, and not suffer a hardship to get that service.

I want to see changes to this legislation which will protect our local services and access to care. Our support services are likely the first target, but direct clinical care is also under attack. Reductions in community control and provincial government accountability will make it easier for governments to implement these threats.

I want to see provided in the bill that cabinet, the minister and the LHINs may only exercise their powers in the public interest, with "public interest" defined to include preservation of the public, not-for-profit character of our health care funding and delivery system.

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

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

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

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

—LHINs should be required by the bill to do an annual survey of unmet needs and to report unmet needs in annual reports to their communities.

Of course, this is all my personal opinion and what I see from the position I hold within this community.

The Chair: Thank you. There is only one minute left, so why don't we take 30 seconds each. I'll start with Madame Martel.

Ms. Martel: Thank you for making a presentation today. I've already said what I have to say about competitive bidding in home care. What's interesting is that two of the basic changes that could be made that would give more home care to more clients, which the LHINs have absolutely no control over, would be to get rid of the current regulation that limits the amount of home care a client can receive and, secondly, get rid of the regulation that says you have to have a basic care need, a bathing need, in order to get homemaking services. While the minister says this is about service as close to home as possible, those two regulation changes are solely within the power of the government, and the LHINs have nothing to do about them. If you made those changes, more clients would actually get the care they need.

Given what you've seen with respect to competitive bidding, when you think about the possibility—because it's not explicitly forbidden in the bill—that this could be expanded to other sectors, where do you think this is going to lead, not just for workers like yourself in the sector but for the clients who need those services?

1530

Ms. Plaetschke: We of course see a lot of palliative care and long-term care, but mainly in the palliative, these people don't want eight or nine different service-providers coming in in the last few days of someone's life. That's the last thing they want to see: total strangers, time and time again, having to learn their whole medical situation before they leave. With the competitive bidding part of it through the access centre, that's exactly what's happening. We remove these people's right to privacy, basically, because so many people come in to deal with this person in the last few days of their life. I don't want that to happen when I go to a hospital, that I have to go from one hospital to another and to another to finally get the service I need because it's not offered, even though at one time it might have been in my local hospital. That's my worry.

Mr. Leal: Patty, thanks very much for your presentation. I have two quick questions. First, when you talked about the regional disparities and people having to travel to other areas, it seems to me, and I'll get you to comment, that one of the goals of LHINs is to reduce those travelling disparities and regional disparities, to get treatment closer to home.

Ms. Plaetschke: But how do you do that when the LHINs have places in our region now that I've never even heard of?

Mr. Leal: They're going to be doing planning for the local area.

My second question. I forget what page it is, but in your brief you say, "I've heard questionable things about the people appointed to LHINs already"—

Ms. Plaetschke: I didn't read that, and I'd actually like to remove that from there.

Mr. Leal: Oh, you would? I was going to ask you a question: Did you check the facts or did you just put that in there?

Ms. Plaetschke: As I say, I've only heard little bits, so that's why I chose not to read it.

Mr. Leal: I appreciate that you removed it from your formal presentation.

Mr. Wilson: I should probably know this, as labour critic for my party, but perhaps you, Helen or Doug could tell me: Are all the CCACs unionized?

Ms. Plaetschke: Yes, they are, I believe, in some shape or form. If it's not CUPE, it's ONA or OPSEU.

Mr. Wilson: Does CUPE have a majority, or do you know how it breaks down?

Ms. Plaetschke: No, I think it's ONA more than CUPE, because they have to have a degree in nursing or therapy to work as a case manager within the offices. In some access centres, the positions are not always clearly defined. Some are through the health units and some are with the access centre, depending on how they split up the access centre and health unit back in 1999 or 2000 or 2001 or something like that.

Mr. Wilson: And the people who actually deliver the services are really scattered.

Ms. Plaetschke: Yes, and those are through the outside agencies, which are done through the bidding process now. Those poor people, as you'll hear from my colleague from the access centre a little later on this afternoon about the bidding—you'll find what's going on at that end from her.

The Chair: Thank you for your presentation.

KINGSTON MUNICIPAL SUPPORT GROUP

The Chair: The next presentation will be by teleconference. Do we have Matthew Gventer? You have the line, sir.

Mr. Matthew Gventer: Thank you so much for letting me appear. I am speaking on behalf of a group of citizens of Kingston who have worked together to increase the voice of citizens in the municipal affairs of our city. I do not claim that we have a great deal of special knowledge or insight into the workings of our health care system. We do bring to this committee our insight into the development of community and the importance of community input into the planning of any service to be delivered to that community.

I spent many years working with First Nations people in our federal prisons. I spent many hours listening to native elders provide counselling and guidance. Often, they spoke at great length with intriguing stories that seemed unrelated to what we were considering. What was overwhelmingly evident at the end was how profound their messages were and how relevant and effective their communication was. I hope you'll be similarly patient with me and what I have to say, and similarly rewarded.

To illustrate the points I will be making, consider the analogous example: In our city there's currently an issue working its way through city council. City council has voted to build the central ice skating multiplex in the outskirts of the city. To avoid competition with ice space available elsewhere in the city, the original proposal was to close three neighbourhood rinks. What is driving this proposal is the bottom line, financially. It is intended that outside tournaments be drawn to the multiplex, which will help finance the facility. It will be a state-of-the-art facility. The proposal was closely monitored by the public and by an advisory body attached to the committee deliberating this proposal. Evidence was presented to show that important neighbourhood functions, especially in a less-advantaged district of our city, would suffer if they closed the neighbourhood rinks. It was learned that children and others used the rinks for general recreation to a larger extent than occurred at other rinks. This has led the city council to delay the decision to close the existing neighbourhood rinks.

It is this capacity for a community to mobilize its resources and bring pressure and information to bear on a decision that is being denied in the LHINs legislation. We know enough about the past dynamics of structural change in the health care system to know from where this policy is coming.

The Ministry of Health has been frustrated by being thwarted in its intentions in the past. This is certainly very evident in the process of restructuring health care in Kingston. The Duncan Sinclair hospital restructuring commission recommended the integration of all hospitals in Kingston and the closing of the Hotel Dieu hospital. This intention stirred great resistance, including from our MPP, John Gerretsen, which forced the reconsideration of that decision. Hotel Dieu remains open and is operating in a totally co-operative and functional way with the other hospitals in Kingston.

We want the legislation changed so that communities have the right to appeal decisions of the local LHIN; that there are announcements well in advance of decisions so the public can have the opportunity to learn of changes that will impact on their communities and so they will have time to react; and that the evidence justifying the change be made public so the communities can refute or accept the changes.

I carefully reviewed Bill 36. I agree that I'm not a legal expert and that much of the language is hard to penetrate; however, it is clear to me, it seems, that the legislation claims to be responsive to local communities. It has promised that community consultation will be built into the development of strategic plans. What also seems clear to me is the exclusion of the community from what are questionably called "integration decisions." Decisions will be available at the head office. Only parties to agreements will be allowed to appeal decisions, and the community is not considered a party to a decision. The appeal period will be limited to 30 days.

I once chaired a Kingston social planning council committee called the Planning for People project. We would receive announcements of intended zoning and city plan changes. We'd then have the chance to survey the neighbours affected and find out how they viewed the changes. Sometimes the reactions were very strong and hostile, and people reacted by organizing themselves to address the proposals. In most of these cases, changes were implemented in the proposals that made the development more acceptable to the neighbours. Larger fences were built or uses were restricted slightly or plans were downsized a bit; access routes might be ensured. On occasion, the neighbours were able to resist the most imposing changes. What may surprise you is the frequency of neighbours saying that the changes were reasonable. In one case, I remember the neighbours all saying that the business asking for the changes had been an excellent neighbour and they totally trusted the business to take the promised action to avoid intruding into the residential neighbourhood.

The committee of the Planning for People project was resented by the planning board and the developers and lost its function when the privilege of advance notice was withdrawn. This was a significant loss to the community and to the planning process.

I'm asking your committee to show more maturity and more trust in the public. Don't exclude the community from the process. Don't fear transparency and accountability to the community. We are not customers, as our city likes to call us when we phone in to city hall; we are citizens and taxpayers. I treasure the years when the political parties espoused citizen involvement at every stage. In fact, it wasn't so long ago when the Liberal Party considered this to be a foundation of its policies. The Reform Party identified itself as a grassroots movement. The NDP continues to claim citizen participation to be essential to its identity. Parties in the last provincial

election ran on a platform of open government and full public disclosure.

I've given some examples of the value of meaningful community participation. Now allow me to remind you of examples of communities suffering from the kind of top-down decision-making envisioned in this legislation. I turn to two examples of CCAC decisions regarding Kingston health care deliveries.

Hospice Kingston lost palliative home care contracts in 2002. Ten nurses were laid off. These nurses were leading practitioners of palliative care and care for the dying. They were vital parts of the service program of Hospice Kingston. Hospice Kingston was and remains more than a source of clinical home care services. It provides respite care and a residential sanctuary when needed. It coordinates hundreds of hours of volunteer support services for the sick and dying. At that time, it helped families with bereavement services. What a heartless and thoughtless decision was the withdrawal of funding for home care nurses from Hospice Kingston. It left the organization with a debt of $250,000. It forced the sale of a respite facility. It forced the cessation of the bereavement services.

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The survival of Hospice Kingston is a tribute to the dedication and spirit of the Kingston community. One has to wonder how a CCAC board would have made that decision if it looked at the larger role of Hospice Kingston. I remember meeting one of the lead nurses of Hospice Kingston after the loss of the service. She had been a leading figure in the development of palliative care service in Kingston. She had been the leader in the development of palliative care clinical nursing in Kingston. Now she was left with her career suspended. I remember so well her expression of consternation over the fact that she had been asked to provide training for the successor company. Isn't it ironic that the chair of the southeastern Ontario LHIN was president of the successor company, a private home care company, All-Care Health Services?

Another sad case of undermining the charitable spirit of our community was the transfer of home care service from the VON Kingston to another organization. Not only were full-time salaried nurses turned into casual labourers without benefits, but the CCAC had to disregard the support role that the VON plays as sponsors of Meals on Wheels and other community maintenance services. You don't disrupt the stability of an organization like the VON without challenging the integrity of the community.

Clearly, the health care community is more than just a bottom line. It is a coherent, organic whole. Decisions need to reflect the organic community. Providing for community representation and decision-making and community input into decision-making is critical to the process.

Allow me to digress just slightly. I want to put a human face on the instability created by the picking and choosing of who will do what from year to year. This may not be an outright bidding system yet, but the legislation implies it and certainly involves a radical moving of services in and out of organizations and communities. I was canvassing for a political party a few weeks ago. I knocked on the door of a basement apartment in a lower-market-rent apartment building. The door opened and a middle-aged woman answered, thin and dressed in a low-cost housedress. She was dismayed to see a politico at her door. Almost in tears, she confronted me with her experience as a home care worker. Standing in the doorway, I could see that this woman was living in an apartment furnished with what could well have been Salvation Army seconds. Be assured that the apartment was clean, neat as a pin, and so was she. She was not a disorganized, poorly functioning individual. She related her experiences as a home care worker. A dedicated worker who cared deeply for her patients, she had not been employed by one employer for more than six months at a time. Denied benefits, denied secure employment, she was forced to work as a casual and accept assignments on an on-call basis. Her pay was dismal. She had to find the means to get to her patients at her own cost. What could I do for her, she asked. If my candidate had been elected, you can be sure people like her would have been at the top of our agenda. Instead, it is up to you to act on her behalf.

Bill 36 is an extension of the CCAC system. It needs to be rethought. You have the power to redirect the process. We are all counting on you to do that.

If I had the time, I would have discussed another matter in depth: the power of the minister to redirect charitable property to any health care body, non-profit or for-profit. I consider this to be a travesty. It should be reconsidered. In preparing for this presentation, I researched an extensive, albeit partial, list of charitable donations delivered by the community to hospitals and health organizations in our local communities. The goodwill should not be abused and disrespected by diverting them out of the community that donated them and out of charitable organizations.

For example, I quote from a recent letter in the Kingston Whig-Standard from the chair of the Hotel Dieu and Kingston General Hospital foundations:

"You may be surprised to learn that only about 5% of the total number of children served by KGH and Hotel Dieu must go to Ottawa or Toronto for medical and surgical treatments. This number is so low because our hospitals are able to provide highly specialized, world-class paediatric care to children in our region. The government doesn't provide all of the funding needed for the outstanding paediatric health care we provide, so we must look to our community for help," and they went on to describe the extensive funding that was provided by public charitable donations.

I spoke to a CEO of one of our local hospitals about this issue. He was not concerned. His view was that the ministry wouldn't be so stupid or irresponsible as to close or privatize a local hospital. If it is stupid and irresponsible to move charitable resources into private, non-charitable hands, why include that unfettered power to do so in the legislation?

Thank you for listening to me. I was a bit emotional, but there's a lot of feeling in this.

The Chair: Thank you, Mr. Gventer. You've used the 15 minutes total, so we thank you for your presentation. Have a nice evening.

The next presentation is from the Elementary Teachers' Federation of Ontario, ETFO, Limestone local, Kingston and area. Is anyone here from that group? There's not.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 2875

The Chair: We'll move to the next one, which is the Canadian Union of Public Employees, Local 2875, Ottawa. You can start any time you're ready.

Ms. Roseanne Dean: Thank you. My name is Roseanne Dean. I'm a registered practical nurse and also the president of CUPE Local 2875 at the Queensway Carleton Hospital. I have Doug Allan and Joy Stevens with me.

Once again, the Ontario government wants to transform health care and certain social services, this time by creating local health integration networks, or LHINs. 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 health services have been, as health and long-term care minister George Smitherman says, initially excluded, along with privatized labs and clinics. The government has also allowed doctors to escape the LHINs. If passed, Bill 36 will give the government and LHINs new and troubling powers to restructure public health care and social 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, 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.

The government describes the legislation as a made-in-Ontario solution that would give power to the local level. In fact, the government's reform takes the worst aspect of health care rationalization in other provinces and combines it with the worst aspects of health restructuring in England. It would create a new layer of bureaucracy and would be unaccountable to local communities.

The LHINs cover vast and diverse areas. The LHIN boundaries have been formed based on the 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.

The Champlain LHIN covers the area from Mattawa to Brockville, with a large rural community stretching from end to end, where patients would have to drive long distances and many hours for medical services. The large socially diverse areas covered by the Champlain LHIN also suggest that there will be significant conflict over resource allocation.

What services will the LHINs provide in each area of the LHINs? Unlike government, LHINs will not be able to increase revenue. The smaller communities may be the first to see their services integrated into other communities. The government will control the LHINs' funding and each LHIN will be required to sign an accountability agreement with the government.

1550

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

A key goal of this reform is to constrain costs by integrating services, but this also raises questions about cutting services in local communities. At first, the government talked only of the integration of support services. Cutting back services is dangerous and inefficient. It often requires more highly paid and trained staff to take over the functions formerly done by hospital staff. Hospital-acquired infections already kill thousands in Canada every year.

The government plans to regionalize hospital support services. The Champlain LHIN is already exploring the possibility of a supply chain and an IT system to connect the Champlain LHINs. In the Champlain LHIN, where distances are particularly large, this could add a lot of travel.

Clinical services are threatened, and in the Champlain LHIN, patients will be forced to drive up to a few hours, and sometimes more, for services, as some are already doing for birthing services. Even where distances are measured in driving many kilometres, specialization creates special problems. Instead of being able to deal with their problems at one centre, health care services will be spread over many health care providers, creating a real problem for those with multiple health issues, especially the elderly and poor families.

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, previously at the recently closed Doctors Hospital in Toronto, is supposed to move 1,700 procedures from hospitals and do an additional 5,000 cataract surgeries. This, the minister 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 clinics.

The man behind Canada's first privately owned clinic is setting his sights on Ottawa, which is in the Champlain

LHIN. He intends to open an 11,000-square-foot health diagnostic and physiotherapy centre without long waits. Patients would pay an enrolment fee of $1,200 and an annual basic charge of $2,300. The $2,300 basically covers the medical plan.

Private health care undermines the public system. It will do more harm than good as it takes medical personnel out of the medical system. When you take patients out of the public system, you also take caregivers out of the public system. Universal access to health care is a cherished social program. Private centres provide service for basic ailments and refer patients back into the public system for more complicated matters. That is the cream-skimming part of the operation. They earn the big bucks and leave the high-cost stuff to the public health care system.

This 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 of 1997 to many potential changes in employment that could result. 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. 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 the entity is not the provision of services within the health care sector. This may allow LHINs or the government to transfer work without providing health care workers the right to a union representation vote. We would like to make it crystal clear that the employment security protections in our collective agreements cannot be overridden by this bill.

Because of these concerns, we believe that this bill and the government's attempt to restructure health care need to be rethought. We have made some suggestions for how health care reform could unfold. We urge the government to take a considered and consultative approach.

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

Respectfully submitted, Roseanne Dean.

Ms. Joy Stevens: Good afternoon, honoured members. My name is Joy Stevens. I'm a registered nurse and I have a PhD. in ethics. I work in the area of community mental health outreach and addictions. The topics I address today have to do with how Bill 36 affects and impacts these areas.

I am troubled to see that community mental health outreach and addictions are not specified in the act at all. I will begin with a discussion, briefly, of the strategic plan. I understand that the integrated health service plan needs to be consistent with the ministerial plan. To accomplish this, the LHIN is expected to engage the community. I have some concerns about that because I believe that the structure actually creates barriers to local community control. There's no ministerial obligation to fully consult the community prior to imposing the accountability agreements, and this is troubling. We need to define what we mean by "community" and "community engagement" and "decision-making at the community level."

Since community mental health and addictions are not mentioned in the act, these are areas in which there is a need for consultation with the affected communities. We need just representation of the health sector employees and other health professionals on the advisory committees that are mentioned in subsection 16(2) of the act. I remind you that public interest arises whenever the aims of quality improvement and fiscal responsibility in public health are considered together.

My second point is on the funding model. We do not know exactly what the funding model is going to be like. We do not know how funding to, say, heart disease or schizophrenia is going to be allotted. As the act, again, is silent about community mental health and addiction services, I urge you to set aside protected funding for these services. In other words, the local health integration networks need to be adequately resourced to fulfill the important mandate of these community services. I want to remind you again that these are preventive services, preventive strategies, because they not only improve the quality of life in the community—and I've seen that—but they respond to the importance of economic efficiency in reduced hospitalizations.

On the boundaries, the vast area that's covered by the LHIN boundaries cannot represent local community interests. With government control from the ministry level to the board level, and with pre-existing accountability agreements, we're concerned that funding can be flatlined or reduced. The boundaries of expansion for health services are increased, but secretive budget cuts can be, and have already been, the case. Since community mental health and addiction services are, again, not specified, we're concerned about protections.

At my workplace, we've already lost an important service through the cutting back of the extended hours team. The extended hours team used to work until 12 midnight seven days a week. These services were cut to 8 p.m. With mental health patients, this is a concern. What happens is, the clients are left with seriously unresolved issues. They're left to wait till morning. This is very difficult for people with severe mental illness and addictions. In the morning, community support workers take up the slack, and then their clients, who are seen on an appointment basis, are the ones who suffer and have to wait longer. I've seen the results of this in clients who react with anxiety, helplessness, paranoia, anger and many acting-out behaviours. So in this sense, the system makes them sick.

Number 4, the not-for-profit character of community mental health and addiction services is under threat, and this is quite a concern. We know that privatization is a buzzword for seizing profits. Instead of integrating a service, please know that the competitive bidding process

will fragment it. It will leave it vulnerable to cheaply acquired and often lower-quality service provisions.

Please remember that in community mental health and addiction work, relationships of trust with clients are vital, and these take many months or years to establish. Quality engagement holistically involves levels of multiple domains that include psych care, physical health care, legal issues, housing advocacy—many of our clients are homeless—and spirituality, to name only a few. Purchaser-vendor agreements have the potential to shatter these therapeutic relationships and to cause harm. I'm really concerned about that. As I say, relationships of trust are so vital in this work.

In addition, in community mental health and addictions we're not tightly organized with language in collective agreements to provide employment security, so I do urge you to take care to protect working conditions, bargaining rights and employment guarantees, which are respected by all parties to a purchaser-vendor contract. I remind you, too, that the terms of collective agreements are devised by persons who are involved in and who are most knowledgeable about the nature of the work they do. Thus, collective agreements affecting the work conditions and lives of devoted outreach professionals must not be overridden by Bill 36, and I do urge you to clearly stipulate this in the act.

1600

Finally, free enterprise in a health care system: The basic premise of Bill 36 is equal access to health care, and the vehicle for accomplishing this is integration of services in purchaser-vendor agreements. The values that govern free enterprise and those governing delivery of health services very often conflict. That's because the economic rationalist aim and the aim of optimum health care for each member of a community entail different responsibilities. The former system is geared toward efficiency and profit, and the health care system is based on optimizing the health of all community members, and this is a common good. Decisions about health care are substantively different from business decisions. Furthermore, the values that are given priority in any decision will differ among people according to your beliefs, your experience and your professional background. The omission of community mental health and addictions in the wording of the act speaks directly to the values and aims of the architects of this act, and that's troubling.

Who makes what decision is critically important, keeping in mind that health care decision-making affects all of us. So I'm asking you: What kind of ethical framework was applied in the design of Bill 36? I suggest that every decision needs to be vetted by an ethics committee which is made up of persons with training in ethics—unbiased professionals who can clarify ethical boundaries, who can identify unsound and unfair proposals and who can help to formulate an example of ethics-based health care legislation. Thank you.

The Vice-Chair (Mr. Khalil Ramal): Thank you for your presentation. Your time is over; you used your 15 minutes. There is no time for questions. Thank you.

OTTAWA RAGING GRANNIES

The Vice-Chair: Now we have a second group with us: the Ottawa Raging Grannies.

Ms. Pat Howard: We're going to sing you one verse of a song, and then—

The Vice-Chair: Excuse me, before you start, can you mention your names, if you don't mind, for the record?

Ms. Ria Heynen: My name is Ria Heynen.

Ms. Peggy Land: My name is Peggy Land.

Ms. Joanne Bennett: Joanne Bennett.

Ms. Howard: Pat Howard.

Ms. Jeannette Pole: Jeannette Pole.

The Vice-Chair: Go ahead.

Ms. Howard: Later we'll treat you to the rest of the song.

L-H-I-N-S—more bureaucracy
  What would Bill 36 do for you and me?
Centralize services, less democracy
  Too much power in the hands of one ministry.

Ms. Land: There's more to come. Thank you for this opportunity. I'd like to share some of my own experiences within the health-service-providing community in which I have been working for many years. I would like to emphasize that these are my experiences; I don't speak for my profession. But I have been working for 35 years as a physiotherapist and have witnessed the steady erosion of public accessibility to health care under OHIP, especially for physiotherapy. Sometimes I'm also a Raging Granny, and I'm pleased to be here to speak for those women especially who are vulnerable and in need of quality health care.

The concept of locally-integrated health care is a good one, but if such services are to be contracted out under an LHIN umbrella, then I foresee serious problems with this plan and that it can only deliver results that are very inferior to the current system of medicare and hospital-based services.

In the 1960s, all physio was provided through OHIP in hospitals. Some of you will remember this. People got the treatment they needed. Therapists provided the care that was needed. We were all paid salaries, not per-patient visit. There was no conflict of interest, because there was no profit to be made. There were no privately—or combination private-public—funded clinics. Then OHIP paid some private clinic owners to provide additional outpatient physio, and the physios were paid by the visit, in part through OHIP and in part by the patient. This is where things started to go really wrong. We were not paid very much, had no job security and no benefits, and often had to see more people per hour than we were used to seeing in hospitals. Two per hour for outpatients is adequate, but four is assembly line. If you've ever experienced being one in four people being seen in an hour by a physiotherapist, you'll know what I mean. Sometimes it was, and still is, worse than four per hour, depending on the amount paid per therapist and the pressure placed by clinic owners. We found that, gener-

ally, when visit time is shortened it takes more visits to get people better. It's that simple. But more visits paid more money, and of course there was a conflict.

Clinic owners had sold their businesses for escalating amounts until it was not uncommon to pay at least $1 million for such a little gold mine, but the costs only got passed on to those patients who could pay to avoid longer waits in ever-shrinking outpatient clinics in hospitals which were being steadily underfunded themselves.

This situation has not gone away and threatens now to be instituted in LHINs, in my opinion. The clinic situation has continued to worsen. When clinic owners found out that physio could be mostly covered by extended health insurance plans for some, they could charge more per visit. This was supposed to mean that the physios could be paid more and thus see fewer patients per hour. But, given the escalating costs of rent, equipment and office staff, and that physios were hired as independent contractors, not by the hour, the temptation was, and is, to pressure the therapists to see more than two patients per hour. Again, the patients were, and are, the losers because no matter how much they pay they are often rushed through, given insufficient time per treatment, and limited by their own insurance coverage in number of visits as well.

A growing number of privately owned clinics are now actually part of larger chains. Physio has become franchised and very competitive. Not all, but some, are parts of franchises. Some clinic owners are getting rich in the process, but it is not uncommon for therapists to have two or three part-time jobs, all insecure and not well-paying. Two years ago, the hospital outpatient clinic I was working in was closed down because of underfunding. But about 85% of its costs were for salaries of staff; the space and equipment were already owned. So our expenses were very low and we offered a very good service—so good that some referring doctors told people to wait, that they would be better treated than in some private or semi-private clinics. Our waiting list was six months, and now it's up to two years for the only remaining open-access OHIP clinic in the city.

I have to apologize for some typos in my handout here; I wrote this on my lunch break.

Nonetheless, hospitals have become the employers of choice again because physios, speech and occupational therapists, dietitians, social workers, nurses and RPNs are unionized and—dare I say it—get fair salaries and, best of all, have no conflict of interest to deal with.

Under a system of contracting out, LHINs will never be attracting the best-qualified staff, because they will be working in hospitals. People want quality time with their health care providers, they want not to be treated as numbers, and they want timely treatment too. But real health care is about all of this, not just part, and it is not found in for-profit, conflicted situations which would be built into LHINs, which contract out.

I think it would be better just to put the money it will take to run LHINs right back into the not-for-profit hospitals and let them deliver the same services.

Meanwhile, what assurance can you give me that the LHIN plan does not include awarding contracts to the lowest bidders, and what assurance is there that bidding will not be restricted to even only Canadian-owned providers?

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In the same way that Wal-Mart practises predatory pricing, health care franchises and chains can set up business and offer cheaper prices initially, plus inferior service, until the competition is killed off, and then just raise their prices. How would LHINs prevent this from happening?

Of course, a growing population of aging baby boomers and the elderly, living longer but not necessarily better, has put enormous strain on the whole system. A sadly high proportion of the poorest are elderly women with no extended health care coverage, often living alone and becoming more and more vulnerable. They remind me every day that growing old is not for the faint of heart, and I agree.

How will LHINs provide better care for people, especially the frail and vulnerable, when they themselves—the LHINs—are inherently conflicted and unaccountable? I hope you'll seriously consider these concerns before jumping off what looks to me to be a springboard to contracted-out disaster.

Now we'd like to finish our song for you.

L-H-I-N-S—more bureaucracy
What would Bill 36 do for you and me?
Centralize services, less democracy
Too much power in the hands of one ministry.

This complicated bill.
The one they want to pass
It seems to us it will
Become a horse's ass.

The privates they would bid
On services we get
We're headed for the slippery slope
And through our safety net.

L-H-I-N-S—it's a horse's ass
It's plain to see
For you and me
It should never pass.

We'll just take note of how they vote
And notify their mothers
And then we'll all get down to work
Replace them with some others.

The Chair: Ladies, we do have a minute each. I think Mr. Wilson may want to continue the singing.

Ms. Heynen: I would like to say a few words before we finish. In the first place, please, the Raging Grannies are dead serious. As you heard, the Raging Grannies, although not claiming we are experts on the issue, have a deep distrust of Bill 36, which will create the local health integration networks. The legislation is so unclear, so

vague, it makes our old—but don't forget, still rather wise—heads spin.

One of our conclusions is that LHINs seem to give enormous power to the boards of directors of the 14 regions, which are appointed by the government. Public input, I think especially from the health care workers themselves, will be missing.

Since the Liberal government has been shown to favour the private sector in our health care system—I'm just thinking of the two P3 hospitals, and are there more to come; and what did they promise during the election?—what, then, are the instructions given to the LHINs? How can we know what our government is up to? It seems that all restrictions, as far as I can figure out, are off in regard to keeping our health care system public. Indeed, there seems to be no protection against for-profit privatization in this legislation.

The Grannies are shuddering at what LHINs might mean for our home care, for example, for psychiatric care, for our health care workers themselves and for our local services. This whole system could very well develop into a very costly, bureaucratic, unhealthy, competitive nightmare, not to mention the legal wrangling it will create.

To begin with, if this government wants to pursue it, then it is their duty to provide enough clear information on Bill 36 which every person here in Ontario can understand. The public has to know about and be fully involved in this radical restructuring of our health care system. Yes, the public has the democratic right to even reject Bill 36 and agree with what the Grannies sang:

L-H-I-N-S—it's a horse's ass
It's plain to see
For you and me
It should never pass.

Thank you very much.

The Chair: Down to 30 seconds each.

Mr. Wilson: Thank you very much, ladies. It was enjoyable. Of course, I'm in opposition, so I really liked your song. I'd just say thank you. A number of the points you made have been made before, but to have people with your seasoned experience come before us, we appreciate it.

Ms. Martel: Thank you very much for your presentation here this afternoon. Let me just say with respect to the very serious comments that were made regarding competitive bidding that if the government means what it says, that competitive bidding is not going to be used by the LHINs to acquire services, then they need to put that in the bill. Then we might all have some comfort that that is indeed the case, but because it isn't in the bill, you and every other group are right to come before this committee and raise your concerns with respect to this very important matter. Thank you for doing that today.

Ms. Wynne: Thank you very much. You are wonderful.

You used the word "centralization," and many groups have talked about their concerns about centralization. How is taking $21 billion and the responsibility for allocating and making a plan for the distribution of money and identifying gaps in a region—how is taking those responsibilities and putting them in the hands of a local health body like a LHIN centralization, when right now those powers and the control over that money sits in the ministry at Queen's Park, in the hands of the minister? How is it centralization to put that into the community? I'm supporting this. I'm happy to be doing this because I see it as a decentralization and a giving of control to local bodies.

Ms. Land: I spoke to the importance of funding our hospitals, and I just see this as the imposition of another structure that's going to make a whole lot more bureaucracy. It centralized in that it's from above; it's imposed. But people aren't necessarily asking for this; what they're asking for is better-funded hospital care through medicare. I think that's all we're really asking for.

The Chair: Thank you very much for your presentation and for answering the questions. Have a lovely balance of the day.

I'll go back to the Elementary Teachers' Federation of Ontario. Is someone now here? That deputation was to be at 3:45. Is someone here? That is the Elementary Teachers' Federation of Ontario, Limestone local, Kingston and area. There's nobody, so we'll move on to the next one.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 870

The Chair: The next presentation is the Canadian Union of Public Employees Local 870, from Ottawa. You can start any time you're ready, for 15 minutes in total, please.

Ms. Susan Arab: Thank you for the opportunity to present before your committee today. My name is Susan Arab; I'm the servicing representative for CUPE Local 870. Bonnie Soucie, the president of CUPE Local 870, who was originally slated to present today, is home sick with the flu.

I am speaking on behalf of Local 870, which represents approximately 600 workers at the Perley Rideau Veterans' Health Centre. This is a not-for-profit long-term-care facility here in Ottawa that provides services for both veterans and community members.

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There are many elements of Bill 36 that are extremely worrisome. From a union perspective, the impact that the LHINs will have on the health sector employees, their jobs, their salaries and their benefits, will likely be devastating. But Bill 36 hurts more than health care workers. It will hurt health care services, it will hurt the people who rely on those services, and it will hurt the individual communities where those health services are currently provided.

I want to focus on three areas where Bill 36 will both impact on services and devastate health care workers' jobs and livelihoods. First, I believe Bill 36 will foster the establishment of a competitive bidding model in the

provision of at least some health care services, and it's possible that Bill 36 will allow the establishment of a competitive bidding model that could reach eventually to encompass most health care services provided in Ontario.

Second, we're very concerned that Bill 36 will open up the health sector to widespread private, for-profit delivery of both clinical and non-clinical health care services. Certainly, as I will discuss below, a competitive bidding model has been known to foster commercial interests in the health care sector over non-profit community-based interests. Furthermore, the powers allocated under sections 28 and 33 of the act could easily result in the transfer of huge portions of our health care system from the not-for-profit agencies and organizations to for-profit commercial ventures that currently have little or no experience in the health care sector.

Finally, we have a concern with the fact that the act ensures that those who make decisions regarding health care, namely the LHINs, are virtually unaccountable to the affected public.

On competitive bidding: Bill 36 will create the conditions to establish competitive bidding among health care providers, not just in the home care sector, where it is currently being used to the detriment of home care clients and workers, but throughout the health care system. I'm sure that government members on this committee are likely to protest and say that nowhere in the legislation is a provision that establishes competitive bidding. However, a close reading of the legislation, in conjunction with the Minister of Health's own comments, indicates that competitive bidding will be the outcome of Bill 36.

If you look at sections 19 through 21 of the act, they stipulate that LHINs can fund health services on terms and conditions they consider appropriate. The act also stipulates that LHINs must allocate funding in keeping with the strategic plan of the Minister of Health. The Minister of Health has indicated that his plan for future health care funding is to set prices for hospital services on a service-by-service basis. Instead of global funding, hospital services will, in the future, be provided on a—dare I say it?—fee-for-service basis. The minister has already identified five clinical services that will be the first to be funded in this fashion: cataract surgery, hip and knee replacements, cancer care, MRIs and CAT scans. The amount of funding for each of these services will be set by the LHIN, and the LHIN will put out to tender who will provide these services from among the health care facilities.

The powers provided to LHINs under section 26 of the act will allow the LHIN to set the prices for the health procedures; set tenders, if they choose, among health care providers; move from global funding of health services to a fee-for-service model; and purchase a service. These are all key elements that can open the way to competitive bidding in the health care system that we have today.

Mr. Smitherman also indicated in his press conference and in interviews that other health and possibly even social services will follow on this model. This is extremely unfortunate, because the experience of competitive bidding in Ontario home health care has been devastating for health care workers and their clients. As you know, the Conservative government introduced competitive bidding in community-based health care in 1995. Agencies got to bid on a three-year contract. They also cut beds in the hospital sector, arguing that they could move those services to the community. What happened as a result in the home care sector was that stability vanished. Long-standing not-for-profit community agencies have either gone bankrupt, have closed or have been severely decimated. The VON in Kingston is closed; the VON in Hamilton is gone. Visiting Homemakers in Ottawa was devastated by cuts two years ago when they lost their CCAC contract. Years and years of agency experience and history in community home health care has been wiped out in under a decade. Instead, we have large commercial health care corporations with no connection to the community they serve. The most reliable figures show that the percentage of home care nursing market share provided by for-profit corporations has increased from 18% in 1995 to 48% in 2001.

So for health care staff providing home care, it was and is a race to the bottom. Agencies that won CCAC contracts cut labour costs to win the tender. Staff lost their modestly paying full-time jobs. They found less-well-paying part-time jobs. Turnover of staff was and continues to be huge. Home care clients suffer from the lack of continuity of care.

Dr. Jane Aronson is a professor of social work at McMaster University and has spent the last several years studying the effects of competitive bidding on women in the home health care sector, both the women clients and the women health care workers. In an interview with the Ontario council of hospital workers she described the insanity of competitive bidding. If you'll indulge me, I just want to quote this. It's a long quote but it's quite interesting.

"The organization and the home care workers who I followed here in Hamilton experienced this cutting and demoralizing process in the early years of managed competition. But then in 2002, when the rationing of supportive home care became more pronounced and more clear as a central injunction to CCACs, the demand for home support services in this community and other communities all over Ontario started to plummet very suddenly. And non-profit organizations like VHA couldn't accommodate it because they had infrastructure, they had unionized employees, so they couldn't start asking people to take wage cuts or start laying people off in an unsystematic way. They couldn't sustain their structure. And they asked the CCAC, the government, local MPPs, can we renegotiate our contract price for now, partly because we have 2,500 clients here in Hamilton who will suffer if we go under. And also because the alternative providers in Hamilton, which were all for-profit companies except one, actually had contracted with the CCAC for higher rates, so it'd actually be a cost generator for the CCAC to see them go under. All those appeals went nowhere and they were told the contract had to stand as it was, that market rules

prevailed, that nobody could do anything about it. So the agency declared bankruptcy. Three hundred-plus workers got laid off—front-line workers—and 2,500 clients had to be transferred to other agencies. So major disruption for those clients and for the workers concerned.

"I followed them out twice, a few months after the closure and then a year after, and 62% of them had left home care altogether. Some of them were still unemployed at four months; 62% said they would not stay in home care. One woman I remember saying to me, 'I can't afford it.' Of those who did, 38% of the total—it was a group of about 45 or 50—went to alternative employers, most of whom were for-profit.... One woman I remember particularly said, 'I went to agency X, because this elderly person I'd had a relationship with for years, who was used to me, who I didn't want to see suffer—they transferred her there so I went there too.' When she got there, she got paid less. So there was a sort of irony: She got paid less while her new agency got paid more by the CCAC than had her defunct, bankrupt non-profit agency. And this was deemed a reasonable decision."

If the Ontario government is sincere in its assertions that they have no intention to introduce a competitive bidding model into the broader health care system, then concrete safeguards have to be written into the legislation to this effect. Bill 36 must be amended to ensure that services will be integrated only amongst not-for profit providers and that the government will not use competitive bidding in the allocation of funding for health services.

The second issue is the privatization of services. There are two sections in the act that point to an agenda to privatize health services and increase the delivery of health services by for-profit companies.

Section 28 of the act essentially gives the Minister of Health the right to seize the assets of a not-for-profit health care service and transfer those assets to another health care organization. The Minister of Health does not have similar powers with respect to for-profit health care services. As a result, the minister could, under Bill 36, seize the assets of a not-for-profit home for the aged—say, for example, the Perley health centre—and order it to cease operations, fire the board of directors and generally significantly change the ownership structure. However, the minister will not have similar power over a for-profit nursing home in the same city—for example, Extendicare or Versacare. As a result, if there is a determination by a LHIN that there are too many long-term-care beds in Ottawa, Bill 36 provides protections to for-profit nursing homes at the expense of not-for-profit homes for the aged. That, in and of itself, will mean that not-for-profit agencies will be at a significant disadvantage when decisions are made to rationalize health care.

Second, section 33 of the act allows cabinet to order any public hospital to cease performing any non-clinical service and to transfer it to another organization. This means that the government can centrally dictate how all non-clinical services are to be provided by hospitals, long-term-care facilities and other health providers. It allows cabinet to privatize the delivery of these services by contracting them out to companies like Sodexho, Telus or IBM without debate. It allows cabinet to take these services completely out of the purview of the health sector.

My first issue with this section is its general assumption that non-clinical services are not really health care and can be provided by a non-health-care provider. All of our members, whether they are in the kitchen cooking the food or in the bathrooms cleaning the toilets or in the office organizing the records, are health care professionals. The work they do is part of the health care system and needs to be recognized as such. In our hospitals, these employees risked their lives to go to work during the SARS crisis. Hospital cleaners, as we all know, are vital to preventing the spread of infection, and every food and nutrition employee can tell you that you don't get well if you don't eat well.

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Section 33 gives cabinet the authority to contract out these services despite the wishes of the health facility. Not only will it result in significant layoffs and job loss for our members; it will also mean that our public dollars are being spent on the profits of corporations instead of on improving care. Just to let you know, CUPE will not stand down if these services go to companies who are going to skim 10% or 20% of their revenues towards profit. This is not an efficient spending of public health care funds.

If the provincial government is sincere in its claim that Bill 36 will not result in the increase of private for-profit health care, then sections 28 and 33 should be scrapped.

The final section that I want to comment on is the issue of accountability and consultation. We have strong concerns regarding the dearth of mechanisms to ensure that the public have a say in LHINs decisions before, during and after they are made. The LHINs are not structured to conform with the known community of interests within our province. They do not conform to our political boundaries at the riding level, at a municipal level or even at a regional level. What does Bancroft have in common with Scarborough? What does Deep River have in common with Ottawa? Civil society does not structure itself around the boundaries created by the LHINs. There is no political history or political culture that allows the people in Cornwall to travel three and a half hours to meet with people in Mattawa.

Board members are not elected by and are not accountable to the population that they serve. Board members are appointed by the Minister of Health. They are accountable only to the Minister of Health. There are no specific provisions in the act mandating meaningful consultation, transparency of decision-making or public avenues for appeal. Board members do not answer to the public for the decisions they make. Members of the public have no legislative vehicle for protesting decisions made by the LHINs.

I have a series of recommendations that we are proposing:

We need to provide for the democratic election of LHIN directors by all residents in the geographic area.

There should be a requirement in the bill for extensive public consultation on the existing geographic boundaries of the LHINs. LHIN boundaries should reflect the real communities of health care interest so local communities can have an impact on LHIN decisions.

We need a ministerial obligation to meaningfully and fully consult with the community prior to imposing an accountability agreement.

We need a requirement that each LHIN must establish a health sector employee advisory committee made up of union representatives and representatives of non-unionized employees.

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

Thank you for listening to our concerns.

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

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1559

The Chair: The next presentation is from Rebecca Phillips from CUPE, Local 1559. CUPE, Local 1559 already spoke earlier. I believe that's the second one from the same union?

Ms. Rebecca Phillips: Yes.

The Chair: All right. Please proceed. You have 15 minutes total time. You can start any time you wish.

Ms. Phillips: My name is Rebecca Phillips. I represent CUPE, Local 1559. I've worked at the Access Centre for Community Care in Lanark, Leeds and Grenville for 16 years. It's taking an extraordinary effort for me to be here today to speak to you. Unlike many who have spoken before me, I am a novice at public speaking, so bear with me. But I strongly wish you to hear our concerns about Bill 36.

All of us want quality health care for Ontario. We want quality employment as well, and viable communities. That's important. Bill 36 is a start, but it most certainly needs amendments.

Our first concern is that there is no community control. The legislation ignores accountability to health care users. There is no community control of health care, largely because the board would be appointed, yet the minister talks about bringing decision-making closer to home. An appointed board covering my LHIN area, from Belleville to Cardinal and north to Madawaska, is not what we call close to home. There isn't anything in the legislation that ensures that all communities will equally be part of the decision-making—or be part of the decision-making at all.

Mr. McNeely, representative of Ottawa–Orléans, mentioned in a recent assembly debate that they will get a large LHIN area with Ottawa being the core of it. In referring to the LHIN board CEO and chair of the LHIN board, he said: "It will certainly be a group of people who will be able to make the decisions to the benefit of the people in the Ottawa area." Then he continued on to say: "We're going to have equity in the system."

There's no equity in a system that will pull away health services from small communities. If services go to the companies and agencies that are best set up to handle mass quantities of patients for procedures like cataract surgery, eventually hysterectomies and other procedures, the smaller communities that make up a large part of Ontario will suffer. In the evaluation process of the bids, it seems reasonable that locations requiring the least amount of people to travel would be preferred, which would mean cities with larger populations like Ottawa, Kingston and Belleville. Of course, larger cities are doing the majority of procedures anyway, but certainly if small communities don't have a voice, more and more of the procedures that we perform now will get pulled away. It will mean far fewer jobs.

It will also mean travelling unreasonable distances too often to obtain services. If I had more time, I could describe to you the painful challenges that people in our community already have getting to health services. I provide information and referral for the access centre. I take calls from the public looking for community services like transportation. I know the challenges that they face. Centralization will make accessing health services many times worse for seniors, disabled people and those who don't or can't afford to drive. Any health care money gained through efficiency will be needed to pay for transportation to access care.

We want someone on the LHIN board from our community, someone who we feel is open to listen and can relate to the health care needs in our community and who is accountable to us, the health care users. The legislation needs to be amended to provide for each community the right to elect a director for the board, with the chair and vice-chair being selected by the directors. Local members of the provincial Parliament should be ex-officio directors of the LHINs. It is our health care dollars and our care, and we want someone that our community elects to make the decisions that will affect us in the LHIN model.

Our second concern is that privatization causes job instability and results in decreased quality of care. I want to speak to this because I work at the access centre and we care deeply about the work that we do, doing all that we can so that people receive the care they need when they need it. I see and hear what competitive bidding is doing to jobs as well as the care that patients receive because, as you know, the LHIN model will be based on the contract model that the access centre uses.

Mr. McNeely said that the LHIN "transition is the right thing for health care and there are going to be growing pains and certainly people will be hurt during the transformation." Yes, there will be growing pains, and yes people will be hurt during the transformation to privatization, but it doesn't stop there. Ask health service workers being bounced around from service provider to service provider, depending on who has the contract for home care with the access centre, if they were hurt during the process. They would tell you that they wish it only hurt during the transformation because, in reality, it is the

perpetual never-ending job instability that hurts. Being laid off and having to reapply for the same job with another company each time a contract ends—there is no end to the hurt with this competitive bidding model. This government can do much better for Ontarians.

Unlike non-profit services, private companies provide the service to make a profit. To get the contract but still make a profit, they employ part-time or on a contract basis. If this legislation is passed as is, up to 200,000 Ontarians risk losing secure, full-time employment for part-time or contract work with significantly decreased wages and decreased benefits or pensions.

When the ministry switched access centres to a competitive bidding model to decide which agencies would provide their in-home and school health services, it opened the bidding up to private companies, just as the LHIN legislation would do on a much larger scale. As a result, private companies came from nowhere with large purses and underbid the non-profit companies. They got the contracts and forced the non-profits to close. Laid-off employees then had to apply for their same jobs with the company that got the contract, at less pay and less benefits and no job stability because in three years, when the contract ended, they were out of work again.

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Two days ago, I was talking with a nurse coordinator whom I see often. She works for a private company that has a contract with the access centre. We ended up talking about the different services that they provide and how their company has grown. She pointed out that when they got a contract to provide home support for the access centre, they hired close to 200 home support workers. We both wondered what they will do with those 200 home support workers when the contract ends. Neither of us said this out loud, but I knew she was thinking that too. They will ultimately be laid off and have to reapply to the agency that gets the new contract, likely getting rehired for less pay and benefits. Competitive bidding has driven wages and benefits down in the home care model.

Last week, I bumped into an occupational therapist who works for an agency that has a contract with the access centre. She told me that she was hired by the company on contract; she used to be a full-time, permanent occupational therapist for the access centre. I'm not sure how her contract works, exactly. I asked her how she liked it. She shrugged, with a look of apathy, and replied, "It's fine if you don't need benefits." I asked her if she needed benefits, and she said yes.

The legislation opens the door for privatization of services. What you need to know without a doubt when you make recommendations for changes to Bill 36 is that if privatization and competitive bidding aren't safeguarded against in the legislation, then quality of jobs and the quality of services for Ontarians will suffer.

When the VON closed its doors in our community—sorry, I need to correct that: They didn't close their doors; they stopped providing nursing services when they lost the work from the access centre—I am told that 90% of those nurses went to the hospital sector, because they didn't want to work for a private company for below-normal wages, with minimal mileage and no benefits. One company now, rather than paying hourly, I am told, pays based on a set time for each procedure: for example, 20 minutes for a dressing, 10 minutes for a blood pressure and so much time for travel based on the distance. Therefore, the more patients the nurses see, the more they are paid. They must try to see as many patients as possible to be paid as much as hospital nurses.

The pressure these companies have to make a profit takes its toll on patient care. Often, staff are not guaranteed full-time hours, yet they need a certain number each week to qualify for benefits, so often employees have no benefits, not to mention a pension.

A nurse who has worked for both non-profit and private companies described to me how one loses their sense of dedication and respect for their employer, how one has less enthusiasm and respect for the job that they do when the almighty dollar comes before the patient. I think this would be true in all health and social service jobs. It doesn't matter whether contracts are awarded based on price or not; without a doubt, a profit is what private companies will be looking for, and they are the ones that will be providing the services. Therefore, we can avoid negative effects on jobs, people, service provision and our communities if the legislation includes concrete safeguards built into the legislation to prevent competitive bidding and contracting out.

If I had time, I would tell you more about how privatization affects quality of care, but let me just say that a case manager told me that they were seeing a lack of dedication from companies that set up shop because they get a contract. For instance, a company was given a contract for medical equipment for the CCAC. In one case, they delivered the wrong stomach tube for feeding a child. A weighted tube was ordered, but a plain tube was delivered. They couldn't use it to feed the child. When the case manager called to have the correct one delivered, she was told that they didn't know when it could be delivered. Their company was from a city larger than ours, so it was a distance away, and it would be some time in a six-hour window when they could deliver that tube. The case manager was mortified, knowing how the child's mother must feel, not being able to give her very ill child nourishment. She told me that there is a distinct and definite difference in the sense of dedication and obligation between a company that sets up or expands to a community just for a contract and a company that was part of the community and has a history with the agency. Contracts negatively affect quality of care.

There isn't the sense of community or obligation to take care of the people in the community. She described that when private companies pay below normal, pay low mileage and don't have a pension plan, nurses and homemakers don't go out of their way, because they don't feel respected for what they do. We all know that we get what we pay for in everything.

She told me that it's harder and harder in small communities to get homemakers and nurses, because the companies don't pay them enough. Access centres have

waiting lists for services because there aren't enough nurses and homemakers employed by the agencies. The access centre even has a waiting list for palliative care. Access centres strive hard to arrange care for people in their homes when they need it; illness and death don't wait.

Is this the right thing for health care? This government has come up with legislation that's based on the principle of whoever can provide the best care in the best fashion will be providing that care. If this legislation is passed as is, this government can add "at whatever cost"—the cost of quality service, decent jobs, community viability and access to care.

In conclusion, we ask that this committee strongly consider supporting that the following two amendments be made to the legislation so that the viability of small communities, job stability and quality of health care are protected: Specifically exclude competitive bidding from the legislation and provide for each community the right to elect a director for the board, with a chair and vice-chair being selected by the directors. Local members of the provincial Parliament should be ex-officio directors of the LHINs.

We'd like to thank this committee for listening to our concerns and suggestions.

The Chair: Thank you for your presentation. We'll move on to the next presentation. There is no time for questioning.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1974

The Chair: The next one is the Canadian Union of Public Employees, CUPE, Local 1974, Kingston. Louis Rodrigues? Please have a seat at the front. You will have 15 minutes if you wish to speak to us, and if there's any time left, we will be able to potentially ask questions of your statement. Thank you.

Mr. Louis Rodrigues: Thank you. My name is Louis Rodrigues and I am the president of the Canadian Union of Public Employees, CUPE, Local 1974, representing over 1,400 hospital workers at Kingston General Hospital. As well, I hold the position of first vice-president of the Ontario Council of Hospital Unions, OCHU, representing approximately 25,000 hospital workers province-wide. I am pleased to be here today to express concerns on behalf of my members.

I submitted my submission; I was hoping to do my submission, but actually get into some personal issues, not the follow-through, as I'm sure you've heard—I've been here most of the afternoon, and it gets repetitive. They are major issues, major concerns, but I don't want to go on and on over the same issues.

At Local 1974, we have the same concerns as expressed here earlier: privatization, contracting out and competitive bidding. I've heard the response from the committee that that's not the intent or whatnot, and like previous speakers, I do say that if that's not the intent, let's make it clear.

I've been an employee of Kingston General Hospital since 1972. I started working there in the kitchen as a cleaner. Over the years, I worked myself up to chef. I'm a certified chef, and the reason I say "certified" is, I used to take a lot of pride in what I did. A time came when regionalization and restructuring were major factors across the hospitals in order to save money. Our food comes from Ottawa, the hospital food service, HFS. Our food comes in in bags and containers. It's frozen, and we heat it up and send it to the patients.

I did not lose my job; I lost my dignity. I used to have pride in what I did. I'm still employed; I'm still making the same wages—I don't mean I'm making the same wages; we've negotiated a new collective agreement. I continue to work there and get the essential increases that we were able to attain through negotiations. But what I lost was the dignity of providing the services that I was qualified to do. I took a lot of pride in preparing the best food possible. I spent a lot of nights going to school, raising my family and earning—at that time, it was probably around $7 an hour, looking at 1972, to do the services that I thought I could do.

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My family was in construction. I quit school at the age of 16, and it was important to me to put some time in, because my dad wouldn't have me in the company: I was too young to go into construction. I fell in love with the environment of the hospital. I wasn't too bright then—not that I'm any brighter now; I'm still there. But it was something you learned. You got to know these patients, you got to know the people. I took a lot of pride in it.

If I can turn the clock back, I wasn't born here. I was born in Portugal in 1955. I emigrated to Canada in 1966. What a wonderful country—not that the climate was any better; I'm from the Azores. But the opportunities that we had here—education was really, really important. My children have taken advantage of it. I was at an age where it was a little more difficult for me, but what was offered here was for everybody; most important, the health care services.

I don't know if we have the best health services in the world, but they rate among the better. I come from a small community, and the closest hospital—I'm just estimating here—is probably a two-hour drive away. I had surgery in the hospital—an arm. I can show you the scars, and I'll have them for life. The surgery went well—good hospitals, good doctors—but no services in my community for after the surgery. What I have are scars that will be with me for life. My brother, at the age of five, fell and cut his ear. It was just hanging through the bottom. He had to be transported to a hospital miles away. He also has scars for life. We do have doctors, and it wasn't that the community I come from was still in the horse-and-buggy era. Actually, the doctor drove a Mercedes. But the first-come were people who had the cash to pay for the services. How many children were lost on the way to the hospitals? How many people have suffered injuries that will be with them for life? I don't know that. I know that it's important. But I'm not here to speak about myself. My parents also emigrated and I'm

proud to say that everybody in my family is a Canadian citizen by choice.

What was the most important thing here? Freedom. We come from a country where dictatorship was the norm. Here, we had the freedom. Slowly, we see it going away when, through legislation, through a proper process, people make decisions that impact whole communities on how something as important as health care—you can say education or social services or whatnot—can be changed through legislative dealings. I'm not saying it shouldn't be changed. It should be consulted. Talk to people. What's the impact?

I'm not sure what the act actually says. We hear from the people who advise us that there are a lot of dangers in this bill. We hear from the promoters of this bill that that's not the intent. For me, it's a very simple solution: If it's not the intent, why does it exist? I don't want to say that we've been fear-mongered; that's not it at all. Why is it that our people feel that there are dangers here? Through previous restructuring in Kingston, we can talk about what happened with the Hotel Dieu and Kingston General Hospital. It was the same as these LHINs: local agreement. Local agreement was wonderful when they were doing the paperwork. Once the ink dried, everybody was in the courts. It took years. Hotel Dieu was slated to be closed. It's still open today. I'm glad to say that both hospitals are working together and moving forward, but it took a long, long time, major expenses and a lot of animosity within the community.

We see this as opening up the door to many, many downfalls. We've seen that in Picton. There were services there that were supposed to be closed. They mounted a campaign with over 500 people showing up at their meeting to talk about the closure of these services in Picton. We don't want to see major disruption in the health care sector. We need to rethink where we're going with the health care services.

We have a lot of issues that we can talk about—and please forgive me; let me know when I'm running out of time, but—

The Chair: You have five minutes.

Mr. Rodrigues: I'm doing fine.

A key goal to reform is to look at all avenues. Nobody is trying to propose that we shouldn't consolidate services if those services benefit the communities. I would have been really proud if this committee had come to Kingston and given my members and people in Kingston the opportunity to be heard. I don't know how many people put in to have standing at this committee, but it would have been nice. It would have been nice if we'd just spent the time to see how this is going to be beneficial to us.

Cost savings are very important; I understand that. The confusing thing for me is when you hear that this is the best time that Canada has ever had. We're into surpluses, unemployment is down, but we can't afford health care. Is this the mandate of our people? Are our MPPs telling you that their communities are supporting the opportunity to privatize, contract out to the lowest bidder, competitive services? We're afraid of working in one hospital and two years later applying to another hospital. We're afraid of what's going to happen if it is a non-union environment. I've been unionized all my life and, to be totally honest, I don't know if I'm here speaking on behalf of the union, on behalf of my family, on behalf of my community or all of the above. It is a major thing that we have to look at.

These people are committed. Earlier on I told you that I started working here in 1972. I'm now getting closer to my retirement, but I'm proud to say that my youngest son just started at the hospital about a year ago. I'm hoping he can make a career out of it like I did. I lived modestly, I raised my family, I was able to give them an education and we're very comfortable. We're not wealthy, but we've got a decent job, a well-paying job, a secure job. What we see here is our job security gone, uncertainty, bidding for another job every two years, losing services in the community, the fear of travelling 100 miles or 100 kilometres, 200; I'm not sure what this is going to do. There are a lot of uncertainties there, and all I'd like to do is urge this committee to put pressure, slow it down, have some proper consultation and see if there are better ways, long term. Look at buyout packages or retraining people, look at job security. These people are committed for the long haul, and they deserve the security and the respect that we should give them as users of the health care system. We are there for the people, and I'm sure that we will continue to fight this bill or try to make amendments to this bill so that it's going to be a benefit to everyone.

The Chair: There is a minute and a half if you wish to speak. Otherwise, I'll ask the members to take 30 seconds each. We'll do that. Why don't we ask Madame Martel; maybe she has a question for you or a comment.

Ms. Martel: Do you know what? I don't. I think you said what you had to say and you said it very well, and I appreciate that you took the time to come here today from Kingston to have your say. On behalf of yourself, your members, your family, whoever you wanted to speak about, thank you very much.

Mr. Fonseca: Yes, Sr. Rodrigues, thank you very much for your presentation. I was also born in Portugal and I've come here. The LHIN legislation, how I see it and how our government sees it, is really about building our health care system and it's for sustainability. It's in place so that the hospital, the community health service providers and those who have not had a voice in health care are at the table, because it has always been only about the hospital. We want to make sure they have a voice and we can have an integrated system.

We have 14 LHINs, but there is a provision in the bill that if they're not local enough, if they're not addressing those local needs, more can be created. There can be more LHINs; there can be more than 14. We've learned from other jurisdictions. In the BC model, they started with 50 and have kept bringing theirs down. This is an evolutionary process, and it's really about the sustainability of our health care system so that your son can work in health care and others can for the long haul.

The Chair: Thank you. Mr. Arnott.

Mr. Arnott: Thank you, Mr. Rodrigues.

The Chair: Thank you. I think you made clear what you wanted. We thank you for your presentation.

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SPECIALTY CARE GRANITE RIDGE

The Chair: The next presentation is from Specialty Care Granite Ridge, Linda Chaplin.

Ms. Linda Chaplin: Thank you very much. Good afternoon. My name is Linda Chaplin. I am the administrator of Specialty Care Granite Ridge, which is a 224-bed, licensed long-term-care home in Stittsville, which is now West Ottawa. Granite Ridge was constructed as part of the 20,000 new long-term-care-bed initiative, and it opened in late 2002.

I welcome the opportunity to present to you on Bill 36. In part, I hope to give you a somewhat different perspective on this legislation, and it comes from being part of an organization, Specialty Care Inc., a company that provides the same services in 13 homes in seven different LHINs.

Overall, I welcome Bill 36. Like my colleagues and community partners, I've always believed that we could do more to improve health care services for the people of our community. More often than not, our ability to do this has been stymied by the constraints of our silo-based system. In its vision, Bill 36 provides a framework that offers me hope that we can finally break down these system barriers. The task is now to effectively translate the major elements of Bill 36 into the reality that is Ontario's health care delivery environment.

Long-term-care homes are a major part of this reality. Granite Ridge is one of 600 homes throughout Ontario that deliver a provincially funded and regulated service on behalf of government. We are a private provider, yet we deliver the same service within the same operating and funding framework as our not-for-profit, charitable and municipal colleagues. We are per diem, not globally, funded, and it's based on our total number of licensed or approved beds. This means that government directly controls provincial service levels, as well as the service level in each home.

However, unlike most other health care services, residents pay approximately one third of this per diem. Residents in Stittsville in West Ottawa write the very same cheque as residents in Ottawa East or Thunder Bay, and they naturally have an expectation to access the same level of service. The potential for Bill 36 to negatively impact this equity is a major concern for my home in two specific areas: (1) core service delivery, and (2) core service accountability. The manner in which Bill 36 currently devolves authority creates the potential to destandardize and destabilize both service levels and service providers, while adding significant and unnecessary administrative costs.

As I indicated, the minister currently has authority over long-term-care services through a governance and operating framework that's tied to licensed and approved beds. The ministry issues a licence to Specialty Care Granite Ridge, other private, not-for-profit, and some charitable homes, for the number of beds that we operate. The remaining charitable and municipal homes have ministry-approved beds. This mix of licensed and approved beds results from three separate acts currently governing operators. My per diem operating funding is linked to my licence and, as such, adjusts directly with any changes to the number of my licensed beds. The same process applies to homes with approved beds.

As a licensed operator, I have a second area of exposure. My licence and the number of beds attached to it was used by the bank when it decided the terms on which to lend Specialty Care a portion of the funding required to construct this new home. Any reduction to the number of licensed beds will impact those terms and thus increase the risk to Granite Ridge as a service provider to the Stittsville and West Ottawa community. In short, Granite Ridge's service is, in fact, its beds.

As you know, government is presently developing a new long-term-care homes act, which may be tabled in the Legislature within the next few weeks. The government's consultation document on this new legislation contains a whole section on the treatment of licensed and approved beds. As a result, we fully expect that in the new act the minister will retain total control over beds and thus over service. In fact, this is appropriate, given that long-term care is a provincial program. It does mean, however, that the language of Bill 36 to devolve service authority to the LHINs is inconsistent with this for long-term care. This inconsistency must be resolved in Bill 36 to mitigate the resulting risks to both residents and providers.

As currently written, the relevant parts of part IV, section 20, provide me with no assurance that my LHIN will fund all of the beds that the province licenses me for. This places the future of those 224 residents who call Granite Ridge their home at risk, and it also increases uncertainty for the 133 citizens on my wait list.

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

As a matter of policy, I am hoping the government will also retain a common approach to funding core services, including the elements of our current envelope funding system. This system was developed for accountability purposes, and one of its most important elements is to ensure that there is no profit made on care and program services.

Centralized funding tied to provincially licensed bed capacity for core services would not negate my home's ability to participate in local service enhancements. In fact, it provides the opportunity for homes to pursue local opportunities and solutions without compromising core service delivery. At Granite Ridge, we are already doing this by participating in the new convalescent care program. We see potential opportunities for other special-

ized services that will help relieve the pressure on hospital service delivery, such as on-site IV therapy.

Bill 36's ability to support homes in delivering this vision can be enhanced by strengthening the authority and flexibility of LHINs to support local solutions within a fair and transparent framework. This could be accomplished by, first, amending part IV, subsection 19(1), to read, "A local health integration network shall provide specialized program funding as deemed appropriate to the health service provider, based on the local population's unique needs"; and, second, by amending part IV, subsection 19(2), to read, "The funding that a local health integration network provides under subsection (1) shall be on terms and conditions that the network considers appropriate with consultation with the respective health service provider(s) and in accordance with the funding...."

As a final comment on the implications of Bill 36 for equity and stability in access to core services, 1 would like to briefly address part V, section 28. Placing homes and their services at different degrees of risk based simply on the type of operator would be turning back the clock in Ontario. The difference was eliminated when the current program governance and operating structure was established in 1993. The sector and long-term-care residents have benefited greatly from this standardization. Initiatives leading to de-standardization would be both regressive and contrary to Bill 36's objective to make the system seamless for the patient or resident. If the basic service in all homes is the same, and the authority over that service already resides with the minister through the control of the beds, then the application of integration orders and minister's decisions to operators should also be the same. Exempting all licensed and approved bed operators from section 28 would accomplish this.

I will now turn to the implications of Bill 36 for core service accountability. This bill creates the potential for two parallel accountability processes in long-term care. One is local, from the service accountability agreements between the LHIN and operators, and the other is provincial, from the inspection criteria we expect to be outlined in the new long-term-care homes act. As an administrator, I could end up being accountable to two authorities with different performance criteria for the very same service. This would be unnecessarily complex, with potential for risk and misunderstanding for me, my staff, my residents, and of course their families. It would support the de-standardization of core services within and also between LHINs.

This potential can be eliminated by adjusting Bill 36 to be supportive of the accountability framework that will be included in the forthcoming long-term-care legislation. This can be accomplished by establishing a single and consistent service accountability agreement that would enable LHINs to discharge their responsibility for ensuring compliance with provincial performance measures. This instrument would be conceptually similar to the standardized service agreement that now exists between the ministry and all homes.

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Language should be added to part II, subsection 20(1) and part IV, subsections 47(7), (8) and (21), to ensure that this standardized agreement is developed in regulation. Further, this language should stipulate that the development process should include consultations with sector associations. The latter point helps ensure that the agreement accounts for the various governance structures in our sector: private companies, publicly traded companies, not-for-profit, community boards, and municipal government.

The front line in Ontario's health care system is already difficult. We will only add more stress if we foster service variations by devolving core service accountability to the local level. This is what occurred in Alberta. We have some examples of that.

Given the already increasing administrative burden, I am not looking forward to jockeying with the over 200 other health care service providers in my particular LHIN for time to negotiate individualized service accountability agreements each year. I would, of course, expect to work directly with my LHIN on amendments to standardized agreements to account for any specialized local services that I deliver on their behalf.

The foregoing impacts will be magnified in multi-site organizations. My service quality benefits from my ability to share common experiences, management processes and solutions with other Specialty Care homes. These benefits, however, will disappear if we are funded differently, with different performance accountability targets and criteria. These are not the only areas of Bill 36 that raise concerns for multi-site operators.

Over 60% of the operations in Ontario are operated by multi-site operators. These would include private organizations such as Specialty Care, as well as charitable and not-for-profit organizations, and municipalities that operate more than one home. In many instances these organizations, like Specialty Care, span individual LHIN boundaries. All of these organizations have achieved degrees of the LHIN vision of integrated service support processes and functions. These processes and functions are often referred to as back-office integration. They can range from shared professional resources, such as nursing and dietary consultants, to IT platforms and payroll systems. It's worth noting that in many companies and organizations this integration often incorporates functions beyond the long-term-care service program and way beyond the scope of Bill 36. For private, not-for-profit and charitable operators, it can actually include retirement homes or home care services. For municipal operators, it could include other municipal departments and services.

In the lead-up to LHINs there is increasing discussion around quick wins that often focuses around back-office integration. Bill 36 supports this direction in part V, section 23, with a broad definition of service to which integration orders can apply. If LHINs begin to exercise the full authority in this definition, they will create significant business and operational issues for multi-site providers that will adversely impact service efficiency

and costs. There will also be unintended consequences for operations over which Bill 36 had no envisioned application. I believe it's appropriate that this committee move to eliminate this impact by changing the language to part V, clause 23(c) to exempt those functions that support the operations of licensed or approved long-term-care beds from the definition of services.

Ladies and gentlemen, I started my presentation by stating that I was encouraged by the prospects for Bill 36 to break down the barriers of our current silo-based system. Over the past few minutes I have outlined some changes that I believe could strengthen Bill 36 in the context of the reality of long-term care.

I'd like to close with a final recommendation. I'm referring to the implementation of a health professions advisory committee in part II, subsection 16(2). It's true that we're all health care professionals. It's also true that we have been silo-based for so long that unless you've worked for an extended period in different sectors—which I in fact have, after 30 years—the clinical settings in other sectors can be foreign. The health professions advisory committee must have the ability to speak from that experience on behalf of acute, long-term care, mental health, home care and the community sectors to provide, and be seen to provide, credible advice to LHINs. In view of this, language should be added to this section to not only define the committee's term and mandate, but to also define in regulation that it contain a minimum of one regulated health professional from each sector. Thank you.

The Chair: Thank you. There's about 30 seconds each. Ms. Wynne, would you start, please.

Ms. Wynne: I want to thank you for coming. We've heard some of these issues from at least one other group that's come before us. I know that you will have dealt with Monique Smith, my colleague who is working on the long-term-care legislation.

My question to you is, given that you've given us some specifics around your sector and some concerns, in terms of the overall benefits of the integration of the local health integration networks, can you see long-term benefits in terms of your sector, as well as generally?

Ms. Chaplin: Oh, I absolutely can. Even in the lead-up to LHIN formation, in the dialogue that preceded some of the consultation process, the intrasector communication was quite remarkable. There was a breaking down of that silo base that can make sectors appear to be operating totally in isolation one from the other, when in fact we're all there to serve the same purpose, and that is to meet the health care needs of all ages and all conditions.

Ms. Wynne: That's great. Thank you very much.

Mr. Arnott: I don't have any questions, but I want to thank you for your presentation. You've done a great job and you've given us some specific amendment ideas, and we appreciate that.

Ms. Martel: Thank you for being here today. You referenced section 28, so you know that's been a cause of concern for a number of groups before us. What would happen if we just eliminated section 28 altogether? You're asking to be exempt from it, but that might help long-term-care operators in the not-for-profit and for-profit sectors. It wouldn't change much for other not-for-profit agencies that may be delivering other services that are not long-term-care beds. So if we just eliminated this section altogether, so that there's no distinction between any operators in any sector, would that do it for you?

Ms. Nancy Cooper: My name is Nancy Cooper. I'm from the Ontario Long Term Care Association. Within the definitions laid out in the act, the only health service providers that are for-profit are nursing homes or long-term-care homes, so the application to other organizations is beyond the realm of the bill, what's being suggested. The health service providers that are affected are clearly named, and home care providers are not named; they're part of the contract to the CCACs. They're outside of the bill. So what we're putting forward is that because long-term care is a standardized provincial program, whether you are for-profit, not-for-profit, municipal provider, we should all be treated the same because we're all funded and regulated in exactly the same manner. Therefore, we all should be exempted from section 28.

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

OTTAWA AND DISTRICT LABOUR COUNCIL

The Chair: The next one is the Ottawa and District Labour Council, Sean McKenny and Bruce Waller. Gentlemen, you can start whenever you're ready. There's 15 minutes total time for your presentation.

Mr. Sean McKenny: I thank you for that. A number of years ago, an individual said to me that I pronounced my name wrong, that it wasn't "Shawn," that in fact it was "Seen" and my name should be "Seen" McKenny. And I said, "Well, it's Sean and it's pronounced 'Shawn,'" and he said, "Well, what about 'Seen' Connery?" That's a true story.

In any case, my name is Sean McKenny, president of the Ottawa and District Labour Council. With me is Bruce Waller, newly elected president of CUPE, Local 4000. I'll commence, and then Bruce will come in to polish up and close off our submission.

The labour council in Ottawa is comprised of 90 affiliated local unions representing approximately 40,000 working men and women in all sectors within the city.

Perhaps most perplexing and frustrating for us once again as we address the proposed legislation is the claim by a government that it is committed to those who are employed in our health care system. In fact, actual wording in this instance as it relates to Bill 36 is—and I quote the provincial government's line appearing in numerous documents and repeated over and over—"The Ministry of Health and Long-Term Care is committed to working with our province's dedicated health care professionals to improve the health care system because Ontarians deserve the best health care."

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You're not going to have an argument from too many people, if any, that those employed within our health care system in this province and elsewhere are an incredibly dedicated and loyal group. These are individuals who, by their very nature, are committed to ensuring that the care provided to those in need of services in our communities is only the very, very best.

We as a labour council, whose affiliates are these workers, take more than notice when the claim is made that the proposed local health integration networks are deeply flawed. They know the system best; they work in it every day. They see the problems; they envision the resolve. They know our health care system better than I do, and I can assure you that they know it better than any of you around the table.

Some argue—and I find it so incredibly unfortunate and, quite frankly, extremely disrespectful—that the workers', that the unions' only and sole interest is to protect their jobs. Protect their jobs? Absolutely. Yet it's only a part of the overall passion and compassion that all those employed within the sector exhibit on a daily basis, because when they protect their jobs, they're protecting our health care system.

Michael Hurley, the president of the Ontario Council of Hospital Unions, says, "The changes that are being planned will result in the slow destruction of our local hospitals," and he adds: "The lowest-bidder approach for health care services that the Liberals are unleashing under the LHINs threatens both access and quality of services." Is he lying?

Sharleen Stewart, president of SEIU, Local 1, says that LHINS are "just the next step on the road to more health care privatization." I suppose that's another lie.

Leah Casselman, OPSEU president, predicts massive job loss and disruption for patients. Again, I guess she's wrong, too.

The message is being delivered in respect to Bill 36 that there exist major flaws. Perhaps most disheartening would be if the government was in fact hearing the message, yet moved towards the LHINs implementation without regard for the comments and opinions based on facts presented by those individuals who know our health care system the best—the workers.

On the other hand, if the provincial government's intent, through the Ministry of Health and Long-Term Care and through Bill 36, is to in effect cause the destruction of our local hospitals, cause massive job losses, negatively affect access and quality of services and privatize our health care system, then the need to listen and act upon the recommendations being put forth by those as noted above becomes moot.

The majority of those employed within the health care sector have stated that they no longer trust the McGuinty government to protect our public health care system. The implementation of the local health integration networks in their proposed form through Bill 36 further solidifies that lack of trust.

We urge this committee, when reviewing these submissions, to give the appropriate weight to those presentations and reports made by those individuals and organizations whose commitment to our health care system on behalf of all our communities and the people in this province is far above most others, and those individuals and organizations are the women and men who work in our health care system each day, every day. Thank you.

The Chair: Congratulations to the new president.

Mr. Bruce Waller: Hi. My name is Bruce Waller. I am the president of Local 4000 in the Ottawa Hospital.

I guess we'll continue on with what Sean was saying. This is part of the erosion of health care as we know it today, and I don't think this was the way health care was set up many years ago, for stuff like this to happen.

The first thing on the agenda is, these LHINs boards are going to have control of these monies; the hospitals are no longer going to have control of their own budgets. How can you run a business without a budget, without having money on hand to do daily stuff? My understanding is, they're going to have to go to the LHIN's board, make a presentation and then get this money back. The way the board was appointed—I mean, as a taxpayer in the province of Ontario and living here all my life, I find I take offence at the fact that I don't even have a say in who appoints these people. These people were just appointed. I elect my school board officials. I elect my city officials. We elect you people around the table to represent us.

Mr. McKenny: Some of them.

Mr. Waller: Yes, some of them. Sorry.

This was just a board appointed by the minister and a couple of other people on his committee, I imagine, and then the CEOs of these boards appointed other people on these committees who had business experience, I imagine. But just the whole process itself is definitely—I mean, in a democratic society I find that it's not democratic. For sure, it's not democratic. So that's the first thing: How can we just appoint people to this board? It's going to control all these monies and all these sections. Then there's a clause in there that even if the LHIN's board does agree somehow with the union to say that we can't do any more cuts or we can't move this service or we can't merge that service, it's inefficient, it's not going to work, the minister has the power to make them do it anyway. So why are we appointing this board in the first place, then? What's the purpose of the LHINs if we already have the OHA, the Ontario Hospital Association, to do this stuff? We're just appointing another level of bureaucracy at a cost to the taxpayers that's going to far exceed the costs they're going to save. We already know they didn't save any money merging hospitals under Bill 136. The proof is already out there. The numbers just don't add up.

Speaking for my members, the membership of the hospital—when we hear comments from the Minister of Health: "Why should we pay the cleaner all this money when we pay the bank employee $8 an hour to vacuum the rug?" or something like that—these people are front-line workers. These people deal with sick people. There

are illnesses in these establishments. We're picking up mercury spills. We're crashing rooms that are contagious with diseases, or there's VRE, MRSA—the list goes on and on. Someone in a bank is cleaning the bank. You don't have these diseases on a daily basis. I'm not sure what the number was, whether it was 45 or 54 people who died in Toronto during the SARS outbreak. This really happened. These things happen, you know. The new disease going around these days is C dif. We have to close down floors in hospitals. Wards are closed down because of these illnesses. There are special cleaning procedures in place to do this stuff. I don't think a contractor really cares how these places are going to get cleaned up. He's looking at a profit. If they're in there for cost-plus, what kinds of services are we really going to get in these hospitals? If these places are already saying that they're not cleaned properly now because of cuts over the years, the erosion of services, how are they going to be cleaned in the future? What's it going to look like three to five years down the road? I certainly don't want to be a patient in a hospital if—there are already moulds in hospitals. We all know this. This stuff is there. There is stuff that's still being cleaned up from years ago, with asbestos and everything else, and now we're going to start eroding other services away for a profit. And who's making this profit—companies like Aramark?

So what are we really saving? What do we save when we give a contract to a contractor? Are we saving any money? Why don't we do a cost analysis on if we actually save money? I don't believe we do save money. It has been proven that we don't save money. We probably have data backing up that it doesn't save money. It's just somebody lining their pockets out of somebody else's situation. I don't think that's ethical. I don't think that's right.

I work in the sterilization department. I sterilize instruments for surgeries. I take my job very seriously. If that one instrument gets missed and it's dirty, it gets sterilized and that patient is waiting on that operating table. We want to make sure everything is clean, and we want to make sure everything is up to par. I don't think that's a service that you can just give to Joe Blow down in Toronto or whatever—"Let's ship this stuff up by a truck and say it's sterilized." Does that meet the standards? I don't believe it does meet the standards. We have to wrap this stuff. We have to sterilize this stuff. We have to make sure it's at a certain degree. I don't want to be the person coming back 15 days after surgery with an infection that was caused because an instrument wasn't cleaned properly or somebody cut a corner because they were doing it to make a profit and somebody didn't come in to work that day and it's like, "Well, do you know what? Let's just get everybody to chip in a little more, because it's cutting into our profit."

I'd just like to close by saying thank you for the five minutes. I'd like to thank Sean for giving me the five minutes to speak. I think you people really need to seriously take this back to the proper authorities and say, "Do you know what? We need some more consultation on this."

The Chair: Thank you. Of course we heard you, and there are also staff of the ministry here who are bringing all the information from everybody. Thanks very much for your presentation.

Mr. Waller: Do you guys have any questions?

The Chair: No, there is no time.

1730

COUNCIL OF CANADIANS, KINGSTON CHAPTER

The Chair: The next presentation is by teleconference. We welcome Michelle Dorey.

Ms. Michelle Dorey: Hello. My name is Michelle Dorey, and I'm with the Kingston chapter of the Council of Canadians. I would like to thank you for this opportunity to express some concerns.

My first concern with Bill 36 is that it does nothing to extend the public health system or promote non-profit health care. The legislation in fact promotes further privatization. The minister may close down, merge or contract out non-clinical services of the non-profit health facilities and services but cannot do the same with the for-profit facilities. We've seen more and more of Ontario's hospitals become public-private partnerships, even though the Liberal Party campaigned against P3s in its election promises. With this move towards privatization in our health care delivery, it's a safe assumption that the newly created LHINs will be moving in this direction as well.

It adds another administrative layer to health care delivery. It's another cost, as well as removing public input or control. Unlike democratically elected school boards, LHINs are appointed by the government. School board meetings are open to the public, but LHIN meetings may be held in camera. So there's a loss of transparency.

Also, the LHIN board personnel may have a bias towards for-profit delivery. Where's the protection or safeguard against this bias? In my region, the director of our LHIN is the owner of a for-profit long-term-care facility. I would be surprised if she did not favour for-profit health care delivery in her LHIN's decision-making.

The LHINs will scrutinize competitive bids from different hospitals for medical procedures. For example, a hospital in Smiths Falls may win the bid to do cataract surgery for the region. This will place a burden on poor people if they live in a city or town not close to Smiths Falls. How will they get a family member there and back? Also, what would prevent a hospital in a nearby American city or town from entering the bidding process? Chapter 11 in NAFTA, which deals with national treatment rights for foreign corporations, would allow foreign bids even if the regulations of the LHINs would try to prevent that. Canadian citizens fund medicare through tax dollars. Medicare should benefit Canadian public health providers, not foreign health providers.

One other aspect of the competitive bidding process which would seem to be at odds with the Canada Health Act is the spirit of competition between providers, as opposed to the spirit of co-operation. Surely, collaboration between health care professionals is more conducive to quality patient care. Also, one wonders if a low-bid hospital would not have cut back on an operational cost such as housecleaning in order to offer a low bid. Perhaps patient rooms would be cleaned every other day, as opposed to every day. So you wonder about the hygiene and whether it would be compromised.

In summary, the biggest problem with the LHINs is the lack of protection and promotion of public health care. LHINs seem to be setting the framework for further privatization of health care. There's also a problem in giving such power and money to these boards when in fact there is very little public transparency or accountability.

Thank you very much for the opportunity to speak.

The Chair: Thank you. We have plenty of time if there are any questions. I will go to Madame Martel.

Ms. Martel: Thank you, Michelle, for participating by teleconference and for taking the time to make a presentation in this way. I don't have any questions. During the course of the public hearings, we've heard a lot of the concerns that you have raised, but I did want to thank you for taking the time to raise them again and for being part of the process.

Ms. Dorey: You're welcome.

The Chair: Ms. Wynne.

Ms. Wynne: Thanks for joining us. It's Kathleen Wynne. I just wanted to clarify a couple of things. The issue of open meetings: The local health integration networks will be required to hold their meetings in public. As a former public school trustee, I can tell you that under certain circumstances there is the possibility for in camera meetings on school boards as well. I'm sure you're aware of that. The majority of the meetings are held in public—oh, hello? She's gone.

The Chair: Is the lady gone? Yes, she's gone. If you wish to make a point, that's fine. There are some people here.

Ms. Wynne: Yes, I wanted to make that point about the open meetings.

I also wanted to follow up on the point that she made about collaboration among providers being desirable. I think that's a key point and it's exactly what we're trying to achieve with the local health integration networks, so that the providers will be able to feed into one plan and that will foster collaboration. I just wanted to make that point.

The Chair: That brings us to the end of this session. We thank all of you for participating here in Ottawa. The next one will be tomorrow morning in Thunder Bay. Again, thank you for your participation.

The committee adjourned at 1736.

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