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Jeudi 2 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
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Thursday 2 February 2006

Jeudi 2 février 2006

The committee met at 0904 in Valhalla Inn, Thunder Bay.

LOCAL HEALTH SYSTEM INTEGRATION ACT, 2006

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

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

The Chair (Mr. Mario G. Racco): Good morning. It's lovely to be in Thunder Bay. I want to welcome in particular the local MPP from Thunder Bay, who is joining our team to hear the wishes of the people, and of course everyone. We have another long day of presentations today, probably until 6 unless there is any change.

JULES TUPKER

The Chair: We will start right away with our first presentation, and that is from Mr. Jules Tupker. There is 15 minutes time for your presentation. In any time left, there may be some comments or questions from the three groups. Please start any time you're ready.

Mr. Jules Tupker: Good morning. My name is Jules Tupker. I am a retiree in the city of Thunder Bay. I have some concerns about LHINs, and I'd like to make this presentation to you. Hopefully there will be enough time to ask some questions; we'll see how that goes. Everybody has a copy, I hope.

The Chair: Yes.

Mr. Tupker: Great.

The citizens of northwestern Ontario have for years been hoping for a provincial government in Toronto that would recognize the size of our region, the sparse population, the extreme weather conditions and the many other aspects of northwestern Ontario that make us different from southern Ontario. That hope was again revived in regard to the many problems we face in our health care services here in the northwest when the Liberal government announced it was looking at changing the way health care was going to be administered.

In November 2004, the government introduced Bill 36, the Local Health System Integration Act, 2005. The bill, as stated in the preamble, is intended to acknowledge that "a community's health needs and priorities are best developed by the community, health care providers and the people they serve," and I believe is intended to localize the provision of health care services by allowing communities "to make decisions about their local health systems."

The bill, however, uses a southern Ontario interpretation of the word "localized." Localized health care in southern Ontario means within an area that is easily accessible or within a short driving distance. That interpretation, however, does not fit northwestern Ontario.

Again, northwestern Ontario—and I'll go into this a little bit further on—is huge in size. If you look at the size of this LHIN, it's massive compared to any other LHIN that has been proposed by the government.

In reviewing the legislation, I have discovered a number of items that cause me concern, and I will attempt to present some of those concerns today.

The local control myth: I believe that Bill 36 and its new way of managing the health care system through a number of local health initiative networks will grant very little power to the citizens, communities and health care providers of the northwest and that it is nothing more than an attempt by the Liberal government to gain more control over health care costs by merging and privatizing health care providers and to create another layer of bureaucracy that will shield the government from the public's wrath.

Bill 36 sets out that the Lieutenant Governor in Council may amalgamate, dissolve or divide a LHIN. A LHIN's board of directors "shall consist of no more than nine members appointed by the Lieutenant Governor in Council." The Lieutenant Governor in Council "shall designate one chair and at least one vice-chair." The government controls the remuneration of the LHIN's board, and each LHIN is required to sign an accountability agreement that ensures it will abide by the government's wishes. Section 36 of the act sets out the issues that the Lieutenant Governor in Council and the minister can control, and it seems quite clear to me that no matter what policies or changes the local LHIN board tries to implement, if they do not satisfy the cabinet or the minister, then they will be vetoed.

What this means to me is that the LHIN and its board of directors are mandated to carry out any plans that the government wants to propose and the LHIN will be obliged to carry out those plans or else face the possibility

of either amalgamation with another LHIN that will carry out what the government wants or face dissolution.

The LHIN cannot put forward any suggestions that would benefit the residents of northwestern Ontario if those suggestions contradict the government's vision of health care. No matter how committed the board of our local LHIN is toward ideas that would benefit the northwest, it will not be able to present or support those ideas if they contradict the government's plans. The LHIN will not be able to represent local health care needs at all.

I further believe that the legislation will stifle any possibility of objection that the citizens of northwestern Ontario have toward government policy, because any arguments that are raised will have to be dealt with by the LHIN, not the government. The LHIN will respond to any argument by claiming that it can only implement practices and policies that are in agreement with the government's vision of health care. The government will hide behind the LHIN and claim that the LHIN is implementing the practice or policy, and not the government. This LHIN model takes control of local health care issues away from the citizens of northwestern Ontario and leaves it in the hands of the government in Toronto.

I would like to point out one major event that brought northwestern Ontario together on health care and demonstrated a true example of regionalization of health care. The event was the creation of the Thunder Bay Regional Health Sciences Centre. The hospital board and the general public were instrumental in the fight to build a larger hospital in Thunder Bay than had been originally planned by the Conservative government. The expanded hospital is the result of a northwestern Ontario inspired desire and need and was not one that the government of the day was anxious to agree to. The government was pressured by the citizens of northwestern Ontario to expand its plans for the regional hospital. The successful fight undertaken by all of northwestern Ontario would have been much more difficult, if not impossible, had a LHIN board been in place at the time.

Bill 36, if implemented in its current form, will not improve northwestern Ontario's health care and may well take away any power we have in health care decisions at this time.

The Chair: Have you finished, sir?

Mr. Tupker: No, I'm not finished. Thank you.

The Chair: Sorry. I was just welcoming one of our local MPPs.

Mr. Tupker: It's nice to see him here on time. Thank you.

Loss of services and jobs: Bill 36 claims in section 15 that the LHIN will have the power to develop "an integrated health service plan" for all of northwestern Ontario and ensure that the plan must be made in the form specified by the minister and "shall be consistent with a provincial strategic plan" that will be developed by the minister.

This integration will give the LHIN the power to request a voluntary integration agreement between health service providers or other entities that may or may not be health service providers. The LHIN, because it has control over funding of the service providers, could also force integration of services between health service providers or other entities by withholding funding from a health service provider that did not voluntarily integrate with another health service provider or entity. The LHIN also has the power to veto a voluntary integration of health service providers, to order health service providers to cease providing all or part of a service to a certain area and the power to transfer all or part of a service from one location to another.

What this means to me is that the LHIN can require a not-for-profit health service provider to transfer all or part of its services to another health service provider or, indeed, some entity that is not necessarily a health service provider at all, thus effectively terminating the operations of that not-for-profit health service provider. The legislation, however, does not allow the LHIN to close a for-profit health service provider or entity. There is nothing in the legislation that requires a surviving health service provider or entity to be in the same community as the health service provider that is being terminated. The loss of a health service provider in a community will necessitate travelling to another community for that service, and we all know the problems related to travel in northwestern Ontario.

0910

The loss of a health service in a community will also result in the loss of the jobs that service provided. As an example, the ability of the LHIN to transfer services to an entity that is not-for-profit or indeed to an entity that has no background in health services will result in layoffs and in lower-paying private sector jobs. Further, section 33 of the act will, I believe, allow non-clinical jobs in hospitals and seniors' homes, such as dietary, laundry and housekeeping services, to be transferred to private, for-profit entities outside of the communities where these institutions operate, again resulting in the layoff of workers. Communities in the northwest can ill afford any more job losses.

Anyone believing that this could not happen must be reminded that each LHIN is bound by the accountability agreement it signs with the minister that covers its performance goals and measures and a plan for spending the set amount of funding it receives from the minister. The LHIN must do everything in its power to control costs.

A further point of interest is the fact that although the act does not give a LHIN the authority to close a hospital in a community, section 36 of the act does give the Lieutenant Governor in Council the authority to exempt a LHIN from any provisions of the act. This leads me to believe that if it was decided by the LHIN that a hospital should close, the LHIN could be exempted from any restrictions in the act, allowing the LHIN to close the hospital; a worrisome thought indeed.

Increased costs: Bill 36 and the LHINs it creates will result in increased costs to the citizens of northwestern Ontario for a number of reasons. First, the possibility of

increased travel to obtain health services that are no longer in a community will not only result in a great deal of inconvenience and loss of time but will cost the citizens of northwestern Ontario a great deal of money. The government in Toronto, contrary to its constant denial, has no concept of the size of the northwest and has not taken into account the time, peril and cost of travel from one community to the next. We have an unlimited number of stories about out-of-town travel that I will not go into.

Second, the LHIN program establishes a service purchaser-service provider model that leads to the expansion of privatized services that will eventually lead to reduced services and higher costs. As an example of privatization leading to a loss of services, one need only look to the CCACs whose boards were taken over by the government because of cost overruns. The government, in its efforts to cut costs, flatlined funding and permitted the tendering of services to the lowest bidders, including private, for-profit corporations, which resulted in a deterioration of service and no cost savings in the end. Privatization of public services in Ontario has a long history of increased costs and reduced services that I will not go into. The British experience with increased costs and reduced services resulting from privatized health care is well documented.

Third, the legislation allows the LHIN to transfer health services from public, not-for-profit entities to private, for-profit entities. This would result in the transfer of health care services from a public hospital to a private, for-profit nursing home. Care in a for-profit nursing home will not be the same as in a hospital, and costs for certain services that were covered in a hospital under OHIP will have to be paid for by the patient. I have yet to find a for-profit corporation that can maintain services equivalent to those provided in a not-for-profit organization at an equivalent cost to the patient.

In conclusion, I have presented to you a few of the concerns I have with Bill 36, and I hope I have been able to convey to you some of the shortcomings I see in the legislation.

As I stated in my opening comments, we in the northwest have unique conditions that we must live with, and I believe that Bill 36, although laudable in its concept, falls short of hitting the mark in a number of areas and clearly will create more hardships than remedies for the health care of the citizens of northwestern Ontario.

Thank you for your time and consideration.

I have also included in my document, on the last page, some stuff that I was going to put into the presentation. What I did when I was putting this document together—I was reading the act, obviously, and I had some other information that I was just sort of jotting down. The things at the end are basically things I didn't put in the presentation, obviously, with the 15-minute limit, but these are issues we could talk about and that are of concern to me also.

The Chair: Thank you. We are going to allow three minutes for comments and questions. We normally start with the opposition. Mr. Arnott or Mr. Miller, please.

Mr. Norm Miller (Parry Sound–Muskoka): Thank you very much for your presentation. You obviously spent a lot of time working on it.

One of the points you made was about the myth of local control, and I think people in southern Ontario don't realize just how huge the northern LHINs are. As an example, I know the one in my riding of Parry Sound–Muskoka includes Parry Sound and James Bay. How large is your LHIN here?

Mr. Tupker: From the drawings I've seen, the actual size of the LHIN here, as far as distances go—I couldn't give you the actual area—is from Marathon to the Manitoba border, and from the international border with the United States all the way up to the top of the province. It's massive. It's huge.

Mr. Miller: And your point is that you actually have less local control. What do you think will happen to hospital boards if LHINs are brought in?

Mr. Tupker: My concern is that hospital boards will lose any power and any control they have. The actual size of the LHINs is a problem. The distances between municipalities are the other problem, and that's where I see the biggest issue is going to be. Most municipalities that are centres of health care, with hospitals or homes, are anywhere from an hour to three hours apart. I can see services being consolidated, resulting in these services closing in one municipality and being transferred to another municipality, and those people having to travel an hour to three hours to get the service they are getting now in their own municipality.

Mr. Miller: And not a local voice.

Mr. Tupker: And not a local voice; exactly.

The Chair: Ms. Martel.

Ms. Shelley Martel (Nickel Belt): Thank you for being here this morning.

Let me follow up on that point. The other concern is with services in hospitals, because there are a number of communities in northwestern Ontario that have their own small community hospital where people can go for a range of services right now; it's the same in my part of the world. For other major services, everybody has to go to Thunder Bay, and in my part of the world everybody goes to Sudbury, where I live.

Having said that, I have no interest in seeing people from Timmins, North Bay or Sault Ste. Marie driving three and four hours to obtain even more services if specialized services are located at the regional hospital. As someone from northwestern Ontario, knowing that there are a number of communities that have small hospitals where people can get service now—it's very clear that the legislation does allow for that transfer of services—what are your concerns in that regard?

Mr. Tupker: Well, obviously the concern is the distances, the time to travel and the inconvenience of having to travel to those locations. A clear example right now is that Dr. Porter used to do knee surgery in Thunder Bay, and it's ironic that it's going away. He used to do knee surgery in Thunder Bay. He's got a private clinic now in Dryden, so if anybody wants to get their knees

operated on by the best orthopaedic surgeon I know of who does knees, they have to travel to Dryden, which is three and a half hours away, to get that service. Likewise, if that service is concentrated in Dryden and some other service is opened in Thunder Bay, then people in Dryden have to come all the way to Thunder Bay for that specialized service. It's absolutely bizarre, what is going to happen.

The Chair: Ms. Wynne or Mr. Gravelle?

Mr. Michael Gravelle (Thunder Bay–Superior North): Thanks very much, Jules, for your presentation. I appreciate your concerns, very much so, and I think we share them. But certainly when I look at the Closson report, which the LHINs are being asked to implement, it speaks about enhanced services, specifically in the communities outside Thunder Bay, and I presume you are aware of that. We look at the proposed designation of Wilson Memorial in Marathon as being a district hospital, and there are others as well west of Thunder Bay, two district hospitals. So the recommendations in the Closson report, which the LHINs are being asked to implement, would certainly go against what you're saying. They are arguing and making the recommendation that we should have enhanced services in communities outside Thunder Bay.

Can you comment on that, because that's the other way of looking at it, obviously, in terms of what's out there now that the minister is working on.

Mr. Tupker: You're absolutely right, Michael. When you see the legislation, you say, "Maybe Toronto is finally going to give us some control over our health care and they're going to implement something that is going to allow the community and the whole of northwestern Ontario to look after itself." But the problem I see in the legislation is that there is an agreement that is signed by the LHINs with the government, and they are going to be allotted X number of dollars to provide that service. If at the end of the day the LHIN finds that the McCausland Hospital or the Atikokan General Hospital is too expensive and the budget for that hospital can't afford to maintain some of the services they have there, then they have to make a decision either to keep the services in that particular hospital or take the services away because they don't have enough money to afford it, and that decision will have to be made by the LHIN. The funding is controlled by the provincial government. At the end of the day, the provincial government, the minister, has control over the funding.

As I said, the intent is wonderful. I think it's great that finally we're going to have something. But when you start looking at the actual document, Michael, I have some grave concerns that, at the end of the day, the LHINs' hands are going to be tied. There is going to be some stuff that's going to be local but, at the end of the day, when the crunch comes down, some of the local hospitals, some of the local nursing homes and homes for the aged are going to suffer. Some of the services are going to suffer. A decision is going to have to be made by the LHINs that they can't afford it in that municipality and it's going to be moved to another municipality. I'm sorry, folks, but that's the way it's going to be. Again, the legislation clearly states that we have no access to the government to make those complaints as we did—and you're very aware of what we did—with the hospital.

Mr. Gravelle: That's not the vision of the Closson report. I know we haven't got time to carry on, but I appreciate your points. Thank you.

The Chair: Thank you.

0920

NISHNAWBE ASKI NATION

The Chair: The next presentation is from the Nishnawbe Aski Nation. Alvin Fiddler and Victoria Beardy, I believe, are both on the list. Just a reminder, sir, as you take your seat, that there's a total of 15 minutes for your presentation. If there is any time available, we'll be able to ask some questions. You can start any time you're ready. Good morning.

Deputy Grand Chief Alvin Fiddler: Good morning to the members of the committee, and thank you for the opportunity to speak with you this morning. My name is Alvin Fiddler. I'm the Deputy Grand Chief for Nishnawbe Aski Nation. With me is one of our elders from Muskrat Dam. Her name is Victoria Beardy.

I'm here to speak on behalf of the 49 First Nation communities that make up Nishnawbe Aski Nation. I wanted to first of all extend my invitation to this committee to our territory. This is not our territory. I've looked at the list of communities or centres that this committee has visited or will visit. None of those are in our territory, and yet we cover two thirds of the province. I think it's only appropriate that this committee make that effort to be in one of our communities to hear directly from our people on the issue that's going to be discussed here today.

This year marks the 100th anniversary of our treaty. Of all the treaties in Canada, Treaty 9 is the only one where the province is also a signatory to a treaty. So we come before you today not as a stakeholder or part of an interest group, but as a treaty partner.

We have several concerns with what's being proposed here. There is a presentation in your package that outlines some of those concerns and some of the issues that we have with the proposed bill.

I want to say from the outset that we totally reject the bill as it stands now. There is a chiefs' resolution in your package from the 49 chiefs from Nishnawbe Aski Nation that support that. Why is that? Because we've always believed that before the signing of our treaty, our society was complete. We had our own systems, including health care. We had our own healers, our own medicines and our own way of looking after ourselves. If you look at the last 100 years, over the course of that 100 years, you will see that today, when you look at the health status of our people, we are number one in diabetes, we are number one in suicides, we are number one in cancer now. As we speak, those numbers continue to escalate.

We want to propose to you, our treaty partner in Ontario, and to Canada that we need to work together in developing a health care system that's going to work for us. We're asking you, as our partner, to help us do that.

I'm going to ask Victoria to speak to how we used to look after ourselves, how we used to heal ourselves and to maintain our health, and how we used to see our elders live longer and healthier, not the way it is today. So I'm going to ask her to speak at this time and I will translate for her.

Ms. Victoria Beardy: *Remarks in Oji-Cree.*

Deputy Grand Chief Fiddler: She's saying that as far as she can remember, it was very rare that our people got sick. Our people did not die of any disease or sickness. They lived to be very old and they used what was given to them by the Creator to heal themselves if they were sick and to keep themselves healthy.

Ms. Beardy: *Remarks in Oji-Cree.*

Deputy Grand Chief Fiddler: She's seen a lot of change over the course of her life. Today she sees a high number of her community members sick with diabetes, with cancer, and children as young as 10 are diagnosed with diabetes. There is also a high rate of suicides amongst our young people.

Ms. Beardy: *Remarks in Oji-Cree.*

Deputy Grand Chief Fiddler: For elders like herself, she still practices and she still uses the traditional medicines to keep herself healthy.

Twenty-five years ago she was diagnosed with diabetes, but since then she's really looked after herself, eating traditional foods and using traditional medicines, and she does not have to use insulin or give herself shots of insulin.

Ms. Beardy: *Remarks in Oji-Cree.*

Deputy Grand Chief Fiddler: Even now in her community, when people have accidents or injuries, they come to her and she provides them with medicine to heal from their wounds and from their injuries.

She wants to see our young people go back to that. She wants to ensure that our young people know that was their system a long time ago, and she wants to see our young people go back to that.

Ms. Beardy: *Remarks in Oji-Cree.*

Deputy Grand Chief Fiddler: She has heard about some of the proposed changes, that the government is planning to restructure or change the health care system, and she is very concerned about that.

That's it.

0930

The Chair: We thank you both very much for your presentation. We will allow 30 seconds each for potential comments. Madam Martel, would you like to start?

Ms. Martel: Meegwetch, Deputy Grand Chief. Meegwetch, Elder Victoria.

I'll probably just make a comment. Yours is not the first presentation we have heard from aboriginal people to express grave concern about the process, or lack of process, that was in place with respect to this bill. In the case of Treaty 9, it's even more distressing, because you are right: You are a partner, not a stakeholder. There should have been a full and comprehensive process of consultation and negotiation with First Nations, particularly with Treaty 9, with respect to health care. The government says now, after the fact, that they are looking at a report with respect to aboriginal health care. That will be released at some point, and we will see where the government intends to go. But I think it is regrettable, especially in light of the announcement the government made this summer that there would be a new relationship between the government of Ontario and aboriginal people, that the government should have proceeded in the way it did with Bill 36, without any consultation with First Nations people. So I hope that from here on in, the process of consultation and negotiation with aboriginal people, and with Treaty 9 in particular, will be much different and will result in a plan where your health care needs can be met and respected.

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

Mr. Bill Mauro (Thunder Bay–Atikokan): Thank you, Deputy Grand Chief, for your presentation.

It's my understanding, and I'm curious if you're aware, that the minister is currently engaged in a process of discussion with First Nations groups to try to address the concerns that they're presenting, as indicated in the legislation. I'm wondering if you're aware of it, first of all, and if you are satisfied with what's being presented to address your concerns.

Before you get a chance to answer—I don't think I'll have a chance for another question—I'd really be interested to know what is going on to address diabetes without having to use insulin. I'd be very interested in that, as an aside, if you could address that question.

Deputy Grand Chief Fiddler: Thank you for the question, Mr. Mauro. Yes, I am aware that the minister agreed to establish a First Nations task force this summer to look at the impacts of LHINs. There was a limited time frame to do that. My concern was—and I told the minister this—that it's very difficult to assess something that has not been fully established yet, that is not fully functional. I agreed to be a part of that, not because I totally believed that this was going to be the vehicle to make a difference, but I agreed to join the task force out of goodwill. I think the concerns remain that even with the recommendations in that report, there is no guarantee, there is no assurance that those will be incorporated in any bill or in any system.

The Chair: Mr. Miller, please.

Mr. Miller: Thank you very much, Deputy Grand Chief and Victoria, for your presentation today.

Your point right at the very beginning: You were saying that you had hoped the committee would go to your traditional lands for a meeting. I just wanted to make the point that I did speak with John Beaucage. He called me about that and asked me if the committee would go to Garden River, I believe it was. I did write to the Chair requesting that on your behalf. I just wanted to make that point.

Thank you for your presentation today. I look forward to other presentations.

Deputy Grand Chief Fiddler: Can I just clarify his comment?

The Chair: Yes.

Deputy Grand Chief Fiddler: John Beaucage is the grand chief of the union. That's a different PTO.

Mr. Miller: I understand that.

Deputy Grand Chief Fiddler: That is more northerly—northeast, northwest.

Mr. Miller: I'm familiar with that. John Beaucage is from my own riding. He's originally from Wasauksing First Nation. I know him, so I think that's probably why he called me just to make that request. I did write to the Chair requesting that we have a meeting.

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

RED ROCK INDIAN BAND

The Chair: The next presentation is from the Red Rock Indian Band, Harold Sault, councillor. Good morning.

Mr. Harold Sault: Good morning, sir. I'm kind of caught off guard here. I thought I was doing something totally different.

The Chair: You have 15 minutes to present your case.

Mr. Sault: Pardon me?

The Chair: You have 15 minutes to present your case as you please. If there is any time left, we may ask questions or make some statements. It's up to you.

Mr. Sault: Absolutely, yes.

First, I'd like to comment that when I come in, I don't see many of our First Nations people in here at all. I'm wondering how this meeting was set up.

I'm going to give a little history of what I see so far, as a First Nations person, how this started to unfold, in my mind, and when we came across this.

Where there are forms to sign regarding grant permission, I think they tried to pass that behind us without our notice. When we do stand up and notice, this bill seems to be crammed down our throats. To me, that doesn't show much faith in working together and trying to come up with something.

It overwhelms me to think that in this day and age these kinds of tactics are still coming from the government, I guess, or whoever is trying to cram this down our throats. There are so many issues. I know most of you, anyway, should have read the dialogue that was being sent back and forth between the Union of Ontario Indians and yourselves—the government. Pardon me. Like I said, I'm not even sure what's—it's so explanatory in this, but there are also other issues.

You can see that this bill they're trying to pass on us is riddled with genocide. It doesn't give us any strength. It doesn't give us any options. All it does, what I read of it—and I read the letters going back and forth—it's losing for us all the time; again, losing, losing. We're losing in every aspect from every department of the government, like INAC and Ministry of Natural Resources and so on.

We were told that we didn't have to sign a consent form and that it was an option to us. If this is an option, how can you call it an option if you're going to have a person with bills that may run into the tens of thousands of dollars pay for it and then expect to send a bill to the government? That's your option if you don't sign this health form.

There are so many things—our loss of services and programs. It sure is a clear map towards that. It's a clear map to losing our rights, our rights that I thought were protected in this day and age. I've heard of court case after court case winning, entrenching our rights, giving the obligation to the government to consult with our people. This hasn't happened at all during the passage of the bill. Like I said, it just shows me the faith we have in each other. First Nations people have been trying to work, broker, deal—everything—to try to get something to work with the government. It's obvious that that's not the trail that wants to be taken.

I honestly believe that our leaders in the higher places should be organizing a lawsuit on the fact of genocide. It might not be with just the health division; it's with everything. Our traditional practices are being eradicated, erased, wiped right out in our areas. That's more of where I am right now. Like I said, this ain't my portfolio, but there are a couple of people who have heard me before—I can talk.

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These areas where we're losing our rights are keeping us down—the poverty on our reserves and stuff like that. When you have a bill like this, that is a blackmail—if you read this, it's blackmail, when you have to sign it or you have to wait. It gives the power to the government to start erasing our rights. We see that happening so much lately, you know, in the last few years, time and time again. Our people are financially limited. They can't afford to buy their medications outright and have it repaid.

I'm trying to look at my stuff I was writing on the drive up here. It reminds me a lot of times of when you were 16 years old and you went to get your licence. You're always told by somebody that it's not your right, it's your privilege to drive; it is a privilege to you. First Nations people have a right. We have that right. We have a right in deciding our own future. We have a right as a nation. We were organized before. We're organized now—semi—and we have that right to work on deals or negotiate, like with this situation here. When you take that right away and you force this signing on us—the first time I saw this consent form thing, I saw an elderly lady dressed in what you would say is First Nation clothing or whatever, all smiling, signing this consent form. It shows how we are still being treated.

Numbers come out that First Nations people are starting to vote more and more and more. I see from the Canadian government flyers, again, three people; it doesn't say anything about First Nations or whatever. But the three people on the cover—and this is from the government—are First Nations people. I see all this stuff in the media that is giving the impression to our people

that we have this relationship that we're building, better and better. I will be the first guy to argue that point, but I also will support the people within the government—and I know there are a lot of them—who do work for First Nations people. But if they don't have a voice—it's like this train that's coming and you can't stop it, and this is one of them. We're losing in so many different areas that we have to stand up for this.

I'd like to say right now that if this comes down to signing a consent form, I will not do it myself. I will urge all our people not to do it. What I will urge is that for this bill that wants to be passed, or however that's going to take place after today, we work on it together and try to come up with some sort of reasonable deal with each other.

I can get into these letters, and I'm sure you've read them. I've read a lot of these issues, and they've been said time and time again. There's not much more to add to it, except that a lot of factors were left out of this. There are a lot of things that should be looked at: the future, what's going to happen. I do believe this bill is a step towards the loss of our rights, further and further, and I will not support it and I will not stand for it.

I don't know if there are any questions.

The Chair: We have about a minute and a half available for questioning. We'll start with the Liberals this time. Ms. Wynne, 30 seconds.

Ms. Wynne: Thanks for coming this morning. I just wanted to pick up—I think the consent form may be part of another process. Maybe we can talk about that afterwards.

As far as this bill goes, the conversation that's going on between the minister and First Nations, what we're expecting—and I just want you to know this—on the committee is that there will be an amendment to the legislation that will actually go some way to addressing the issues that have gone back and forth in those letters you're reading and that, you're right, we have all seen. I don't know exactly what the nature of the amendment is going to be, but the changes the minister is talking about with the First Nations groups are going to address those concerns. It is our expectation. You said that you think we should be working on it together. I completely agree with you, and that's why the minister has been meeting with the First Nations to come up with a change to this legislation. I hope by the time it's ready to get passed, you'll be able to support it.

The Chair: Thank you.

Mr. Sault: I'd like to comment on that. It's like shooting a bullet at somebody: You can't stop it. You're forcing this upon us and then you say, "We're going to force this on you and then we'll talk about working it out later." You're saying there's going to be an amendment to the bill?

Ms. Wynne: Before it passes, yes.

Mr. Sault: Before it passes? So it's passing?

Ms. Wynne: It hasn't passed yet.

Mr. Sault: No. But that's my point: The push is on to pass this bill. It's hard for us to pass this bill, for me to say, "Okay, pass it, and now we're going to talk; then we'll start talking within it." Is that what you were saying: the amendment?

Ms. Wynne: No. The amendment comes before the bill even gets passed.

Mr. Sault: I understand that.

Ms. Wynne: So the conversation is happening now, and then the bill goes back to the Legislature with the change already in it and gets passed in that way.

Mr. Sault: My point is, and you can correct me if you want, but once this bill passes, everything that's in it is also passed. Correct?

Ms. Wynne: True, but we're talking—

Mr. Sault: That's right. Everything in this bill is already passed, so the area—

Ms. Wynne: No. Not yet.

Mr. Sault: Okay, I'm sorry. If this is passed, the bill—

The Chair: Mr. Sault, if I can be of assistance: The groups we are meeting here today, and everybody else, that is to hear what you have to say and suggest to us any change that you want, which you are doing right now, and supposedly—I can't guarantee that—your suggestion and other suggestions will be incorporated. I think that's what you have been told.

Mr. Sault: Scrap the bill.

The Chair: You did a good job by telling us what concerns you have. Hopefully, we'll be able to address them before the final reading. But I'm sure the other parties may want to add something to that when it's their turn.

Mr. Sault: If that's what you want to hear from me, I'll tell you: Scrap the bill and start from scratch with First Nations people. That's basically it. There's too much genocide in this. It's directed toward genocide.

The Chair: Mr. Arnott.

Mr. Ted Arnott (Waterloo–Wellington): On behalf of the Progressive Conservative Party of Ontario, I want to thank you for making your presentation today. Our party shares many of the concerns we've heard over the course of the last few days of hearings. We have heard from a number of First Nations organizations that there was completely inadequate—nonexistent consultation in some cases. I was pleased to hear the parliamentary assistant to the minister just now acknowledge that and indicate that there is consideration being given to amendments. I think that's the first we've heard of that so far. I think you should be encouraged by that, but at the same time continue with the persistent points that you've been making. You're absolutely right: The government is very determined to pass this Bill 36 in some form. In fact, they put the cart before the horse by setting up the local health integration networks, by appointing CEOs at very high salaries, and boards all across the province, before they even had the legislation in place; in other words, the legal authority to do it. I think we have to continue to be very vigilant on some of those issues. Your participation today has been very helpful in that respect.

Mr. Sault: Thank you. I also would like to add—I know my time probably ran out—that I would ask every-

body here to please not consider this as consultation. I was asked to come and speak my mind. As you know, this is not a consultation, so please don't consider it as that. Thank you.

The Chair: Ms. Martel.

Ms. Martel: Thank you very much for having been here to give your opinion, to speak your mind today. We appreciate that and we understand, or I understand, that this is not consultation in any way, shape or form as would be understood or accepted by aboriginal people generally, and by yourself specifically. I think the point that has to be made is that there was no consultation with aboriginal people with respect to this document. There wasn't and, frankly, the way to resolve this is to put forward an amendment that would exempt aboriginal people from the provisions of this bill and then, as you said, start a full and fulsome dialogue, consultation, negotiation, with First Nations about what is necessary to meet the needs of First Nations people with respect to health care.

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I don't know what the minister is going to do in this regard. What I have seen is a lot of work after the fact; that is, after the bill was presented and First Nations reacted negatively to it. Then we started to see some consultation in a meaningful way about what to do next. That process should have happened before the bill was ever introduced and I regret that it did not. We hope there will be a process that will truly recognize First Nations as partners and we hope we will see that unfold in the near future.

I wanted to ask about the more specific health care concerns you bring today with respect to your own community. I'm assuming that diabetes is a very large problem in the community, but perhaps you'd like to tell us some of the key health issues that need to be addressed in your community.

Mr. Sault: I feel the health issues have been spoken about so many times. Coming from my mouth, I'm not sure it's going to change anything. Our health concerns in our community, of course, are the diabetes and alcoholism. There are numerous problems that our community shares with other communities, and with non-native communities. Our biggest problem, when it comes to how it appears to me this is going to work, is being forced to sign a consent form. I understand that if this consent form part is taken out, fine—well, not "fine"; pardon me.

It's a financial problem now, a financial burden. If you want to go and keep doing what you have to do, you have to sign a card that says we recognize you to do it, but in doing that, we also cannot recognize you if we want. That's one of the big issues, that a lot of people like myself, who are stubborn, to help in the control of the future of our people, will not sign this. A lot of them are elderly people. It is a very big health risk when they can't get the medication they want.

The Chair: Thank you very much for your comments.

Ms. Wynne: On a point of order, Mr. Chair: I just want to put on the record that the Speaker of the House ruled in May that there was no contempt of the Legislature in the setting up of the LHIN boards in advance of this legislation. I just wanted to make that point.

The Chair: Thank you very much.

TREATY 3 NATION

The Chair: The next presentation is going to be a teleconference with the Treaty 3 Nation. We have Simon Fobister, Deputy Grand Chief. Are you on the line, sir?

Deputy Grand Chief Simon Fobister: Yes, I am.

The Chair: Please proceed with your presentation, sir. You have 15 minutes.

Deputy Grand Chief Fobister: Good morning, ladies and gentlemen. I've been recently appointed as a Deputy Grand Chief for Grand Council Treaty 3. We represent 17,500 stakeholders from our Treaty 3 Nishnawbe Nation. We have deep concerns with Bill 36, the Local Health System Integration Act. I want to cut to the chase and go right to the presentation.

This is Grand Council Treaty 3's position on this bill. While Treaty 3 is in general agreement with the objectives of the task force recommendations, it recognizes that the forum for achieving many of these goals may not be the LHINs and that a more pragmatic approach may provide more common ground for our discussions.

We are also concerned that by asking for an exemption from the LHINs, any of the meagre funded and staffed programs etc. that would be used for aboriginal programs or for work in First Nations communities will be given to other programs or services in non-aboriginal communities. When it comes time to provide services to our community, we again hear that funds have been allocated elsewhere or that no funds exist. We do not want to have to wait for years to catch up to the level of services that other, non-aboriginal communities have. A look at the terms of reference for the task force will give a common framework for our discussion.

We would place the role of Health Canada at the top of our priorities, as the First Nations and Inuit health branch of Health Canada is the delivery agent, provider of funds, programmer and partner in the health care we receive in our communities and for our membership. Their participation in any discussion concerning health care networking is extremely important. Many of our communities have different and complex relationships with the First Nations and Inuit health branch. These range from government staff providing services, to the delivery of defined services through a yearly contribution agreement, to the provision of services through a five-year transfer agreement and to the potential of services provided through self-government agreements.

Under these circumstances, Bill 36 may provide some positive opportunities for communities, yet cause negative results in most other communities. This wide variation should indicate to Ontario that aboriginal people will not benefit from a single solution to this issue.

On that note, I further indicate that the area covered by LHIN 14 will provide more complications for health

planning and delivery. We have isolated, rural, and urban communities within these boundaries. The number, size and population of the isolated, semi-isolated and rural aboriginal communities can skew the health care delivery system. I'd also point out that the limited aboriginal representation anticipated for the board of directors of the agencies will not allow for proper community input into the planning and delivery of programs and services.

The patchwork of service delivery and programming that exists in First Nations communities requires that all levels of government work together to ensure that not one of our people falls through the cracks in the system. If it is our desire to ensure that this does not happen, then an approach that is aboriginal-specific must be developed to meet the needs of First Nations, Canada and Ontario.

Governance and accountability: The issues raised above also impact on the design and implementation of the LHINs. First Nations cannot agree to the delivery of services that may reduce both treaty and fiduciary responsibilities that the federal government has. The provinces have never wanted to take on these roles, and it seems that the current desire to have the LHINs provide services to First Nations may put Ontario in the position of taking on treaty and fiduciary roles and responsibilities.

Health system planning and evaluation, service delivery coordination and integration, and human resources staffing and requirements: Again, these issues require that all health delivery agencies, as well as Indian Affairs, Human Resources Canada, universities, colleges, education and training departments, etc. sit down together to plan for the future integrated health care delivery system.

Aboriginal health programs: We would like to reiterate the position that we are not mere stakeholders in the health care system. As treaty aboriginal people, we have aboriginal rights relating to health and treaty rights to health and are a fiduciary of the federal government. This provides us with special status when it comes to health care programming and to the whole issue of self-government and self-determination in relation to health care. We cannot enter into a relationship with the LHIN while these issues are swept under the carpet and both the federal and provincial governments try to act like they do not exist.

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I would now like to set out a series of recommendations that Treaty 3 sees as necessary if we are able to proceed beyond our current situation. The recommendations are as follows:

(1) For a truly integrated health planning, delivery and funding system, First Nations, federal and provincial health departments must sit down together and form a real partnership to provide better integrated health services to our community.

(2) There must be a non-derogation clause in the legislation, or stated in some manner, in order to address the aboriginal treaty and fiduciary rights issues. This requires direct consultation with First Nations.

(3) For LHIN 14, the board of directors must be expanded to ensure that an appropriate mix of isolated, semi-isolated and rural aboriginal points of view are represented.

(4) That funds for new or additional programs, services and staff, as well as the current levels, be protected or set aside for aboriginal communities while discussions are ongoing.

This ends my presentation. I'd like to thank you for taking the time to listen to our concerns.

The Chair: Thank you for your presentation. There's 30 seconds for each group to ask questions. I'll start with Mr. Arnott or Mr. Miller.

Mr. Arnott: Thank you very much for your presentation. We do appreciate the advice that you've given the committee. It's important that you've had the opportunity to participate in this consultation, because we're in the process of continuing our public hearings for the next few days, and then, hopefully, the government will be coming forward with amendments. Certainly our party will be doing the same and hoping that we can improve this bill to ensure that it's in the best interests of First Nations and all Ontarians.

The Chair: Ms. Martel.

Ms. Martel: Meegwetch. Deputy Grand Chief, congratulations on your new role as Deputy Grand Chief in Treaty 3. I have written down the recommendations, but I would ask for clarification on one point. You want a non-derogation clause in the bill, which of course would then ensure respect of treaty rights. Would Treaty 3 also want an amendment that would exempt Treaty 3 and other First Nations from the bill as well, to be absolutely clear that nothing will happen with respect to First Nations health care services unless and until there is a better consultation process to arrive at what those services are?

Deputy Grand Chief Fobister: Yes.

Ms. Martel: So both would be required, then: a non-derogation clause and a second clause to exempt First Nations, urban and on-reserve, from the bill?

Deputy Grand Chief Fobister: Yes.

Ms. Martel: Thank you very much for your participation.

The Chair: Ms. Wynne.

Ms. Wynne: Thank you, Deputy Grand Chief, for joining us this morning. I just wanted to clarify and reassure you that I know that a number of the issues that you've raised—in fact, all of them that you've raised—have been raised with the minister when Minister Smitherman started meeting with First Nation groups as long as a year ago, February 10, 2005, and he's met a number of times since then. In April 2005, the decision was made to create a task force. The recommendations that have gone to him include many of the comments that you have raised.

On the issue of the federal delivery of services, the LHINs—the new organizations—will not be directly delivering services, so those relationships with the federal government won't change. I take your point about the federal and provincial governments needing to sit

together. Are you satisfied that the recommendations that have gone forth to the minister are ones that you can support, the ones that went forth from the First Nations task force?

Deputy Grand Chief Fobister: I just want to add that I'm new to the file, so I don't really know what occurred previously and I don't know what position papers were given to the minister. I really can't comment on that.

Ms. Wynne: That's fine. Thank you very much for joining us.

CANADIAN HEARING SOCIETY, THUNDER BAY

The Chair: We'll move to the next presentation: the Canadian Hearing Society, Thunder Bay; Nancy Frost and Carolyn High. Good morning.

Ms. Nancy Frost: Good morning.

The Chair: You can start any time.

Ms. Frost: My name is Nancy Frost. I am the regional director of the Canadian Hearing Society, Thunder Bay region, and with me is Carolyn High, who is a director of our provincial board, as well as a member of our community development board for the Thunder Bay region.

I'd like to start by saying that the Canadian Hearing Society is a non-profit agency that provides a wide range of services that enhance the independence of persons with hearing loss or who are culturally deaf. We support the concepts and basic philosophies of the LHINs, those being accessibility, coordinated services, consumer focus, community-based promotion of wellness, independence and aging in place, as they are in keeping with the philosophy and approach of the Canadian Hearing Society.

Before Carolyn can highlight what health care must look like and what the LHIN must have in place, I'm going to spend a bit of time covering who the individuals are that we're talking about: Who are they, and what does accessibility mean to them?

Hearing loss is the largest and fastest-growing disability in North America. The two main causes of hearing loss are aging and noise. Thus, in this region, under the LHIN 14, with high industry, a large aging population, a large aboriginal population, we're seeing that we far surpass the national average of 23% of the population. We're looking currently at about 25.5% of persons under the LHIN 14 who experience some degree of hearing loss or are culturally deaf. This percentage is going to continue to increase as the aging population increases.

Persons who have hearing loss or are culturally deaf, again, represent the largest disability group that requires accommodation. Individuals who are affected by these issues are not homogeneous, and they can be seen or identified as four distinct groups, one being culturally deaf: They are members of a linguistic, cultural minority group. They are not persons with a disability. Their language is a visual, gestural, three-dimensional language, and they are of a deaf culture.

The other three groups I mentioned—hard of hearing, late deafened, and oral deaf—all rely on spoken language as a communication mode, and they use a whole host of communication supports from various devices to hearing aids, note-taking, real-time captioning. I think it's really important that you fully understand the individuals we're talking about, that they've got very unique needs, very unique requirements for different accessibility options.

The next page you've been presented with has statistics, which I briefly covered, in northwestern Ontario. You have them in front of you, so I won't take time now.

What I want to take time on is really talking about accessibility for these individuals. In the current LHIN legislation, access is taken to mean ease of geographic access to services or making appropriate services available in the local community. To the 25.5% of individuals who have hearing loss or are culturally deaf under the LHIN 14, access means far more than this. It means the removal and the prevention of barriers—communication barriers. It often, we find, is a hard concept to appreciate, so I've provided a definition of "accessibility" on another page.

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Access in any service, and in particular health care, must mean not only the ability to know where services are, to be able to enter a service, but also the ability to obtain or make use of, to be able to communicate. That means ensuring that an interpreter is booked, ensuring that there's a note taker, ensuring that you've got visual fire alarm systems, that nursing staff take the time to face a person, to use pen and paper, to ensure that the person is fully comprehending what is being said. Without that full access, you're not going to get full participation. A patient is not going to understand what's being asked of them. They are not going to be able to participate in their diagnosis or in their health care or treatment.

At this point I'm going to pass it on to Carolyn, who's going to elaborate on health care and the expectations of consumers.

Ms. Carolyn High: I would like to thank the LHINs standing committee for the opportunity to make this presentation. The focus in this portion of the presentation is health care expectations of culturally deaf and hard-of-hearing consumers.

The first point I'd like to relate to you is the duty of accommodation. It is a right of health care consumers to expect barrier-free access to health care. This means appropriate accommodations to be made to allow consumer understanding and participation in an integrated fashion. The onus is on the service provider, not the consumer, to automatically provide accommodations at the entry level and systematically apply them throughout the delivery of the health care.

Effective communication and accessibility are a legal right established by the Eldridge decision in 1997 in British Columbia. Being able to communicate your symptoms or your medical history and being able to understand what is being said by service providers are imperative to effective health care. This is also a legis-

lated right as described in the Accessibility for Ontarians with Disabilities Act, 2005.

Culturally deaf and hard-of-hearing consumers require communication supports, whether it be ASL interpreters, real-time captioners, note takers, flexibility in scheduling or whatever, to truly have adequate health care.

There also needs to be a provision of equitable health care. Only by providing a barrier-free accessible environment can persons with a communication disability achieve equitable health care. There is also a need for equitable health care between the 14 LHINs. This may require provincial standards or a health care consumer bill of rights to ensure that accessibility for disability groups is enshrined into the everyday practices of health care providers.

There is also a need to develop a holistic, integrated, one-stop-shop approach to hearing health care that is consumer friendly and accountable. Recognition of community-based services should be incorporated into this model, building on present unique community strengths and knowledge of consumer needs.

At present, health care is time-consuming and costly, involving physicians, ENTs, audiologists, hearing aid dispensers and hearing counsellors. A consumer must navigate a very fragmented system over a period of months with little or no follow-up. An integrated system using qualified professionals which builds on the strengths of community-based services would provide a seamless, consumer-centred model.

It is also cost-effective to foster independent living, reducing the burden on hospitals and long-term-care facilities. Hearing care counsellors are an integral component allowing individuals to live independently in their homes. They can help modify the home environment and provide information on communications strategies as well as provide information on technical assistive devices, which might include visual smoke detectors or amplified or voice carry-over phones, TTYs etc. In addition, hearing care counsellors and deaf counsellors can provide follow-up for hearing aid devices and provide information for family members.

To enhance independent living, there needs to be an increase in public funding assistance for persons on fixed incomes, particularly seniors. At present, only a portion of the cost of hearing aids is subsidized. This needs to be extended to other assistive devices. In addition, OHIP funding needs to be reinstated for audiologists. There is a safety factor if a senior leaves their door open because they cannot afford a visual doorbell. It is a safety factor if a deaf or hard-of-hearing individual does not have a visual smoke detector.

Another issue in the north is the shortage of ENTs, audiologists, ASL interpreters, real-time captioners and note takers. We need to attract, train and make the best use of our resources by using a more integrated approach.

We need to make sure that we develop qualification standards for our professionals in the hearing care area and to maybe use different strategies like incorporating centralized video conferencing technology; for example, the NORTH Network at our hospital here. Presently CHS uses the NORTH Network and the Smart Systems, where they can have interpreters and real-time captioners and note takers centralized who can reach out to rural areas.

There's also a need for systematic sensitivity training for health care providers. The training must be adequately funded, mandatory and ongoing, with the involvement of consumer groups.

Another area that is important is the involvement of consumers at the development, planning, audit process, advisory capacity and eventually, in time, within the LHINs board. It's important to integrate and work on the strengths of community-based service groups in the provision of the model.

In conclusion, the ideal health care system is consumer-friendly, has integrated access, is time-efficient and affordable, with appropriate entry services and follow-ups. It would have a holistic focus, including preventive health care and maximizing effective health care practices. If a person with a communication need is not accommodated, the chances are that he or she may be misdiagnosed. For example, a senior with a hearing loss may be diagnosed as having dementia and placed in a long-term-care facility. It is cost-effective for service providers to get it right from the beginning in making sure the health care system is truly accessible.

We basically support the philosophy of the LHINs. We want to ensure that the system is accessible to people with disabilities in general and to those who are culturally deaf, oral deaf, deafened and hard of hearing specifically. We are able to help the LHINs and the ministry through the provision of training. We want to be sure that the Ministry of Health understands the unique needs and requirements of our populations for specialized services. We want to be sure that the Ministry of Health understands the unique financial and administrative issues faced by the voluntary sector. The legislation must speak to the issues of public interest, due process and public consultation. The legislation must address the issues of provincial programs, agencies and their interface with local providers. We want the ministry to consider hearing loss and deafness as a priority issue with province-wide attention.

We'd like to thank you very much. If there are any questions for Nancy or myself—

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

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ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 710

The Chair: The next presentation is from the Ontario Public Service Employees Union, Local 710, Thunder Bay. Brenda Clapp is the president. Good morning.

Ms. Brenda Clapp: Good morning. I'd just like to mention that I've given Madam Clerk copies of this presentation for the panel here. I'd like to also make another comment: if I could have for myself and for any other presenters the full attention of the people who are here.

Sometimes it's very distracting when there are side conversations happening. Thanks.

I'd like to say hello and good morning to everyone. I'm very glad to be here today and to have been given this opportunity to voice concerns regarding the LHINs, better known as local health integration networks. This group, which is comprised of 14 regional boards throughout our province, are appointed; they are not elected. Also, the LHINs have very little or no medical background.

Before going any further, I would like to introduce myself and just share a little bit of my history with you. My name is Brenda Clapp. I am employed with the Ministry of the Attorney General. I have spent the past 27 years working in the offices of the Superior Court of Justice. Also, during these 27 years, I have been a proud and active unionist with the Ontario Public Service Employees Union. Currently, I hold an elected position on my local's executive as president of Local 710. I will say strong and proudly to you that OPSEU has worked intensely to ensure that the best public services possible have been provided to the people of Ontario, such as excellence in health care.

Throughout this time I have witnessed many changes; none, however, so radical and so far-reaching to the wellbeing of the people within our communities. As you can determine, I am not a health care worker but I am here today to lend my full support to the Ontario Health Coalition, to ONA, to CUPE, to SEIU and to OPSEU in their joint endeavours to preserve and enhance an already viable health care system. These four unions represent approximately 200,000 health care workers and are prepared to fight the LHINs. These four unions are speaking on behalf of the people of Ontario as the documents of the LHINs that have been proposed have been rushed through two readings at the Legislature without any consultation with Ontarians.

Our health care system is second to none, and is recognized around the globe as one of the best, if not the best, in the world. Hospitals in the communities deliver a universal level of health care. It is believed that Bill 36 will allow the LHINs to close many community hospitals and organize medical services somewhere outside our present community. Our present health care system does not discriminate who you are, what you are, and it especially doesn't discriminate where you are in Ontario when you need medical care. All people are given quality medical attention in our hospitals because it is available in communities across our province.

I ask just for a moment that you focus on the word "authority." This can mean many things to many people. An example of an authority can be when lights in an aircraft go on, telling you to stay seated and do up seat belts. This authority comes from the pilot. He is there to keep you and me safe. Another example of an authority could be a parent setting an 11 p.m. curfew for a teenager. This authority is there to keep the teenager safe. Now I ask, who is the authority with LHINs? The LHINs are appointed; they are not elected democratically. Who will ensure that Ontarians are safe and will have access to multiple medical services now being offered in our communities within our hospitals?

LHINs are aiming to allow health care providers to bid low for services. Is this what we want our health care system to become: bid for profit? Providers of these services will cut corners, they will try to reduce their costs, and the care that you and I receive will definitely suffer. The quality of health care will diminish, hospitals may close, and services now available within these hospitals will be severed and transferred, causing negative effects across this province and in our communities. Bill 36, "integration of the local system for the delivery of health services," is mainly comprised of grey areas with absolutely no successful model to compare to.

Local health integration networks are moving toward having only specific services available at very specific hospitals. They are already speaking of hip replacement surgery and cataract surgery being in specific locations within Ontario.

Because so many of us have had cancer or have had family members with cancer, I will use the oncology unit and the cancer treatment centre at the Thunder Bay Regional Hospital as my example to you in an attempt to localize the devastation the LHINs plan can cause those of us living in northwestern Ontario. The oncology unit at the Thunder Bay Regional Hospital is where people go to receive medical treatment after cancer surgery or recovery from cancer. Many patients return to the hospital after chemotherapy and radiation therapy because of the many ill side effects. Once the patients go home, they can now contact the doctors and nurses at the oncology or cancer treatment centre via telephone for personal consultation regarding their ongoing health issues.

Now the big question is, if the LHINs decide that the oncology unit or the cancer treatment centre at the Thunder Bay Regional Hospital should relocate to another site in Ontario, what would this mean to our patients, to their families and to the health care workers who provide these life-saving services? Many of our patients would incur a great financial burden: the expense of travelling, such as making flights to another community for health care, accommodation while away from home, such as hotels or motels to stay at, meals, and don't forget the time off work for the family member who has to care for the patient as well. This, my friends, undoubtedly creates a two-tier health care system. If you can pay for health care services, you will receive them.

Now, for the workers, the LHINs scheme would mean reapplying for jobs when a new employer takes over. There are no guarantees that you keep your benefits or your pension. There is no job security. This would certainly lead to other economic losses and deter other health care workers from locating in our communities.

The boards have been ordered to merge, transfer and combine services. If the LHINs don't do what has been mandated to them, the government simply moves in and does the job itself. This definitely indicates that services, as well as jobs, as we now know them will be disappearing.

In view of the fact that my background is with the Superior Court of Justice, I will touch on some of the factors that apply to the court system. These facts were noted in the documents labelled "Health Law" put together by the law firm of Cassels Brock and Blackwell. "Health service providers could request the reconsideration of LHINs' integration decisions and minister's orders within 30 days of receiving the decision." LHINs and the minister could enforce integration decisions and ministerial orders by applying to the Superior Court of Justice for an order directing the party to the integration order to comply. It is believed that these orders will allow the LHINs and hospital service providers the ability to override existing collective agreements.

Our collective agreements protect our jobs, they protect our members, they protect public services and they have ensured a safe health care system for all Ontarians to enjoy.

I have spoken to many people I know and to numerous people in my union. The message I have put out is that it is time to get involved. It is time to speak to your local MPP. It is time to tell others about the LHINs and write letters to the editor. We Ontarians can no longer trust the McGuinty government to protect our health care system.

The Chair: There is about a minute left. We'll make it 30 seconds each for questions. We'll start with Mr. Mauro.

1030

Mr. Mauro: Thank you, Brenda and John, for the presentation. As a northern member—Michael and I have had an opportunity to talk about this—obviously health care has been chronically a very serious issue for people who live in northern Ontario in terms of access to services, quality of service and the cost involved in accessing that service. So we take very seriously when concerns are presented from anyone about legislation that may erode what we think already is a very difficult service provision situation right now.

Clearly, from the list of presenters, there is a lot of agreement among the different union groups represented here today that there are concerns with this. My question to you and to John, whoever would prefer to answer it, is if you could give me examples of powers or authorities that the LHIN legislation is going to put in place or give to them that presently do not already exist within the Ministry of Health that could potentially make it worse than it already is. Because my read on it is that there's nothing being transferred to the LHIN that the ministry can't already do, whether it's an integration or a hospital closure or a privatization. I'm trying to find some examples of things they'll be able to do that don't currently exist.

Mr. John O'Brien: First off, Bill, this legislation, in our opinion, should be scrapped and you should start over—I think some of the First Nations people already indicated that—because you haven't consulted with anybody. It's already had second reading. So it's totally a lack of planning. What you're doing is putting the cart before the horse. These LHINs have already been put in place. For example, you have the chairs, you have the CEOs already appointed. There's no transparency. You're going to turn over $21 billion of taxpayers' money to 14 LHIN groups across the province to distribute taxpayers' dollars as they see fit. There are requirements that the LHINs have to do certain things, and if they don't do certain things the Minister of Health will step in and make sure they're done. That's going to really devastate our area in northwestern Ontario.

I'd like to bring up in regard to that the current situation in northwestern Ontario with the forest industry, where it's taking away from the smaller communities, feeding the bigger communities. In regard to health care, we see that happening in the northwest too. For example, hospitals in Red Lake, Sioux Lookout, Dryden, Marathon, Nipigon could actually be closed over the next 10 years, based on this cheap type of service when you shop out information.

I guess we're out of time.

The Chair: You will have more opportunity. Mr. Miller.

Mr. Miller: Thank you for your presentation. I'll follow up on the one point you were making about the process, the cart-before-the-horse aspect of this. I know that in my area I've already met with the hired CEO for the LHIN that represents Parry Sound–Muskoka, yet the legislation has not passed. The government appointed the boards and hired the staff and the legislation is just midway through the legislative process, which does seem to be putting the cart before the horse.

You raised the point several times about the fact that the boards are appointed, not elected. So I assume that means you'd rather, if this bill passes, or an amended version of it, see the boards elected. Do you have any advice on how that should happen?

Mr. O'Brien: I think you're right on. The legislation has had second reading and is now going for third reading as early as March. You've put into position high-paying jobs, you've announced closures of Ministry of Health offices that are going to put 300 people out of work, you've got the LHINs in place, and the legislation and the authority hasn't even been passed. So it's totally ludicrous to think that now you're coming out to consult. This is crazy. You're supposed to consult before you put the stuff before the Legislature. We're asking your committee to go back to the drawing board, kill this legislation, do your consultation—because you're doing it now.

It needs to be in a lot more than four communities in this province. We have over 500 municipalities that are going to be affected by this legislation and you're going to have four cities where you're going to talk to people? That's crazy. If you saw the first presenter this morning, from Treaty 9 in the Kenora area, you're not even going anywhere near that place. Your committee is not going there. You're coming to Thunder Bay for one day and then you've got three other cities, and that's it. And they call that consultation? I can tell you, the general public, in fact your own MPPs in our area here, had no idea what

LHINs meant six months ago. The public doesn't know anything and our own members, 90% of them, don't know what LHINs are. And we're going to have it in law as soon as a month from now. That's crazy.

Ms. Martel: Thank you for making a presentation today. I wanted just to touch on the powers that the minister and/or the LHINs have. Some of these are shared; some of these are exclusive:

"(a) to coordinate services ... between different persons and entities,

"(b) to partner with another person or entity in providing services ...

"(c) to transfer, merge or amalgamate services, operations, persons or entities,

"(d) to start or cease providing services,

"(e) to cease to operate or to dissolve or wind up the operations of a person or entity."

That's under the definition of "integration."

My point is that nobody should have those powers—not the LHINs, not the minister. The sad part of what is happening here is that the government tries to say the LHINs are going to be close to the community; they're going to be able to make decisions on behalf of the community. The fact of the matter is, the LHINs are agents of the government. They are appointed by the government; they serve at the behest of the government; the budget they have comes directly from the government; the accountability agreements that they have are with the minister, not with the community—and the list goes on and on.

My concern is that you've got powers with respect to the minister, for example, that are the most that we've seen in terms of centralization in any other piece of health care legislation, including even what was done under the previous Conservative government. But what you have now is the government establishing a buffer between itself and the community so that with really nasty, unpleasant decisions the minister can say, "Oh, don't blame me. Go blame the LHINs." You can't go blame the LHINs because they're not accountable, they're not elected, they're not appointed by the community. So you've got nowhere to go when nasty decisions are being made. How comfortable and confident do you feel, with that kind of control by the minister to the LHINs, that the local community is going to have any kind of important say in the decisions that are taken?

Mr. O'Brien: The LHINs are saying this is local. This is not local. Some of the LHINs are the size of Nova Scotia and Manitoba—for example, ours is. It's the size of a province and you've got nine people appointed. And they have unbelievable powers. That's totally inappropriate, in a democratic society, to have a board that's appointed. They don't have to go before an electorate, they don't have to go anywhere and they're going to control $21 billion of the health budget—that's two thirds. It's ludicrous to even think that.

We're asking your committee to decide to scrap this bill and start over. If you want to do this, start over and do it the proper way, by consultation first, then proceed on to legislation if you want to make those changes. But you can't put the cart before the horse, because this is craziness.

The Chair: Thank you very much for your presentation.

Ms. Clapp: Thank you.

CANADIAN MENTAL HEALTH ASSOCIATION, THUNDER BAY

The Chair: The next presentation is from the Canadian Mental Health Association, Thunder Bay, Maurice Fortin. Good morning.

Mr. Maurice Fortin: Good morning. I understand I have 15 minutes, so I won't read the presentation to you. But I want to touch on some aspects of it that I think are important.

The Canadian Mental Health Association, Thunder Bay, has existed in this community since 1975. We're a non-profit, registered charity that came into being as a result of a need for aftercare services for folks being discharged from hospital. Today we provide a range of services, including a day program for folks who have serious mental illness and a crisis program for the city and district of Thunder Bay that really serves all of those communities in the sense that it answers the telephone for whomever calls. We anticipate that we'll hear from more folks as we see layoffs across the Thunder Bay district. We are accountable to this community through a board of directors of 15 individuals who represent families, consumer survivors, the business community, and health and social service providers.

My first general message to you is that the mental health and addictions sector gets it. We've been involved in developing integration strategies over the last three or four years. Many of us sit at mental health and addictions planning tables and we are already developing strategies to integrate service. So hopefully as LHINs come forward, they will look at some of the important work that we've done and continue to build on that. Currently, we're developing an early psychosis program as a regional program, and that will serve both districts. It is causing us to partner with any number of service providers, both hospital and community, across 14 communities. We're very excited about that.

1040

I want to speak to some of the important issues within LHINs that we have some concern about. First I want to talk about the integration piece. I want you to know that we support the need for LHINs to hold organizations accountable for the delivery of the integrated service plans. But we are concerned about the section of the legislation which provides power to force non-profit organizations to cease operating. We don't really believe that LHINs should have the power to make an organization that has existed in this community for 30 years go away. There is also a very practical issue around causing organizations to cease operations. We have a number of contractual obligations with other organizations. The

Minister of Health and Long-Term Care is not our only funder. So certainly from a practical point of view, you need to think very seriously about this particular piece of the legislation.

It was interesting this morning that on the CBC news I heard one of your ministers express some concern about potential changes to childcare funding which will cause you to be in some serious breach of your contracts with providers. I think it's ironic today that we are in that position and that you are mandating that position.

We have no problem with the withdrawal of funding for transfer payment agencies that aren't meeting their contractual obligations.

I also want to point out that part V of the legislation, which allows for 30 days to request consideration of a LHIN's integration decision, is simply not enough time. The legislation must allow for due process and fairness, including expanded time frames, to allow organizations to respond to such important decisions.

There's a section of the legislation that addresses the alignment of community care access centres and provides for the future expansion of the mandate of CCACs to assume a broader role in the future. While it's not stated in the legislation, certainly within the provincial, regional and local networks of mental health service providers there is unanimous opposition to the development of a coordinated access to service through a single access point operated by CCACs. We are concerned that in allowing for a broader mandate, you are moving in that direction. The opposition to a single access point stems from two perspectives.

Routinely, individuals with mental health and addictions issues access the system through multiple points. They include crisis centres, detox centres, emergency departments, primary care centres and regular intake processes. Their need for services is often acute and immediate. A system requiring individuals to queue up for assessment and referral will not serve the needs of this population. Mental health and addictions providers should be supported by the LHINs in developing "every door leads to service" strategies to ensure timely access to service.

Our second concern about that approach, specifically a managed competition proposal call process where potentially service will go to the lowest bidder, is that mental health and addiction services require highly skilled interventions by competent and trained professionals. Consumers of mental health and addiction services and their families require long-term, continuous interventions and strategies to support their full return to community life.

I want to say a little bit about the provincial strategic plan, which is also referenced in the legislation. It is no coincidence that the priorities related to mental health and addictions during the LHINs consultation process were virtually the number one priority across the province. In most jurisdictions they either scored 1 or 2. We know that the prevalence rates for health issues related to mental health and addictions continue to rise and are resulting in profound individual and societal impacts and costs. We want to encourage the Ministry of Health to protect the mental health and addictions envelope within its strategic plan. Historically, such services have been poor cousins to issues such as cancer and heart, and we expect that to continue. Within the LHINs process, there is concern that those better-known, more acceptable health issues, often supported by public sentiment, will become the funding priorities. Will we be competing with organizations such as hospitals and cancer care centres to make our priorities known?

I want to comment as well about the community engagement issue. We support the need for the LHINs to include the facilitation of the involvement of service providers and health system users in planning and in developing the plans for service delivery. However, the degree of involvement of consumers and families of mental health and addiction services is of particular concern. This group has historically been marginalized as a result of social and economic issues such as poverty or the devastating impact of illness. We encourage the Ministry of Health and Long-Term Care to recognize the need to consult consumers and families on mental health and addictions planning and to require their involvement through your stated policy. This has been the case in other jurisdictions such as Australia.

One of the concerns with respect to the LHINs legislation is that it has not referenced or included other determinants of health. Those determinants of health include an adequate income and safe housing. We are concerned that a number of these issues are under the jurisdiction of a number of other ministries: income and disability under the Ministry of Community and Social Services; housing under the Ministry of Municipal Affairs and Housing; children's mental health under the Ministry of Children and Youth Services; health promotion and illness prevention under the Ministry of Health Promotion. How will these important functions that impact on the determinants of health and, ultimately, on your strategy and your vision for health be recognized and connected to the provincial plan and the LHINs planning process?

Of particular concern to our sector is the role of planning for safe and affordable housing, either with or without supports. We would recommend to you that the ministry continue to assume central responsibility for the planning and delivery of supportive housing for mental health and addictions consumers.

Finally, the issue of LHINs and accountability: While the legislation refers to the need for LHINs to engage in community engagement, those terms are not well defined. Given the vast geography of LHINs 14, what mechanism will be in place to ensure participation of communities such as Atikokan, Manitouwadge and Red Lake, to name but a few? How will First Nations be engaged in urban centres and on reserve? Most importantly, what will be the mechanisms to ensure that LHINs do not ignore a strong consensus in planning and direction from community stakeholders? The legislation requires that LHINs act in the public interest, but the concept is not well defined. What will be the mechanisms to ensure the

accountability of LHINs to the communities and to the region they serve?

In closing, I want to thank you for the opportunity to speak to you today about this important legislation, and I welcome any questions you may have.

The Chair: There really isn't time left for questions, but we thank you for your presentation.

1050

THUNDER BAY HEALTH COALITION

The Chair: The next presentation is from the Thunder Bay Health Coalition, Charles Campbell, spokesperson. Mr Campbell, you have 15 minutes in total, which you can choose to use or allow us to ask some questions.

Mr. Charles Campbell: Like the previous speaker, I won't read through the entire package; you folks have that. I want to hit on a couple of specific areas of concern.

First, I would like to compliment the government. The principle laid out in the preamble to the LHINs document is very positive. Probably with the exception of the LHINs structure itself, we think that most of the goals and things that are laid out there are very strong and positive messages. Our concern is that Bill 36 is not going to achieve those goals, but is going to achieve a much different end.

We're also concerned that the LHINs' mandate, of course, ignores or excludes practitioners, clinics, public health and a number of other areas. The concept of integrating the health care system, when you've got some of those key delivery agents not part of this exercise, is a significant concern. I know that members of our aboriginal community have spoken, and will be speaking as well, about their concerns. The issue of jurisdiction around the federal and provincial responsibilities is key in those communities.

Geography is one of our big concerns here in the northwest. You're dealing with a part of the province that has 2% of the population, so in terms of provincial priorities, most of us recognize that we don't register very strongly. However, we've got 60% of the land mass. If you pick up the northeast, you're probably picking up about 35% of the rest. If the LHINs model is about low-cost delivery, we're cooked. We can't deliver over that land mass the kind of efficiencies you're going to get in an urban area. I'll quote somebody who would probably be quite happy to see a LHINs-type model introduced, and that is Michael Decter. His comment from his book, Four Strong Winds, in 2000 was:

"The early evidence from two of the first Canadian provinces to adopt this model"—that is, regionalization—"Alberta and Saskatchewan, is that the system works well in urban areas.... However, the regionalization of rural health services, which have been accompanied by the closure of many small hospitals, is less clearly a success."

The reality is that if you look at Alberta, Saskatchewan and BC in Canada's situation, rural areas continue to be hammered by these sorts of services. It's fine to be able to have a shorter wait list, but the reality is, if that shorter wait list means you're now spending three weeks in a hospital in an urban area 1,000 or 500 miles away from home, incurring a lot of those operational and travel costs yourself, the health care system just saved some money, but you haven't had any real benefit to yourself as far as your costs are concerned. You've just transferred those costs, and that's a concern.

Under the current system we're operating under, we've got Dr. John Porter, who's going to be doing joint replacement outside of Thunder Bay. In a LHINs model, I'm not sure that would be a cost-effective way of doing it. If we find a hospital in Ottawa that can do joint replacements, I am concerned that we then leave ourselves open to saying, "The model says economy and efficiency. Let's start shipping people to where we can do the cheapest surgery." I won't revisit the issue of the travel subsidy and the partial costs and the other issues there, but clearly if you're going to start shipping people and you're not bearing the cost of that, you're not properly reflecting the reality of the geography we deal with.

The second issue I want to touch on briefly—I'll try to be brief—is accountability. The government is restructuring health care again with the LHINs. There are a lot of things, as I said, in the preamble that sound really positive about where we want to go. But when I read through the document itself, the LHINs are being given significant powers to reorganize and restructure health care in the region. Although there are words about accountability in the preamble, when you read through the details, they're also given very clear mandates that refer to accountability to the minister and to the Ministry of Health, not to the communities.

There's consultation with the communities and providing the communities with an opportunity to say things, but the reality is that when you read through section 5, with the specific language around accountability, clause (b) makes "recommendations to the minister," clause (e) is "be accountable to the minister," clause (k) is "in accordance with provincial priorities," clause (m) is "to account to the minister," and clause (n) is "that the minister specifies." Those are all references to the minister's responsibility.

Nowhere in the material did I find references to being accountable to the community. There is no formal structure to provide accountability to the community, other than through the ministry. I'm not sure how making you accountable to the minister is supposed to provide a warmer, fuzzier feeling from us out here that there is accountability to the local community, because the ministry is accountable to the minister. How have you changed anything if the lines of accountability go back to the ministry anyway?

There are some other things, as I said, in the package that I won't go into in detail here. We are concerned, however, about the fact that one of the bill's mandates is to have the LHINs established, staffed, put together, and then go out and try to plan out what it's going to look like

to deal with conflict of interest guidelines. It seems to our organization that if you're going to establish a body with these kind of powers and you're going to staff it through central appointments, you should have had an accountability framework that was starting from—as opposed to having people put in a position where they're given a series of responsibilities and then, after that fact, they're given responsibility for creating their own conflict guidelines.

The third concern we have is very much around the free market model. We can say what we want about all the warm and fuzzy words that are referenced in the package around the need for Canada Health Act enforcement, but the reality is that what we're talking about is introducing a system which, as its primary criterion, evaluates the medical system, the health care system costs in a market fashion: in effect, set pricing, try to find the lowest price for services, throw all the services into a bag, bid them out, put price stickers on all of these services.

We don't have a problem with trying to assess and properly value the health care system we have. However, if you want to set up a sticker price system for health care services—the practices are being followed in other jurisdictions in Canada, in Europe, in New Zealand and in the US—you establish a pricing system. You then, in effect, are introducing an opportunity for private business to come in and say, "Okay, now we know what we're bidding against."

No disrespect to the process of tender, but the reality is that once you've got the contract, when the bills start to come in, are you going to hire from a private service agency and start to say, "You know what? Maybe you'll just have to put those patients out on the street because your prices are too high"? No. The reality is, once you've introduced that tendering system, once you've brought in a pricing system that allows people to establish, "Here's what we have to target for our pricing," you will see more privatization of the system.

We've seen that with the boutique clinics in Alberta and other jurisdictions. This will lead to that, if that's the process we're going to take, because the LHINs legislation does not fundamentally show anything in that material, that we could find, that is establishing community value. It talks about accountability, it talks about efficiency, it talks about finding the most effective price for delivering a service, but it doesn't talk about what happens if the doctors who are in Terrace Bay are told, "Your pricing is a little high. We can get the same service somewhere else. We'll transfer you to Toronto." It doesn't talk about the community impact of those communities. It doesn't talk about the fact that downsizing in places like Atikokan in the medical system has meant that people have to come to Thunder Bay if they're looking at doing a delivery or any kind of practice, and those costs are not something the LHINs have to deal with. So those are significant concerns we have.

In conclusion, we believe in a strong public health care system. We believe the accountability framework that is discussed in the preamble to this bill is good—that is, establishing local input, allowing local contributions to the process—but we are concerned that the bill, in its actual execution, is deeply flawed.

The Chair: Thank you. Thirty seconds each.

Mr. Miller: Thank you very much, Mr. Campbell, for your presentation. You talked at length about accountability and how the LHINs will make the system accountable to the minister, but not the communities. What do you think will happen with hospital boards after this LHINs legislation passes?

Mr. Campbell: I'm not sure the hospital boards will have a fundamental change in how they operate. However, my concern is around the integration issue. The hospital boards may well survive, and the issue of accountability there may also be an interesting one in terms of providing more open-meeting details and more openness toward how hospital boards are operating. That would have been good to see.

I'm more concerned about things like a lot of the social service agencies; for instance, the one that was here just before me, talking about their local community boards and how their relationship with the health care system could be changed if the LHINs, given the powers they have, say, "Health care services are more effectively done by one agency. We're going to merge five of you, and now we're going to tell you where your assets are going to be transferred," because the legislation does allow for that to happen.

Ms. Martel: Thank you very much for your presentation today. I want to focus on the market tendering system, or competitive bidding or cutthroat bidding. You just have to look at the CCAC model to understand that there has been huge privatization of home care under the cutthroat bidding model. The U of T did a study in 2001, and even though it had only been in place for about four years at that point, there had been a shift from 18% of those in the marketplace, or for-profit, to 48% by 2001, and I suspect we're well over 50% by now.

The minister, on the first day of the hearings, said, "There's nothing in this bill that says we're going to have competitive bidding. People who purport to say that are providing misinformation." My point is there's nothing in the bill that says it's not going to happen, either, so if it's not going to, then put it into the legislation. Given what's happened in home care already, what are your concerns if that model is applied to all of the other health care services that LHINs will have some responsibility for?

1100

Mr. Campbell: Similar to your comments, whatever is said in the bill, clearly there is nothing said about not using competitive bidding. The other thing is that although competitive bidding is not explicitly referenced, the wording of the bill around the accountability issues, when you look at other jurisdictions in Canada where these sorts of regionalizations have happened, unless the government is planning on trying a brand new model for regionalization, the competitive bidding process seems to be the way that accountability and efficiency—those words are used heavily in the document—are introduced.

If the government is looking at introducing something that looks differently from the other regions, it would have really been appropriate, I think, for the government to go through the process of that consultation and the minister's strategic plan consultation prior to erasing the existing bodies and establishing new ones. I'm not sure exactly what the LHINs are supposed to implement in the next 12 months, unless there's a document on a shelf somewhere that most of the public has not seen that tells us what health care is going to look like.

Mr. Gravelle: Charles, as always, thank you for your very thoughtful presentation. I know you put a lot of work into that.

In terms of accountability, that's a huge issue, and even in terms of representation. I spoke earlier when Jules Tupker was up here as well. There's an assumption that there will be fewer services as a result of this. It's the assumption that's being presented.

I work from a different premise. We're going to have representatives from many communities throughout the northwest. We know the northwest LHIN is a huge one. It is going to be really challenging, but the fact is that we've got representatives from communities who understand better than anybody else the need that they maintain services, and we have recommendations from Mr. Closson's report which suggest more services in the communities, more service to be provided out of Thunder Bay to take off some of the stress that's presently on Thunder Bay Regional Hospital, for example.

My question, if there is one, is—I mean this as politely as possible—why do you assume it will be going in the other direction when I think we're going to have people who are going to be able to very clearly, on a regional basis, make the point very strongly that we should be having an expectation that whether you live in Dryden, Kenora, Marathon, Greenstone, there are enhanced services? Again, recommendations are out there to quite literally enhance those services by putting in the district hospital designation that Mr. Closson has recommended.

I would not be supporting a reduction in services myself, as the member representing a large part of the northwest LHIN, but your thoughts on what I'm saying?

Mr. Campbell: The reality is that we definitely need more services. We recognize that. We certainly have heard a lot of good things in terms of verbiage about the services we need from various groups in the health care system. My concern is, and I'll go back to what I said a few seconds ago, where is the strategic document that's supposed to lay that out?

Why have we removed one group that was being selected from within communities prior to this LHINs model? We had a number of regional health care agencies in place. We've wiped those organizations out, replaced elements of them with the LHINs, so we haven't changed, I don't think, community accountability other than we've got fewer LHINs than when we used to have the old health agencies. We've reduced the number of bodies that are representative. We've reduced the number of members. There's a maximum cap of nine on each LHIN's board.

The community representation: I don't want to take anything away from the people on those boards. A number of us on the local health council thought it might be appropriate to apply for those boards as well, but our concern is that those boards are clearly accountable to the minister. The minister has not chosen to show his hand in terms of what that strategic plan looks like, and those boards are very much directly accountable to cabinet and the minister for their existence, similar to the situation we've seen in other boards, certainly in the way the province dealt with hospitals and the boards of ed under the Conservatives. When you've got a board that is directly accountable to the minister and cabinet, it really makes it a little bit harder for you to voice concerns than would otherwise be the case if you were accountable to members in the community.

Michael, I hope you're right, that what we're going to see is an increase in services. However, the verbiage and the language around the responsibility of the LHINs is very clearly around the structuring and restructuring of the system. I don't see a lot of verbiage around strengthening communities. I see a lot of verbiage around how the system has to be rationalized. My concern from other jurisdictions is that unless we see something other than that sort of verbiage in the operational lines of the LHINs, I have a hard time trusting any government until I see some track record that says we've got a stronger commitment in the legislation, not just in the verbiage press releases that come out after it.

The Chair: Thank you for your presentation.

KENORA RAINY RIVER DISTRICT ADDICTION AND MENTAL HEALTH NETWORK

The Chair: We'll move to the next presentation, from the Kenora Rainy River mental health and addiction directorate's network.

We have another name, so maybe you want to introduce yourself. Welcome.

Mr. Jon Thompson: Yes, Diane wouldn't be too impressed. I'm not trying to pretend I look like her. She's much more attractive. But we do agree on many other things. My name is Jon Thompson and I'm one of the other managers that is part of the northwest network.

The Chair: Please start any time you're ready, sir.

Mr. Thompson: Thank you very much. I apologize, too. We had a technological malfunction this morning, so you don't have our five recommendations. But we'll get through them now and we'll give them to you afterwards, perhaps.

First of all, just as an overview, the Kenora Rainy River Addiction and Mental Health Network—just briefly, as to know our context and who we are—basically represents the 16 funded addictions, mental health and consumer provider organizations in the Kenora-Rainy River district, basically north and west of here. Some of those are sponsored, some of them are free-standing, some of them also provide violence and sexual assault services as well. For 25 years, we have been advocating,

planning, coordinating and trying to improve access to care for the folks that we provide service to, providing both efficient and effective services at a local and district level. I think we've tried to encompass the spirit of much of what the proposed legislation is intended to do in the new LHIN environment, in the sense of being open, flexible, visionary and progressive in our thinking, as we work with each other across the vast distances in our districts.

We'd like to start too by saying that we certainly echo much of what you have heard already, or will hear, in your series of hearings around the province, particularly the things being said by the Canadian Mental Health Association, the Centre for Addiction and Mental Health and the federation of Ontario mental health and addictions programs. We share a lot of similar interests, sentiments and whatnot, but today we'd like to take a bit of time to talk about and highlight our particular perspective on some things in the Kenora-Rainy River district.

Overall, we certainly do endorse the main principles underlying this particular legislation. We are way overdue for reform. We welcome it, almost reaching out for it; we really desperately want it. But there are a number of concerns with this particular legislation that we share with others.

Our first recommendation is around the recognition of how broad the prevalence of mental health and addictions problems is in our area. Directly, right now, we are probably providing, or are accessible to provide, service to almost 22,000 folks in the part of the catchment area that we serve outside of the district of Thunder Bay. With that kind of impact—I think the socio-economic costs of addiction and mental illness are well established. The importance of making this sort of silo mainstream is the opportunity now, and if we could bring that in in an appropriate way, we think that would be a major home run for health care in general and certainly to make this sector feel a full and important part of it. So our first recommendation along those lines is to ensure that the regulated and non-regulated mental health and addiction services are recognized as primary care services and included as core components of the northwestern Ontario health care system to ensure a holistic, consumer- and family-focused and coordinated approach to care.

Our second recommendation is related to funding. At another hearing last week, we talked in more detail about our perspective on that, but this particular legislation doesn't seem to address the funding mechanism issues very well, as far as we can see. The funding for our sector in particular is, frankly, just a big mess. It ranges from the inflexibility of the silos to the inadequacy of funding in some cases, to the lack of provision to move things around to do things in more effective and efficient ways. So, along those lines as well, our second recommendation is that this legislation needs to develop or commit to a funding mechanism that is sustainable over a period of time, recognizes the need for both re-allocation and increased resources, recognizes the cost of accountability and compliance—and by the way, we have so many of those things. I, myself, do 29 reports 73 times a year, and I didn't go into this business to do that.

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Also, as others will say, I think our sector has a sense that our resources need to be at least protected for a while—the notion of ring-fencing or a protected envelope—to ensure that they don't filter off, or, as we compete with some of the bigger players and whatnot, we don't just get lost in the shuffle.

The third recommendation is related to the principle that I think this legislation is headed towards, which is to ensure that there's no wrong door for service and that all doors are open. So from a consumer point of view, wherever they reach into the system they are going to get the appropriate range and scope of services that they need. To do that, our services have to be fully recognized, as I said earlier, as core services so that people identify the need for them, no matter where they are, and can access them. So there needs to be responsiveness, accessibility and that type of continuity of care.

That led us to another thing: We're somewhat puzzled because we want to be more inclusive, and we're wondering why this legislation is leaving out some other significantly big providers of health care. That led us to recommendation number 3, which is recognizing that service providers in our sector are, first of all, health care providers and that also physician, pharmacy and public health services should be somehow included in the scope of the LHIN. We realize these latter three groups are currently excluded, but we really can't see how we're going to make much progress on the integration, the breaking down of silos, if these things don't come together very much.

Our fourth recommendation is related to the issue of engaging the community: providers, consumers and that type of thing. It's not clear, again, from this legislation how that's being defined. For example, "local" in this case might be the whole of the northwest LHIN, which you've heard is a very large area. I think we'd like you to consider the concept at least west of here. Most of the services are organized along both economic and social lines, along the catchment area concept. There's a hub in the small community. There needs to be a range of direct services and supports there, and so on and so forth. We certainly don't want to lose that. We think that's a winner right now, and we certainly want to be able to preserve that. So we can't see how a lot of direct services can be delivered on a regional basis, and we're wondering how that's going to happen.

We're hoping that the legislation in this case, recommendation number 4, legitimizes and recognizes the role of progressive consumer and provider networks such as ours by delegating and resourcing specific planning tasks to be accomplished. I know this is going to be a very challenging matter, but I think there's some good work that's been done already that we could certainly build on here in the northwest. But we have to have the authority to do some things, some clear mandates to do some things, and the cost of us getting together to do these

things has to be recognized. Right now, I think our network northwest of here feels like we're doing a major planning function for addictions and mental health. It's not really recognized by anybody, and yet we seem to be asked to do a number of things.

Our last recommendation is around the notion of integration and what it means. "Integration" seems to mean everything from, "Let's talk together a little bit more," to, "Let's all get together in one family type of organization." We have a fear that too much of this legislation is focused on that end of integration, meaning that there should be less transfer payment agencies, particularly in our sector. We know there are quite a few, but one of the things we have to emphasize is that there's such a richness in our tradition over maybe 20 or 30 years—our history, culture, diversity of approaches to health care, the philosophies of care that we use—that we feel it would really be lost in larger organizational structures. In any case, even if you pull us all together, there's not a lot of money to be saved. We don't make up much more than 4% of the total health care budget. So even at our worst, floundering about, we're not costing anybody a whole significantly relative lot of money on that level.

The other thing too is, a lot of folks are fearful of section 28—or the "hammer," as I guess some people might like to think of it—a provision that the minister or the Lieutenant Governor in Council would have to force mergers and whatnot. Our sector really doesn't need that. I think we've recognized the ability and the need to change and have done so on many occasions, probably more along the lines of coordinating services, redistributing resources, partnerships and that sort of thing, rather than all being part of the same organization. I think we've had some success with that.

Our last recommendation is related to this. We would certainly recommend that there must be more due process or procedural fairness in regard to some of these integration decisions. We also think the decisions should reflect some other dimensions, such as ensuring there's a comprehensive range and minimal service availability, particularly in some of our small and local areas, the accessibility question and also supporting services where there's been good focus on the quality of care.

Thank you for your time today. I'd certainly welcome any questions.

The Chair: Thank you. We are right on the nose, but we'll allow 30 seconds each, if I may. I will ask Madam Martel to start with 30 seconds only, please.

Ms. Martel: Thank you very much, Jon. I'm not sure how far you had to travel to be here today from Kenora-Rainy River, exactly what community, but thank you for making the trip.

In my part of the world, the community mental health and addiction organizations have long operated as a cohesive unit. There is no duplication. Just because of the funding they've received and the lack of professionals, they've had to work together for a long, long time, so we don't see that kind of duplication. What we do see is a need for additional funding to provide additional services. There are no savings to be had by cutting any groups out any more. If anything is required, it's to get some actual funding to provide new services. I don't know if you can speak to that from your perspective in this part of the world.

Mr. Thompson: Yes, we've done some work on that. We don't want to sound like we are—because everybody sounds like they're whining for more money, but at least the ministry needs to recognize their own benchmarks for funding. They've set some minimal levels in our service for 15 years—and I think it's been the responsibility of the last three governments of all parties—and the bureaucracy just hasn't got the job done that we sense is mostly their job to do, which is to make sure our services are sustainable. We are still at levels of funding—we've had 2% or 3% increases over 15 years. That's not fair or equitable or going to get you good quality. That gets you people leaving, trying to do other things and so on.

We estimate that the gap right now in the Kenora-Rainy River district—just using those simplistic kinds of notions—between where we are now and where we should be is about $9 million. We got $1 million last year, which we very much appreciate, but it took a great deal of creativity to get it into the right kinds of silos so that we could provide the kinds of services and make sure it was meeting the basic gap needs that we felt we had.

Mr. Mauro: Jon, thank you very much for your presentation. You used one of the words in your presentation—"silos"—that people talk about all the time, that it is why the health care system in fact is not a system, that there are so many inefficiencies created and resources wasted as a result of the inability of the different sections of the health care section to actually work together as a system. One of the things that the LHIN is hopefully going to be able to do, if in fact it moves forward, would be to have local, resource allocation decision-making authority, so that communities and sectors of the system like yours would be in a position on a local basis to ask for and potentially receive more resources.

Quite frankly, you learn in this job that, historically, hospitals are viewed as a big drain on the health care budget by other sector providers like yourself. People will come into my office and say that historically, the hospitals have always had their budgets funded when they've overspent and that it's to the disadvantage of other groups like mental health service providers. So I was very interested in your comment. It seems to me you see the potential for something positive here as it affects mental health because a LHIN would have resource allocation decision-making authority once the finances flow in 2007. I wonder if you could comment on that a little bit more.

Mr. Thompson: Sure. Yes, we would agree with that, but I think what we're saying—and I actually should have emphasized this too. Our group and some of my colleagues have been quite involved with the planning initiative of the LHINs that led to this legislation. The number one administrative priority, as I hope you know,

in this district, was let's get the money right, because it's so fundamental, before we get into this thing. I think we've got to do some transitional things. We've got to up-resource some of these sectors to balance this off before we all hit the ground running after the establishment of the LHIN. Our fear is that the assumption will be that the status quo is all right or it is what it is, and we don't see how we're going to do much differently, and we're probably going to be more at risk if we go into the LHIN environment with that. So we want to go in and we want to be part of it and break down those silos—very much so—but we have to have an ability to be there. If we're not there, if we're cutting back and reducing services, there will be less and less of us to be at the table to even have this discussion with or, more importantly, for the consumers to get the service from.

I guess it's important to have more emphasis on looking at models. We've got ideas, others have ideas—good, bad, ugly, whatever they are. But we've got to find some other ways to finance this too. We've got to look at other ways to bring the resources into the system, not just pound the table and say the same old same old. That's why we're saying there are reallocations that could be done and there's also so-called new money that we need to find.

Mr. Miller: Thank you, Jon, for your presentation. The Canadian Mental Health Association presented earlier. I noted in your presentation that you said funding is a mess. The Canadian Mental Health Association said they are concerned that, through the LHIN planning process, mental health might be sort of pushed aside. What they said exactly was that within the LHIN planning process "there is concern that those better known, more acceptable health issues, often supported by public sentiment, will become the funding priorities." Are you worried that, through this model, mental health will receive less funding?

Mr. Thompson: Yes, we're worried, but I guess that's why our first recommendation was about getting the public engaged, as they are by receiving our services already, but recognizing that their more traditional medical issues like heart attacks, strokes and cancer all have psychosocial, mental health and, actually, addictions and violence aspects, if you really want to drill down into these issues, as we've learned. We're trying to avoid that debate, actually, so we don't want somebody to say: "Look, you can have a mental health counsellor or you can have a heart surgeon. What would you rather have?" We're saying we'd rather have both in the appropriate amounts and where they need to be. That doesn't mean we have to have in each of our smaller communities a range of tertiary heart surgery specialists, but I think we're saying that we need a range of community counselling, mental health kinds of services that are very much direct service and right at that front line.

The Chair: Thank you very much for your presentation.

The next presentation has cancelled. We will have a five-minute break. We should be back just before 11:30.

The committee recessed from 1125 to 1142.

WESWAY

The Chair: We will resume for our next presentation: from Wesway, Carol Neff, community services facilitator.

Mr. Gravelle: I'm escorting her, Chair.

The Chair: Oh, thank you, Michael.

Madam, you can start any time. There are 15 minutes for you to make a presentation.

Ms. Carol Neff: Okay. Thank you very much, and thanks for the opportunity. My name is Carol Neff, and I'm from an organization called Wesway.

Wesway has proven its leadership in the field of respite care services for the past 32 years and offers a full range of respite care services for family caregivers, including in-home and out-of-home service models, delivered by volunteers and by staff. Flexibility and creativity are the hallmarks of our success in meeting—

The Chair: Madam, I'm sorry. I'm told that there are some technical challenges. Can you start all over again? We were not able to record what you were saying properly. So we have to start over. Just one second.

Madam, you can start now, please.

Ms. Neff: Okay. Great. I wanted to speak about respite care a little bit before we get into our specific recommendations, because that's the service we provide, and we're very much involved in the life of the community. We believe that family caregivers are the real bedrock of the community care system, and we have to provide them with the breaks they need to renew their energy. The responsibilities of providing 24-hour, ongoing care can be very stressful on families, and the timely provision of sufficient levels of respite care can sustain the strength of a family, while preventing potential crises, family breakdown and much more costly alternative interventions.

We see respite care as something that benefits absolutely everyone: the individual, the family and the community, and the service system as a whole. Respite care is so cost-efficient that it makes sense to invest more in this area, even when dollars are scarce. Personalized respite care services result in stronger families, the preservation of dignity and respect for people with special needs, and clear cost savings for the service system.

I want to say that Wesway actually has a very proud history of success through collaboration, integration and creative partnerships. That's at the core of this new legislation. We've also been blessed in that we have a multiplicity of different government funding streams, and we serve many different target populations and have lots of community connections, which has helped to generate some unique opportunities for maximizing our resources. I wanted to give a couple of examples of how that has worked for us.

For example, we have one of our respite home locations where we serve both children with high and multiple needs, as well as seniors with Alzheimer disease or a related dementia. The capital development and operating expenses for this site have been co-funded by two different ministries, together with contributions from

charitable foundations. So without the collaborative funding arrangements, the vital respite services that we offer there just wouldn't exist.

We have other examples where we've maximized the effective use of space by partnering with other organizations to make the most of the sites that are available.

In terms of our expectations in terms of working with the LHINs, we believe that the LHINs are founded on the principle that local people are best able to determine local health care priorities. The aim is to create an environment where local health care providers come together and coordinate their service delivery through integration and collaboration. Wesway certainly supports the provincial government's vision of improving health care delivery by focusing on individuals and their families and becoming more responsive to local health care needs.

With our aging society, the need for sustainable and effective community support services is greater than ever. Most people wish to have services available at home so they can continue to live in the community as long as possible. That's what Wesway strives for every day. So we're actually very excited by the prospect of new partnerships and opportunities emerging with the new health care system, and we're fully committed to working with the government and our community partners in the new LHIN structure.

There are some critical themes that we wanted to identify that relate to the LHIN structure, but also specifically in the area of community support services and, even more specifically, around respite care services. I don't believe we've begun to see the impact that respite care services could actually have in terms of alleviating some of the pressures on the health care system. There's a huge potential, and we could play an enormous role.

A flexible range of respite care services will help to generate huge savings, compared to the more expensive alternatives such as hospital admissions and long-term care homes. The onus for care has clearly shifted to family. Up to 90% of the care of elderly people is provided by family caregivers, and the health system would collapse if they didn't make that sacrifice. Perhaps the most severe alterations to caregivers' lives are the changes in their own health status. They report high stress levels, fatigue, negative emotions, depression, psychological distress, interpersonal conflict, loss of sleep and social isolation. Caregivers often put their own health in extreme peril, resulting in additional hospital admissions. By 2020, seniors are going to comprise 20% of our population—in other words, one in five people will be a senior—and the current system providing community care remains fragile, inadequate and not ready to meet the aging challenge.

Institutional care is estimated to be 10 times more expensive than providing care at home in the community, yet the emphasis on institutionalization persists. In fact, only 1% of the total health care budget is allocated to community support service agencies.

Families seeking respite care may be placed on a lengthy waiting list, where they may wait many months, even years, and all too often their family members die or are placed in long-term-care homes before receiving respite care. So trying to manage without the respite they need may be possible for a time, but sooner or later the health and well-being of caregivers is compromised. Crisis develops, and much more costly and intrusive measures may be required along the lines of hospital admissions or long-term-care home admissions.

The demand for respite care is growing rapidly, and for the caregiving families the need for respite is urgent, and the timing is actually very critical. Appropriate respite care is preventive in nature and a very cost-effective investment for long-term community support. So when we respond to Bill 36, Wesway supports the underlying principles—certainly the changing culture, expectations and behaviours to achieve a vision of health care that is client-focused, results-driven, integrated and sustainable.

Local health needs and priorities are best understood by the local community. Active community engagement is a critical component to facilitate responsible decisions. A better coordinated health care service delivery is essential to support people to navigate across the continuum of care more easily.

Choice is an essential component of our health care system, and individuals and their families need to be engaged. Equitable access based on individual need is required as close to home as possible. Measurable, results-driven outcomes based on strategic policy formulation, effective planning and information management will certainly aid in accountability. People-centred, community-focused care that responds to local population health needs is at the core of an improved system, and shared accountability involves providers, government, community and citizens.

Wesway sees that there are a number of overarching requirements. First of all, the LHIN legislation must embrace the fundamental values contained in the Canada Health Act—specifically universality, accessibility, portability, public administration and comprehensiveness in the broadest definition of health care—and also of the Commitment to the Future of Medicare Act, including open accountability, transparency and public administration.

LHINs must work to ensure the acute care sector focuses on acute care clients only. Specifically, we need strong community-based respite care services for people with disabilities, the frail elderly population and people with Alzheimer disease and related dementias to assist family caregivers in the community. A more vigorous concentration of resources in this area will help to avoid visits to the ER or hospital admissions and keep space open for people with acute care needs.

There's a need for consistent criteria as to what "community engagement" means. Wesway looks for a broad-based, inclusive consultation process with a strong voice for local community-based service providers in the development of the integrated health service plans and health services integration initiatives.

All health care provider organizations have a responsibility and obligations to coordinate care for people as

they move through the system in their health care journey. Every person has a unique set of needs, a different point of access, and a different path of processes and relationships to transition through. System navigation is not a job description in itself; it's a function of every service provider.

Family health teams must be implemented in a way that involves community support services and community mental health and addictions programs as true care partners. Support for effective information technology is critical in the community sector, and system planning is necessary to ensure human capacity and skills to deliver care where and when it's needed.

There needs to be a shared responsibility across the system and at the local level to ensure meaningful HR planning. A critical consideration in a sector of scarce human resources is the impact of integrating services between organizations with wage disparities. The legislation needs to recognize and encourage volunteerism, which is an added value in the community sector.

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Wesway would like to emphasize the following summary points. First of all, with reference to the local health advisory committees that are indicated in the legislation:

To achieve the goals of innovative, collaborative system change, the advisory committees must have inclusive, broad-based representation from all the partners in the health system to provide advice to LHIN boards.

Wesway recommends local health advisory committees should not be limited to the regulated professions alone, which the legislation currently states.

The staff and volunteers of community support services are at the front line of health care service delivery, alongside regulated professionals. Wesway recommends the community support sector should have equal representation on these advisory committees.

With regard to effective and efficient services, Wesway recommends the definitions of "efficient" and "effective" should be defined in the legislation according to criteria that recognize the value of innovation, flexibility and choice. These are at the core of community-based services and they respond to the unique needs of individuals and their family caregivers. They also need to recognize the value of client satisfaction and community responsiveness, and quality, value-added outcomes that respect the "local knows best" principle. Personalized services that truly meet the needs of individuals and family caregivers will produce more positive and cost-efficient results.

Finally, the point in the legislation that deals with the discretion of the minister to force integration: The legislation specifically does propose that option. Local health care services must continue to preserve local community connections, community-based governance, consumer choice and avoidance of service disruption to individuals and family caregivers.

Wesway recommends establishing a requirement for LHINs to incorporate an analysis of the impact of any integration plan on the people served, the service providers and the community.

The Chair: Thank you very much for your presentation. You have used all the 15 minutes, so there's no time for questions. We thank you for your presentation.

Ms. Neff: Thank you very much.

ONTARIO NATIVE WOMEN'S ASSOCIATION

The Chair: The last presentation before the break is the Ontario Native Women's Association, Josephine Mandamin. You can start making your presentation any time you're ready. Good morning.

Ms. Josephine Mandamin: Good morning, ladies and gentlemen. I am Josephine Mandamin, the executive director of the Ontario Native Women's Association. The Ontario Native Women's Association represents 83 women's local groups across Ontario and was established to promote the betterment and equality of native women. The Ontario Native Women's Association is a provincial organization founded in 1972 which represents aboriginal women and their families on matters that affect the political, social, education, economic and justice issues in their daily lives.

The association has 83 local volunteer organizations, both on and off reserves. These local organizations are divided into four regions across Ontario: north, south, east and west. The locals are autonomous groups and may address any and all issues that affect them. It is based on the belief of unity of all native women. Affiliated with the national Native Women's Association of Canada—NWAC—ONWA represents native women in the province of Ontario, regardless of status or locality. The provincial body encourages the involvement of native women at the socioeconomic, recreational, cultural and political levels.

Aims and objectives: The major tenet on which the organization is based is the concept of unity of all aboriginal women, regardless of legal categories. The main concern of the association is the preservation and promotion of aboriginal culture, language and heritage.

In order to achieve this objective, the association has pledged:

—to create a forum through which native women can become involved in the solution of their problems and the promotion of their interests;

—to help native women increase their feelings of adequacy and their sense of responsibility through planning, developing and managing self-help projects;

—to provide a means through which women can make a contribution of ideas and skills to the social, cultural, economic and political development of Canadian Indian society;

—to provide a means through which native women can assist in identifying those ways which are unique to the Indian culture and through which their role in teaching these ideas to their children can be strengthened;

—to encourage native women to assume a positive and active part in developing skills to support their people in the achievement of their rightful place in society;

—to provide a communications link between native women through which they can relate to each other adequately in fulfilling their roles; and

—to provide a means through which native women can rediscover and develop those traditional skills which have been unique to native culture.

The ONWA cannot emphasize enough the potential hardships the local health integration network process will have on our membership. Without a clear understanding of the governance of the LHIN or its future, we can visualize an enormous breakdown in services and funding allocations to our First Nations organizations and members. Ontario is moving ahead of the national blueprint process without regard or respect for the principles and outcomes that will frame First Nations participation in health systems planning, delivery etc. At the least, Ontario should await the outcomes before introducing their legislation.

Without knowing how the LHINs came about and when they were drawn out, we can only imagine how regional boards will be making all decisions in services and the potential for provincial aboriginal funding to be blended into the mainstream funding, such as diabetes, cancer care treatment, health access centres, HIV/AIDS clinics and many others that I fail to mention here. Funding decisions and priority shifts which are pending will be made by the local LHIN authorities and may reduce the access and scope of health service delivery to our communities and our people.

Without a specific First Nations LHIN board, there is no opportunity to participate in the planning and recovery of health services for our people. Although a seat may be made available on each of the 14 LHINs' framework, we do not see the potential of a strong voice of our people in this promise. The 14 LHINs were implemented and created without consultations with the people of Ontario. Although there were workshops across Ontario in November and December 2004, First Nations were not sufficiently notified of this development, and we watch as the train goes by. The LHIN boards are already established and were in place before we had the opportunity to even consider the affects and effects on First Nations, thereby being unable to provide adequate consultations.

The already established LHIN boards and the LHIN legislation will have significant impacts on the people of Ontario and First Nations health services. We identified areas of concern that our membership has raised.

Language: Our members are entitled to their inherent right to their language, and it must be made available in serving the aboriginal populations in their own language—the Ojibway, Cree, Inuit, and Oji-Cree—as much as the French do.

Transportation: Our members live in outlying communities where travel is a hardship year-round for members on low income; we are all on low income. Airfares are costly. How will the LHINs address these high costs? Will they provide adequate travel to isolated communities, or will they off-load on the federal government?

Legislation of LHINs: If it goes ahead, we require a placeholder that respects our aboriginal concerns, that the legislation will not interfere with our health rights and services, and to be consulted in a fair and reasonable manner.

The legislation mandates the LHINs to search for opportunities to transfer or merge services, to coordinate interactions and create partnerships between non- and for-profit organizations and move to third parties. What impact will this have on services that cannot afford to compete with big businesses?

Provisions for input and community controls are weak or do not exist. There are no provisions for community appeal, few requirements for public notice, and no protection for equality-seeking groups such as the Ontario Native Women's Association.

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The legislation facilitates privatization in that new powers are given to cabinet for wholesale privatization of non-clinical services. There appears to be a strategy for competitiveness in providing key acute care services in hospitals and contracting out their services to for-profit groups.

The terms "restructuring" and "integration" have many meanings to our membership, from creating a new structure from ones that work and cutting and granting health service providers to contracts for private services. The legislation also gives cabinet the power to establish, dissolve or amalgamate LHINs at will; see part II.

Clearly, more time should be given for the public to have adequate input and understanding of how the LHINs' makeup will affect all Ontarians, whether they are aboriginal or non-aboriginal.

We, the Ontario Native Women's Association, sincerely hope that this legislation does not have any favourable response in the Legislature.

Participation on the LHIN board by the ONWA members would enable the women more input into the process.

The Chair: We have at least a minute each. We'll start with Ms. Wynne, please. We will allow everyone to ask questions or make statements for about a minute.

Ms. Wynne: Thank you very much for being here, Ms. Mandamin. There have been a number of meetings. I want to address the issue specifically around the aboriginal dialogue with the minister, which began in February 2005. There have been at least four meetings with First Nation groups about the LHINs. There was a meeting with the ministry in April 2005, there was a task force created and there's been a report written that is being reviewed with an eye to making some changes to the legislation that would deal with some of the issues that aboriginal First Nations have brought forward to us. Was the women's group part of those discussions? Were you part of that task force?

Ms. Mandamin: It is very well to say that the First Nations task force has been consulted, but they have not

been listened to. Their recommendations still have not been responded to.

Yes, I was part of the First Nations task force group.

Ms. Wynne: That's fine. That's what I wanted to know. I know that the response hasn't been finalized. We're expecting that response within the next few days so that there can be changes to the legislation.

Mr. Miller: Thank you for your presentation today. You brought up the point of the LHIN boards. My question is, what First Nations representation is there on the 14 LHIN boards around the province? Is there representation on the boards that have been set up so far?

Ms. Mandamin: That is our lack of understanding of the LHIN boards. There is no communication with the Ontario Native Women's Association, which is all-Ontario. We have the voices of the women in Ontario, but we have not heard from the Ministry of Health and Long-Term Care who these people are. The only way we find information is through the back door.

Mr. Miller: So you're not sure if there's any First Nations representation on the boards?

Ms. Mandamin: I'm not sure. I know that Alvin Fiddler is on one of the LHIN boards, but I still would like to know who the aboriginal participants are.

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

Ms. Martel: It is true that we haven't seen the ministry's response to the task force report. It begs the question, given that we don't know what the outcome is. We have a piece of legislation before us, however, that may well have an impact on aboriginal people. If the government was interested in a separate process and in listening to the concerns of First Nations and having a full and comprehensive consultation, negotiation and then implementation, especially on the line of the blueprint, it would have made sense for the government to have, for example, a non-derogation clause in the bill or a clause that would exempt First Nations from the bill until such time as we could see what the government's plan was for aboriginal health care. Do you think that would have made some sense so that you could have been assured of where you were going to be impacted or when that might take place?

Ms. Mandamin: That would have made a lot of sense two years ago, when the makeup was being developed, because you understand that First Nations are a very diverse group of people. There are jurisdictions that have to be respected. In much the same way, the Ontario Native Women's Association has to respect federal jurisdictions and provincial jurisdictions for on-reserve members that we represent. So in speaking on that purview, I really don't see that having been done by this process. It would have saved a lot of heartache and headache had the First Nations been respected in the first place.

The Chair: Thank you very much for your presentation.

We are going to have a break for lunch. We will be back here at 1, when we are going to hear from Dr. Ken Arnold and others.

The committee recessed from 1207 to 1303.

ONTARIO MEDICAL ASSOCIATION, THUNDER BAY CHAPTER

The Chair: Good afternoon. We will resume with the afternoon session. The first on the list is the Ontario Medical Association, Thunder Bay chapter, Dr. Ken Arnold. I believe there is also a second person. Have a seat, please, and start whenever you are ready. There is a total of 15 minutes available.

Dr. Ken Arnold: Welcome to Thunder Bay. My name is Ken Arnold, and with me today is Dr. Steven Harrison, director of policy at the Ontario Medical Association. I truly appreciate the opportunity to speak to you today about Bill 36, the bill that will make local health integration networks a reality in Ontario.

I'm a family doctor practising here in Thunder Bay. I sit on the board of the Ontario Medical Association and on that association's committee which has been following the development of the integration process. Today I'll outline my thoughts on how you might improve on this bill to make it better for Ontario's patients. I'll also outline a few particular issues relating specifically to the north. I'll be pleased to take any questions you may have following that.

To start, I must make clear how strongly Ontario's physician community wants this legislation to work for the betterment of health care in this province. Our patients are paramount. Any legislation that doesn't work to improve the situation for them would be a waste of time and money. Patients come first. Today, doctor shortages and wait-lists threaten the health and safety of our patients. Over 1.4 million people in Ontario do not have a family doctor. Our doctors are getting older, and many specialties are facing a 25% retirement rate in the next five years.

The government's plan for transformation, the plan that aims to improve the health care system in Ontario, is quite aggressive and has very short timelines. We, the physicians, sincerely hope to work closely with the government as the transformation happens across Ontario. Lessons learned from other provinces—Alberta and British Columbia, as well as others—and other countries in the world have made clear that doctors must play a key role in the management of health care at the local level.

Our experiences and perspectives are unique. Whether we work in a hospital, a clinic, an urgent-care centre, a mental health facility or a long-term-care facility, we all have important views to bring to the table. Perhaps more importantly, we have a vested interest in how care is managed. The better organized a system is, the better able we are to provide the quality of care that our patients need. Physicians need to be involved in the management and organization of health care where they provide it.

This said, I am asking today that you consider amending the legislation to mandate a formal mechanism for physicians to provide input to the LHIN decision-making process. Section 16 of the legislation allows physicians to provide input into a larger committee for health care professionals, the health professionals advisory com-

mittee. While the concept of such a committee seems appropriate, it's not anywhere near sufficient.

I'd like to make three primary reasons for this statement. First, the perspective of a physician is unique and valuable. Second, the voice of one physician on a committee of many health care professionals from across a large geographic area, as we face here, will not be adequate to ensure that all perspectives, all observations, all suggestions and all needs from the front lines are brought forward. Third, all other members of the health professionals advisory committee will be funded by money flowing through the LHIN. Physicians, on the other hand, will be independent of the LHIN in this regard. A separate committee would allow the physicians a unique ability to advise the LHIN without fear of accusations of conflict of interest. Most of the programs and services provided by LHIN funding will be accessed by our patients, usually requiring our approval to gain that access.

Given these points, a form of medical advisory committee that would report to the LHIN would work to ensure proper physician representation. I encourage you to look to Alberta's model to see how all health care professionals are able to report to their regional health authority and specifically how physicians provide input. Dr. Harrison is very familiar with this model and will be able to answer detailed questions should you require. I can tell you that Alberta's physicians work on official Alberta Medical Association committees locally. These doctors work with their members locally, are elected locally, and sit on the Alberta Medical Association council as well. The Alberta Medical Association worked very hard to get these local representatives in place and to get the notion supported by the regional health authorities.

There is also a physician representative who is paid a salary locally by the regional health authority and is called the regional medical adviser. This physician's role is to sit on the regional health authority board and provide information about how the planning is being implemented locally to the regional health authorities. They are responsible to the regional health authority and are paid by that authority. They are not linked with the Alberta Medical Association in any way.

The Ontario Medical Association is developing a model of local representation for physicians that will be applicable in Ontario's new integrated system. We'd be happy to share this model when it's finalized.

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Speaking now on issues directly related to the north, I'm sure you're all familiar with Mr. Tom Closson's report on integrated service for the northwest. This report outlines a potentially positive blueprint for the way the northern LHINs may operate, but there are inherent problems that I'd like to touch on this afternoon.

Mr. Closson suggested that the northwest could be divided into six regions within the LHIN to meet the need of administering the medical profession. By collapsing the medical advisory committees in the hospitals within each of these six divisions and forming a new district MAC, the doctors would be able to have regional credentialing, regional on-call, and regional administrative roles. This may seem like a logical working plan; however, there are embedded challenges. First, this would require a significant change in the Public Hospitals Act. Second, doctors locally, as well as officially through our representative body, the Ontario Medical Association, need to be consulted. To date, this has not happened.

The report also suggested changing the categories of hospitals so that there would be local hospitals to support the local primary care initiatives, as well as district hospitals—the more recognizable acute care facility that we're used to in Ontario. Once again, input from the community and community practitioners would be needed. The issue here was process.

The Closson report, which was commissioned by the minister as an integrated service plan for northwestern Ontario, fails to allow these issues to be discussed with the LHIN in a formal way. These are the issues that are of primary importance to physicians and the patients they serve. The health professions advisory committee will not facilitate this, and there must be a physician advisory committee to give input into the discussion. The north has several unique and pressing needs that the LHIN will be unable to address without physician input. The LHIN process will not be able to deal with the issues of physician recruitment and retention or the dilemma of unattached patients, issues which have unfortunately been part of the culture of health care delivery in the northwest for too long. We will face the difficulty of providing specialist on-call coverage in areas where there isn't sufficient routine work to allow the physician to earn a livelihood.

As written, there is no mechanism for the LHIN to address these issues in the legislation. Physicians can bring these issues forward, and physicians are able to devise solutions. Our voice must be valued, and our voice must be heard.

In conclusion, I want to reiterate that we do want this legislation to work. Our goal is to assist in the successful integration of health care services in Ontario. We want to help create a system that is better for our patients. We must ensure that patient care is paramount, and access to care is not adversely affected. We look forward to working together to help ensure that Ontario's patients receive the best. They deserve it.

I'd be happy to answer any questions you may have.

The Chair: Thank you. We have about three minutes. Mr. Gravelle, do you want to start, please? One minute.

Mr. Gravelle: Dr. Arnold, good to see you, as always. Dr. Harrison, good to meet you earlier. Certainly, I appreciate your comments, particularly related to Mr. Closson's report that came out in terms of the need for more direct physician involvement. I was making reference to it several times this morning in terms of the expectations that we have in the northwest, particularly after Mr. Closson's report.

I am curious, and I appreciate your recommendation about the health professions advisory committee and your

belief that you need to have a more significant role or a more specific role. I know this has happened. You've been at other parts of the public committee process, and I presume you've had some discussions with the Minister of Health about this as well, at least some input from him. I would again make the presumption that he is giving some thought to your concerns. Is that fair to say? If there's time, I wouldn't mind hearing a little bit more about the Alberta model and how that works from Dr. Harrison.

Dr. Arnold: Dr. Harrison has been at some of the other meetings and perhaps could talk more about the minister's response. Certainly, he has been to Alberta to visit there. So I would ask Steven.

Dr. Steven Harrison: First of all, the minister has had multiple discussions with the executive offices of the Ontario Medical Association regarding the physician advisory committee. We had a meeting in December where we brought together about a dozen physicians, including Dr. Arnold, to meet with Ms. Paech and other ministry representatives to talk about the best way to go forward and ensure that physicians' voices are brought into the process. To date, there have been no decisions made as far as we know, but the conversation continues.

A little bit more on the Alberta model: There are two different tiers of this. Dr. Arnold alluded to both of them very quickly. There is an elected representative, elected by the physicians within the regional health authority, to represent them at the AMA council level, as well as within their region, to bring forward issues—whether primary care issues, acute care service issues, whatever—to the regional health authorities, to bring those issues up to speed for the CEOs of boards of those regions. As well, they have a forum where all of their regional health authority members, each one of those elected representatives, get together and discuss broader provincial issues that are occurring.

The second aspect of that is there is the regional medical adviser. That adviser is hired by the regional health authority and paid for by them. They do not usually engage in clinical practise; it's a full-time job. Their job is to go around and, as Dr. Arnold mentioned, take a look at how implementation of provincial and regional plans is going and then report back—they have fiduciary responsibilities—to the regional health authority board. They basically express how things are going and where changes need to be made.

Mr. Arnott: Just to follow up, I gather that the Alberta Medical Association is satisfied that those mechanisms provide them with an appropriate level of input to the regional health authorities?

Dr. Harrison: Yes, actually. There were five or six years at the outset of regionalization in Alberta where none of those mechanisms existed. It was chaotic, to say the least. There was a lot of turmoil between the ministry and the Alberta Medical Association, and between the medical association members and their regional health authorities. Once these instruments were put in place, I'm not going to say everything went away, but a good chunk of the turmoil started to diminish.

Mr. Arnott: It makes a lot of sense, but you're asking for something different. You're asking for a medical advisory committee, a separate committee to advise the LHIN, correct?

Dr. Arnold: You can put different names on it. "Medical advisory committee" is a difficult name because it has certain connotations within our hospital structures. Some people have talked about a local medical consultative committee, or name it what you will. Obviously, we would love to send 12 members to sit with the LHIN and discuss everything with them, but I don't think the LHIN board members might appreciate that.

Mr. Arnott: Not what the minister has in mind.

Dr. Arnold: Having a sort of pyramid, obviously, with someone to go forward and bring the information—

Mr. Arnott: That's the essential bottom line. Thank you.

Ms. Martel: Thank you for being here this morning. I wanted to talk about the Closson report, because it has been referenced here this morning. This Closson report was the way things were going to be in northwestern Ontario, and it's interesting that you pointed out that while it was commissioned for the minister, there is no mechanism to allow the issues that came out of that report to be discussed in any formal way in the LHIN. So where it will end up and what will happen to it remains very much to be seen. It is not a given that the LHIN will adopt it and adopt those recommendations.

Having said that, it's not clear to me that you want to see some of those recommendations adopted anyway, if I read correctly your point in the middle of the brief that says that the changes at least that were proposed for the MACs were changes that your local doctors had no input into. Am I understanding that correctly, that even though there was a proposal by Dr. Closson to have a more regional MAC for a number of hospitals, that was not something that came from local physicians?

Dr. Arnold: That wouldn't quite be so. The Hay Group obviously had an extensive investigation and talked to many people across the province. I think the concern is that, going forward, there's no mechanism under the LHIN process for physicians to be consulted about some of those important issues that need to be dealt with.

As a basic structure, Closson has some good ideas. The regional credentialing would certainly be helpful in a large area like this, allowing some more freedom for physicians to move around and help out. As a local physician is going on holidays in one town, the physician from the next town could more easily cover. That would all be useful. Our concern is the process here that doesn't allow the discussion to take place, because physicians need to be consulted going forward.

The Chair: Mr. Mauro, there is another 30 seconds. Go ahead.

Mr. Mauro: Thank you, Mr. Chair. I appreciate that.

Dr. Arnold, thank you very much for being here. I've just read your brief. Most of your concerns, of course, are around the physician's role in the LHINs themselves. I'm

just wondering if I could get a comment from you generally around what you think about the LHIN model as it's proposed. I had an opportunity to read a book by Michael Rachlis, the Prescription For Excellence. Are you familiar with the book?

Dr. Arnold: I haven't read the book.

Mr. Mauro: Okay. I think Dr. Harrison is saying he has. I read that book. He acknowledges that there is change required if we're going to sustain the system that we have, and he does talk about regional care authorities in his book and that the model has worked. I'm just looking for a general comment, beyond your specific concerns, about the model in general and whether you think it has a chance of success going forward to improve the system as we know it today.

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Dr. Arnold: I'll ask Dr. Harrison to comment specifically about Dr. Rachlis's comments.

Certainly, Ontario, as you know, is the last province, the last territory in Canada to adopt a regionalized approach, and although the structure in different provinces is not the same as is proposed here, nevertheless, as a representative from Thunder Bay, you will recognize that sometimes we have difficulty achieving and getting that connection with Queen's Park. I think that bringing things closer to home will be helpful to us all.

I know the provincial government often complains that the federal government doesn't give them enough money. I often worry that maybe the LHINs will end up complaining that the provincial government hasn't given them enough money and we're going into that tug of war all the time. But bringing things closer to home where we have a better idea of what's going on and how the money should flow I think will be very important.

Dr. Rachlis is bedtime reading for me.

Dr. Harrison: Yes, it's bedtime reading for me. Thank you.

The one fundamental difference of course between the RHAs that are discussed and the LHINs is that the RHAs are purchasers of services, so to speak, whereas the LHINs are supposed to be funders. It's just a transfer of the administration and the funding that currently exists in Ontario. That said, that may seem trivial to some people. However, that's actually a pretty fundamental difference.

To be honest, the design of the LHINs, as articulated in the legislation and previously through consultations and discussions, looks like it will have the potential to do a wonderful thing for Ontario. As I always say, it's how the rubber hits the road that makes the difference, and we don't really have something that we can truly reflect upon from elsewhere to determine whether this is going to be a good model or not. It seems as though it should work, though.

The Chair: Thank you very much.

CANADIAN MENTAL HEALTH ASSOCIATION, TORONTO BRANCH

The Chair: The next presentation is by teleconference, and I want to stress this. They were a group that was listed in Toronto. Their schedule changed and because there was a cancellation, they are calling here from Toronto. That's why they're on the list. They are the Canadian Mental Health Association, Toronto branch. It's Steve Lurie, executive director. Mr. Lurie, are you on the line?

Mr. Steve Lurie: Yes, I am. Can you hear me?

The Chair: Yes, very well. You have 15 minutes. Please proceed.

Mr. Lurie: Thank you very much for accommodating me. I appreciate the opportunity to speak on such an important subject.

Just a little bit about our organization to get started: CMHA, Toronto branch, is part of the Canadian Mental Health Association, which is a national health organization. We provide a comprehensive range of community services to people living with serious mental illness. Last year, we served 2,158 people, with 157,450 client contacts. Eighty-five per cent of our funding comes from the Ministry of Health and is governed by a transfer payment agreement between our board of directors and the ministry. As an organization, we are strongly committed to collaboration and evidence-based care.

We welcome this opportunity to comment on the legislation. We're in support of the ministry's transformation agenda and hope that the LHINs are actually able to improve health care in the province. We also note that despite 20 years of government reports and task forces on mental health care in Ontario, we do not have an adequately resourced and linked mental health system across the province.

This presentation will provide commentary on a number of issues and themes in the legislation rather than a clause-by-clause analysis.

The first theme is community engagement. We believe that LHINs should facilitate systems thinking, not only for the health sector but also for subsectors such as mental health and addictions. With all the talk about integration of the larger health system, there's a risk that the system-building needs in both mental health and addictions will be ignored.

The requirements in the legislation for health service providers to carry out community engagement should focus on collaborative approaches to community engagement within subsectors rather than each agency proceeding on their own.

Let me give you an example. Here in Toronto, there are a number of geographically based mental health and addictions coordinating groups that could engage the public on issues such as access, comprehensiveness and quality of services. As well, each LHIN should ensure that they devote resources to provide a variety of means for consumers and families living with mental illness to participate in the planning and evaluation of mental health services.

I'd now like to turn to public interest. As you know, there is no definition of public interest in the legislation. We believe it should be defined as improving access to comprehensiveness, continuity and quality of health care. Where LHINs issue integration orders, they should

specify how the integration measure will improve health system performance in these areas. As well, they need to be objective about the limits to integration.

Pong and colleagues, in a paper commissioned by Health Canada, noted the following: "While service co-ordination is viewed often as the key to continuity of care, coordination also has negative effects.... Co-ordination may lead to the elimination of diversity of options for service delivery. In doing so, the process may rob certain patients of the benefits offered by some organizations. Some patients may be marginalized or excluded through the standardization of services."

This is a real challenge as we begin to do the planning in the LHINs environment to ensure that agencies that have a niche in the system, whether they're working with consumers directly as consumer-operated mental health service providers or agencies providing services to ethno-racial groups, aren't shut out of the process.

The third theme I'd like to talk about is the issue of a range of integration measures. As you know, the legislation defines integration rather broadly, and it gives the LHINs broad powers to transfer programs and merge organizations. However, there are many ways to achieve integration, and these include the development of assessment protocols, shared staffing, cross-training and consultation, the development of registries etc.

We believe that health service providers should communicate with LHINs about their integration plans. However, decisions that do not involve program or budget transfers should not require LHINs' approval. Many mental health organizations, for example, have a multitude of partnerships and inter-agency agreements. Requiring LHINs' approval for each one would bog the process down and could actually stifle integration activities.

There is a concern in our sector that mergers and transfers will become the default mechanism for LHINs, and this is despite evidence to the contrary. A number of public and private sector authors have shown that restructuring does not necessarily lead to improved performance at an organization or system level. "Private sector studies suggest that while mergers account for over $3.4 trillion of annual economic activity, only about 20% appear to succeed." At the same time, the same authors, Grubb and Lamb, find that "there is evidence that strategic alliances and partnerships can be more successful at less cost."

Peggy Leatt and colleagues, who are from the University of Toronto health administration, have noted that "re-engineering is often unsuccessful in achieving the goals of organization change and caution that the 'business of health care is too serious to be managed or changed on the basis of trends.'

"Mintzberg and Glouberman note that many countries are implementing administrative reforms in health care but there is very little effect on actual service delivery."

The implications of this mean that the integrated health service plans that are now being developed need to focus on incremental steps that can achieve real results in terms of access and improved services within a three-year period, rather than grand schemes that could destabilize the sector and inadvertently lead to service reductions.

Donaldson and colleagues provided some very thoughtful advice in a review they did on international health care restructuring, which was commissioned by the C.D. Howe Institute. "They caution against implementing reforms without evaluation. 'Many of the reforms we have described'—as authors—'were introduced wholesale, without any thought being given to evaluation. This situation has contributed to the ambiguity of the evidence base.' They recommend a controlled pilot program and gradual introduction of reform. Interestingly, they find that in New Zealand and the United Kingdom, competition among providers has given way to co-operation, as the reforms have evolved." I think this is something we should be aspiring to here.

Perhaps the best way—can you still hear me?

The Chair: Hello? Did we just lose him? Sorry, can you get him back on the line? I was going to ask if there were any questions, but I guess he's not available.

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Mr. Lurie: I'm still here.

The Chair: Okay.

Mr. Lurie: Yes. I think I got cut off. Can I continue on?

The Chair: Yes. There are a couple of minutes left, sir.

Mr. Lurie: Let me focus on a few other issues. I'll provide a full brief on how to do the restructuring and some other references.

What I'd like to do now is turn to the notion of focusing on building system capacity. The Romanow and Kirby reports on mental health acknowledge that mental health and addiction services across the country do not have sufficient resources to meet population needs. Despite the investments during the last two years, which have led to some improvements, we need to be mindful of the recently published study by the health systems research unit at the Centre for Addiction and Mental Health, which noted that 55% of the clients of community mental health programs across the province were receiving one or more levels of care less than they required. Moreover, the study showed that only 0.5% of the population was accessing community mental health services when the target should be 2% to 3% for people living with serious mental illness.

Jurisdictions like New Zealand have set targets, protected and enhanced funding to ensure that their health authorities were able to ensure that, at a minimum, people with serious mental illness are able to access services in their communities. The provincial service integration plan must do the same if we intend to improve the access to and quality of mental health care in this province.

The Chair: Is that all, sir?

Mr. Lurie: No, just a few more things.

I think the other point I'd like to make is that in building system collaboration, we need to be mindful of ways to build connections across a supplier chain. So this would require that strategies be put in place to provide ways in which people can work together. In the automobile sector, which is not dissimilar to health care in terms of a variety of providers, supplier networks have the ongoing support of a supplier association, free consulting services, study groups, problem-solving networks, interfirm employee transfers and performance feedback. Similar strategies need to be developed by the LHINs to improve mental health and addiction systems. For example, New Zealand has set up a mental health development team in one of its health authorities to work with hospital and community providers to improve clinical practices and build linkages. As well, a development of client data linkage systems such as they have had in northwestern Ontario, where you now are, would be another strategic way to build systems integration while improving knowledge about client needs and the ability to access services.

Finally, I think we all need to beware the law of inverse relevance given to us by the Yes, Minister television series. It says, "The more we talk about something, the less we actually intend to do about it." We look forward to working with consumers, families, LHINs and our health care partners to develop improved mental health services in the years ahead.

The Chair: Thank you, Mr. Lurie, for your presentation. There is no time for questioning, but thank you again.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 822

The Chair: The next presentation has been moved an hour later, so we are going to the 1:45, which is the Canadian Union of Public Employees, Local 822, Kenora. Carol Favreau, please. Madam, you can start whenever you're ready. There are 15 minutes in total. Thank you. Good afternoon.

Ms. Carol Favreau: Good afternoon. Today I've brought with me Debbie Marcino, a fellow member of my support local—she's a medical secretary in my local—and my national rep, Danny Scheibli, to my right. You've got a copy of my presentation. I might skip over some parts of it.

I'm Carol Favreau, and I've worked in nutrition and food services for 18 years at Lake of the Woods District Hospital in Kenora. I represent over 170 fellow support workers of CUPE 822 who also work in and use the health care system.

Kenora is part of the largest LHIN geographically, stretching from the Manitoba border to past Manitouwadge and up as far as Fort Severn. The proposed system as set out by LHINs gives people living within a LHIN little say over the direction of that LHIN, even if the LHIN board wishes to listen. With the bill, cabinet has the power to create, amalgamate or dissolve a LHIN. The chances of a LHIN being made smaller are slim. For instance, CCACs are to go from 42 to 14. LHINs boards of directors, appointed by cabinet, are paid employees who can be removed anytime. LHINs boards are required to sign accountability agreements with the government—only a formality because the bill is set up such that the government can impose this even if the LHIN does not agree to the agreement. In addition, the LHINs integration plans must fit the provincial strategic plan. This makes LHINs boards responsible to government rather than communities.

Local hospital boards in the present system act in the best interests of their hospital and worked with the government to show them the consequences of proposed hospital cuts. As a result, decisions by government have been reversed and hospitals have been able to continue to provide decent, if still under-resourced, care. If we have problems with the way our health care is being delivered, who do we go to? Government will control the LHINs but LHINs will actually implement decisions. When people have discontent, they will first look to the LHIN boards even if the LHINs' power is really more imaginary than real. There is bound to be conflict for sure in our large LHIN over resource allocation, which will create dissension between one municipality and another, depending on who gets what for resources.

CCACs were taken over by government in 2001. Results were balanced budgets at the expense of thousands of frail elderly and disabled whose home support services were cut or lost altogether. Government-controlled agencies are poor models for health care and social service reform. CCACs have now been given more control, but this is all the more reason that the government-controlled model should not be applied now to the LHINs. LHINs directors should be elected. Boundaries of LHINs should further be explored through public consultation as well as proposed language about the government being able to amalgamate, dissolve or divide a LHIN. The ministry should consult the community prior to imposing an accountability agreement on a LHIN. We need a requirement that each LHIN must establish a health sector employee advisory committee made up of union representatives and representatives of non-unionized employees.

Cabinet's authority to enact regulations closing LHIN meetings to the public should be eliminated. We need to ensure the right to seek reconsideration and for full judicial review by any affected person, including trade unions, of any LHIN, ministerial or cabinet decision or regulation. Small communities, of which our LHIN has many, may be the first to see our services integrated with other communities. Anyone who has travelled the area covered by our LHIN can realize the problems this could create. We have limited train, bus and air services, as well as extreme weather conditions that make travel at times deadly. In our community, we use the Winnipeg health facilities quite often. For example, the daughter of one of my members was diagnosed with cancer. They had to travel back and forth extensively to Winnipeg. The

travel grants only cover mileage, so all of their hotels and other expenses were put onto them. Sometimes they stayed at great lengths in Winnipeg. So our community got together, did fundraisers and gave them the financial support they needed to cover their expenses. It makes it quite costly for us to use those facilities.

Section 25 of the bill gives LHINs the power to issue compulsory integration decisions requiring health care providers to cease providing a service or to transfer a service. Section 28 of the bill gives the minister even more power to order integrations directly. He could order a non-profit health service provider to cease operating, amalgamate or transfer all of its operations; for-profit providers are exempted from this threat.

Section 33 of the bill allows cabinet to order any public hospital to cease performing any non-clinical service and to transfer it to another organization. This means the government can centrally dictate how all non-clinical services are to be provided by hospitals, including through privatization. The bill gives cabinet the authority to contract out these services despite the wishes of the hospital. There could also be considerable controversy because there is no definition in the act of "non-clinical service." This bill paves the way for for-profit corporations, private clinics and regionally based support service providers.

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At the Lake of the Woods District Hospital, in at least the last 10 years, they have streamlined the way they deliver patient care. It makes no sense to further erode a hospital such as ours, which has gone above and beyond to deliver a balanced budget and still retain services. Its services are delivered in mostly one building, which is a valuable tool to the patients using the service. This seems more seamless than what the minister is proposing with this bill. Our community has rallied together to raise funds for such badly needed items as a CAT scan machine. This makes so much sense from a financial standpoint; as well, it's more humane to offer this service here than to transport, in some cases, very ill people as far away as Winnipeg, which is two hours away, to use their facilities, or Thunder Bay, which is six hours away.

Our support service workers have also been streamlined, mostly through attrition. They provide reliable, safe and efficient service. Many of the employees in our hospital are long-term, experienced workers who take great pride in their work because, up to this point, they have had a reliable employer who doesn't treat them like a disposable commodity.

Approximately eight years ago, the hospital had Versa foods come in and run our dietary department. They did not renew the contract with the company when it expired—the hospital found it more costly. They paid Versa to run the department, which included the cost of a manager; without Versa, they only had to pay the manager. At that time Versa came in, we went through a lot of layoffs, restructuring; we lost at least about five full-time employees in dietary alone. I'm only assuming that that was Versa's way of making a profit.

Integration will remove jobs and services from local communities, hampering access. Support services will likely be the first target. In our area, NOHBOS is already being explored. The committee has said this is voluntary at this point, but with LHINs, this could change. Centralizing services is the goal, but geography has been identified already as a problem.

The bill should provide:

—That cabinet, the minister and 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.

—LHINs, the minister and the cabinet cannot order or direct integration, nor approve/disapprove integration. The power the LHINs have to withhold funding is power enough to encourage consolidations.

—The LHINs, 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 structure.

—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.

—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.

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

—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.

Provisions should be placed in the bill that encourage or even require LHINs, the minister or cabinet to preserve the public, not-for-profit character of our health care system. The LHINs create a split between the purchasers of health care and social services and the providers. The LHINs will purchase services, and hospitals, homes, community agencies, and for-profit corporations will provide them. Such a split already exists in CCACs, which purchase home care services though a system of competitive bidding. This system creates unrest in both workers and clients they serve. Contracts come up for renewal, home care providers regularly lose contracts, and workers, who have no successor rights, are laid off. With this kind of job uncertainty, many workers look to be employed elsewhere.

My personal experience with home care: My father was ill about 10 years ago. He's passed away now. The home care support he had, he had the same home care person come in every day to help my mother. I've recently had to use the home support services since it's been changed, having to look after my sister, who was

terminally ill. They gave me four hours a day. They told me that was all they could provide. They said it would be pulled, though, if somebody else needed it more. My sister died last April. Excuse me for a minute; I'm sorry.

I saw big changes in the home care system when I had to use it, and it wasn't nice. I had three different home care people come into my home in one week. My sister couldn't get—I had to bathe her, and it was very difficult to have three different people all the time. They said they just didn't have the staff.

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. The institution of the purchaser-provider split and the expansion of privatization in health care and social services should not be a part of health care reform. We need a requirement that prior to developing a provincial strategic plan, the minister shall convene a province-wide consultation on the appropriate funding formula for the LHINs and the appropriate funding formula for each of the health service provider subsectors. Competitive bidding models should be specifically excluded in the legislation, based on the disastrous results they have already brought to Ontario health care.

Changes in health care delivery contemplated by these reforms open up possibilities for enormous changes in bargaining units, collective agreements and collective bargaining. The bill would extend the coverage of the Public Sector Labour Relations Transition Act to many of the potential changes in employment that could result. Workers faced with this change deserve, at a minimum, a fair process providing reasonable employment security, protection of working conditions, collective agreements and bargaining unit rights.

CUPE is closely examining the impact of Bill 36 and its use in some cases of the PSLRTA to deal with the labour relations issues raised. I'm just going to touch on a couple of the points we would like provided in the bill:

Provide in the bill that the PSLRTA applies regardless of whether a person or entity is a health service provider and regardless of whether the primary function of the person or entity is to provide services to the health sector; and

Employees should continue to be governed by their existing collective agreement and conditions of employment, and these continue to be determined through central bargaining and HLDAA.

Thank you for listening to our concerns and suggestions.

The Chair: Thank you for your presentation. I'm sorry about your sister and father. There's no time for questions, but thank you again.

ONTARIO NURSES' ASSOCIATION, LOCAL 81

The Chair: The next presentation is from the Ontario Nurses' Association, Local 81, Thunder Bay; Judith Carlson, local coordinator. Please have a seat. There are 15 minutes to use as you please.

Ms. Judith Carlson: Good afternoon. My name is Judith Carlson. I'm the local coordinator for Local 81 of the Ontario Nurses' Association. With me today is Marc Young, one of our provincial communications officers.

I've been in nursing for 35 years. I have worked in pediatrics, med/surg, geriatrics, intensive care and, for the last 20 years, in emergency nursing. For all those years I have worked at Lake of the Woods District Hospital in Kenora, and for 10 years I did air medevacs throughout the north as well as nursing, and so I have an understanding of the problems we have with air transport.

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Let me start by telling you that there are 4,500 ONA members in the Thunder Bay area—which we refer to as region 1 in our structure—and the surrounding local health integration networks or LHINs. We have registered nurses and allied health professionals working in all sectors currently included under Bill 36. There are hospitals, community care access centres and long-term-care facilities. We also have nurses in public health services, which, as you know, are currently not included under Bill 36.

The committee has heard from ONA leaders in Toronto, London and Ottawa over the last three days. I'm sure it's been a whirlwind journey for you, and thanks for coming to the north.

We've heard a number of key reasons why ONA does not support the current approach to integration as set out in Bill 36. Nurses in the Thunder Bay area are looking for genuine integration from this round of health reform. We want to see health services integrated, so that our patients have ready access to a seamless continuum of care and a system where our professional practice can flourish.

I should tell you that I was the ONA board representative for this region back in the mid-1990s, when ONA was recommending principles for integration of health care. I spent many days—more like weeks—trying to envision what integration would look like in this area. Because of geography alone, I knew it would be very different than integration in southern Ontario. So I have a long history and interest in getting integration of northern health services right. However, we don't believe that Bill 36, as currently drafted, provides the underpinnings for an integrated health system.

LHIN number 14 is 1,000 miles wide and probably that far from north to south. Services must be delivered in many small, remote communities. The vast distances between major centres make integration of services virtually impossible. In the 140 kilometres between Kenora and Dryden, there is only one village and the road is often closed for long periods, whether for bad weather or motor vehicle collisions. This is also the case east of Thunder Bay. There's only one road and no alternative route.

Many of the communities in the north already have a version of an integrated network. Often many of these

services are run out of, or by, the hospital. This is because the hospital recognized the need and there are no other services or service providers available in the area.

The provincial government has developed a fact sheet in response to the concerns that are being raised about the approach to integration in Bill 36—what they call "myths." I'd like to spend the rest of the time with you to review why we believe the government's interpretation of Bill 36 does not address our concerns with the approach to integration being presented. Nurses are not making up concerns about Bill 36. We don't have time to sit around imagining what might happen. These concerns are not myths; they are based on our experiences.

Bill 36 is all about giving power to unelected boards mandated to identify duplications and concentrate services in particular centres and facilities. The government claims it is a myth that LHINs will mean less access to health services and services being moved further away from our community. But one LHIN chief executive officer, for example, even told a public meeting in Sarnia that in the new age of health care, residents of that city should get used to the notion of travelling to Windsor for certain services. It would be much further in the north. Is this a myth? Nurses don't think so.

Is it a myth that LHINs are not sensitive and responsive to local health care needs? The government argues that it doesn't make sense to micromanage an enormous health budget from head office and that local communities have a better sense of their own needs. So why didn't the government let the communities elect their own LHIN boards? Rather, head office made the selections. What is local about boards assigned to meet the health care needs of populations larger than the province of Saskatchewan?

Moreover, the government can close LHIN board meetings to the public when it wants to: not much sensitivity or responsiveness there. The rationale from the government is that other provinces have moved to undemocratic boards. That's no reason for us to do the same in Ontario. I was told that we would learn from their mistakes. This obviously isn't happening.

LHINs will open the door to privatization. The government denies this, stating that the legislation prohibits any integration that would cause an individual to be required to pay for health services. But in the ministry fact sheet they forget to add the clause, "except as otherwise permitted by law," which in Bill 36 follows the guarantee that patients won't have to pay. The bill also encourages service providers like public hospitals to integrate their services with "those of another person or entity," with no restriction on whether those entities are for-profit operations. This means that procedures and jobs will be moving to doctor-run clinics, perhaps. Finally, the bill allows the government to order a public hospital to transfer its non-clinical services to an enterprise of the government's choosing.

LHINs mean job loss and lower wages. Not true? Just ask hospital workers whose jobs have already been contracted out to private firms. Not only do they work with lower wages, but they're allowed to have less job satisfaction. Our nurses and health care professionals who worked in home care saw their wages and benefits fall when the competitive bidding model pushed non-profit agencies like the Victorian Order of Nurses out of the sector.

The plan lacks a comprehensive plan to deal with employees in any way that protects jobs and improves patient care. The government calls this a myth, but partial and total mergers of health care employers will be ongoing. As the bill stands now, workers who after a merger find themselves employed by firms that are not primarily health care providers will likely not have their pay and benefits protected. Patients will be served meals and depend on laundry services provided by companies determined to cut costs so as to protect their profit margins. Patients who need more nurses and other health care professionals may well see fewer staff as the LHINs pressure hospitals and other providers to economize.

LHINs reduce accountability by placing decision-making at arm's length from the government. With the new scheme, who is accountable? The Minister of Health will be shielded by a new layer of bureaucracy—just what we don't need. Meanwhile, how is the LHIN accountable to its community? The members of its board serve at the pleasure of the government, not of local residents, and accountability agreements between LHINs and health service providers are not guaranteed to be disclosed to the public. The result? Reduced public accountability.

LHINs ignore the role of doctors. This is not a matter of interpretation: The legislation excludes physicians. LHINs will not fund doctors' salaries. This is curious insofar as one of the board's key mandates is to achieve economic efficiencies in a system where the key cost driver is income paid to the doctors. So while it might be defensible to say that LHINs don't ignore the role of doctors, the legislation certainly doesn't take physicians fully into account, or perhaps the government took doctors' opinions entirely into account when it kept them outside the LHINs scheme.

LHINs take away local control, and there is no input from front-line staff. Is this a myth? Let's investigate. The provincial government appoints boards accountable to Queen's Park that will have the power to move services. For example, when birthing facilities and other procedures are moved away from smaller communities and concentrated in regional centres, it is fair to say that the local control is being undermined.

As for input from front-line staff, each LHIN will be obliged to establish a health professionals advisory committee, but the legislation fails to guarantee that those members of the regulated health professions appointed to these committees will be representative or have meaningful input and disclosure. It doesn't sound like a myth to us.

LHINs have the potential to extend the competitive bidding model to the entire health care system. LHIN boards are mandated to economize when encouraging or

ordering public hospitals to carry out full and partial mergers with other health care providers. Services will move out of hospitals to the extent that alternative providers are able to offer them at a lower cost. Despite its disastrous effects on home care, this government has seen fit to continue competitive bidding in this sector, nor does Bill 36 exclude managed competition. In short, the evidence suggests that concerns on this front are far from mythical.

There has not been extensive consultation on LHINs. There have been workshops, as the ministry asserts, at which information has been woefully inadequate and where government officials have done their best to conceal the main ways in which the piece of legislation, as it is presently written, will undermine patient care and bring chaos to the health care labour market in Ontario.

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First and foremost, nurses are concerned about the lightening speed at which the government is rushing towards the implementation of massive change to our health care system without extensive consultation and without a provincial strategic health plan. If you fail to plan, your plan will fail. Let's stop right now. The government should issue a green paper and conduct extensive consultations. Nurses will then work together towards a real reform for a genuine integrated health system.

Thank you.

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

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 720

The Chair: The next presentation is the Ontario Public Service Employees Union, Local 720, Thunder Bay: Doris Meredith. Good afternoon.

Ms. Doris Meredith: Good afternoon. My name is Doris Meredith, and I'm with OPSEU, Local 720. I'm sitting with John O'Brien, who is our regional vice-president.

I'd like to thank you for the opportunity of being here today to speak to the issue of LHINs. I'm a local president at Lakehead Psychiatric Hospital, where OPSEU represents close to 450 nursing, paramedical, professional, and service and clerical staff. I'm also vice-chair of OPSEU, sector 18, which represents approximately 8,000 OPSEU employees who work in the mental health sector in Ontario.

I'm presenting today with the hope that you'll be able to use your discernment of the issues presented today to guide the construction of a legal framework that will preserve certain principles of health care delivery within the 14 regions of Ontario. Northwestern Ontario has a very unique geographical and demographic makeup. I trust that other presentations today have or will provide you with a snapshot of the unique challenges we face here.

Because of time constraints, I've limited my presentation to address one area of process, specifically regarding the priority-setting of the LHINs. I will also address issues of employment stability and briefly speak to the challenge of the importance of constructing the legislation to protect access to mental health services in the province.

My concerns regarding process speak to the illusion of local or regional input into health service provision. I've been following the progress of transition to the LHIN system since the concept was first introduced in late 2004. At that time, community agencies and health service providers were invited to participate in workshops, namely the "Taking Stock" initiative of setting integration priorities in the 14 LHIN regions.

The northwestern Ontario workshop was held in Thunder Bay on December 10, 2004. Two hundred and sixty-six representatives of health service providers participated in the workshop. The group identified 38 integration opportunities and subsequently prioritized the top five patient care and the top five administrative integration opportunities for this region.

My specific concern is that during the workshop, the proposed Bill 36 legislative framework was unavailable to participants. The LHIN concept was referred to as a work in progress, and participants were told to get on board or get left behind. At the time that the workshop participants formed their ideas for integration opportunities, they did not have access to any form of the proposed legislation.

In region 14, only three labour representatives from one union were able to participate. Those participants, of whom I was one, also had not seen the legislation before us today. What was disconcerting to me at the time was that the labour organizations were not invited to participate during the early public consultation phase of the LHIN initiative. OPSEU was able to participate only because of a very perceptive staff that was paying attention to the issues of health care.

The reason unions were not specifically invited subsequently became apparent once the draft legislation, Bill 36, became public on November 28, 2005.

My point is that the absence of any knowledge of the legal framework of the new system during the public consultation phase will cause a two-pronged problem. On one hand, health service providers could not have anticipated the impact of the legislation on the provision of health services during their priority-setting exercise. If they had had access to the legislation, their priorities may have been different. This will cause the public consultation phase of the LHIN initiative to be skewed from its inception.

Secondly, if Bill 36 passes as it is, there is no way to unring the bell. The priorities for regions have already been established under this process and are slated to be passed on to the new LHIN boards. There are no provisions in the legislation to undo this portion of the public consultation process, and there is no provision in the legislation that ensures future public consultation.

Now to my concerns about the legislation itself. As an employee and local president of one of the former provincial psychiatric hospitals, I have gained first-hand ex-

perience of the sense of confusion and instability that employees feel when they're involved in system integration. Despite the sense of insecurity employees felt during the divestment process of the provincial psychiatric hospital from the Ministry of Health to the broader public sector, employees at Lakehead Psychiatric Hospital were able to rely on collective agreement provisions to assist them throughout the transition process. In addition, these employees had access, under the Ontario Labour Relations Act, to other provisions that allowed for employment stability.

The voluntary recognition provisions of the Ontario Labour Relations Act were applied in our case, as there was no intermingling of bargaining units. This allowed the union and the employer to negotiate an agreement that maximized employment stability for employees in the bargaining unit and has allowed the employer to retain its specialized workforce. This has resulted today in better patient care for our community. The same outcomes for staff and employees may not be possible if Bill 36 is passed in its present form.

Negotiations between unions and employers establish a legal framework for workforce stabilization. The most fundamental labour relations implication of this legislation is the proposed extension of the application of the Public Sector Labour Relations Transition Act, 1997, to a LHIN integration decision. Under Bill 136, the OLRB had the discretion to order votes only where there had been the intermingling of employees. If Bill 36 passes unamended, it may lead to a representation vote whenever health system integration occurs.

By giving itself sweeping powers to enforce integration decisions and ministerial orders by applying to the Superior Court of Justice for an order to direct parties to the integration orders to comply, which is found in subsection 29(3) of Bill 36, the LHIN may be able to override existing collective agreement provisions that address employment stability. This will cause radically restructured bargaining units, even when the employees have remained separate and apart. This will undermine continuity in the provision of services and force service providers to be continually training and orienting within other organizations. Not only will health service providers have to deal with these issues; they may also immediately be involved in layoff situations and will face legal challenges regarding notice and severance under the Employment Standards Act. Legal wrangling to deal with these issues will divert attention and precious health care dollars away from health service provision.

If competitive bidding by single-service providers is added to the mix, stable employment will become a product of history only. This employment environment will undermine the stability of whole communities as people are forced to move to other areas of the LHIN region where services may become consolidated. Where two income earners cannot work in the same community as a result of an integration order, families will be torn apart.

Lastly, I'm concerned that mental health services will be particularly hard hit by this proposed legislative framework. Mental health services have often been referred to as the poor second cousin of health services in general and have had to struggle to obtain sufficient funding. By having a LHIN allocate funding for these services from a global health funding envelope, these services will be put further at risk when facing intense competition for funding against other health services in general. Mental health funding must be protected in an amended Bill 36, in order to allow for the discussions that need to take place to establish adequate access to mental health services in the LHIN regions.

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This has been my attempt to inform your recommendations for amendments to the legislation before you. In this regard, I respectfully request that the standing committee on social policy make recommendations that will amend Bill 36 to guarantee:

(a) fully informed comprehensive community involvement in LHIN priority-setting and accountability of the LHIN to the public;

(b) a framework for negotiations between employers and bargaining agents that maximizes opportunities to maintain employment stability; and

(c) a separate funding envelope for mental health services.

I just want to speak to this one quickly. I'm not proposing a model; there are far more articulate people who can speak to this piece. But what has become apparent is that mental health services funding does need to be protected, and we're certainly advocating for that.

Referring back to the priority-setting phase of the LHIN initiative, and emphasizing the point that participants did not know about this proposed legislative framework as they developed priorities for integration in this region, please consider the following quotes that came out of those workshops:

"Ensure that there is a continuum of care that is client-centred."

"Ensure ... access to needed services in a timely manner ... sufficient funding ... support client in setting of choice and ability...."

Finally, "Integration does not mean amalgamations and mergers. Integration means partnerships, collaboration ... appropriate use of existing services."

The Chair: Thank you. We've got just under three minutes, so we'll take a minute each. We'll start with Mr. Miller.

Mr. Miller: Thank you for your presentation. We had an earlier presenter from the Canadian Mental Health Association. They are afraid that the LHIN model is going to mean more or less what you said, that mental health will be competing against other health care needs like cancer care etc. Their concern is that funding for mental health will be reduced. Is that what you are also concerned with?

Ms. Meredith: Yes, I'm very concerned about that. A lot of excellent work has been done by committee after committee. There have been the North West Mental Health Implementation Task Force studies; there's been a lot of work done that I think is just sitting on the shelf at

this point. The recommendations that have been made have been essentially around retaining some sort of control over mental health funding so that services can be rationalized within a system, but within the mental health system itself.

Ms. Martel: Thank you for making a presentation today. I just want to go back to the meeting that was held in December 2004, when all these groups came together. Was there any information given to participants at the time that local control was going to mean people who were essentially appointed by the province? Was there any discussion about who was going to be involved in this and how they were going to be appointed?

Ms. Meredith: There was an information booklet that was handed out, and it did show a LHIN structure. There was a question-and-answer period at the meeting, where people were trying to get answers to those types of questions. But the message that was going out was, "This is a work in progress. We don't have those answers right now. When we have them, you'll find out."

Ms. Wynne: Thank you very much for being here. The reality is that at that time those decisions probably hadn't been made about what was going to be in the legislation. The minister was meeting with a number of people, including—before those meetings, he had met with Leah Casselman. He's talked to many folks from the sectors around the province.

One of the things I wanted to ask you is, those comments that have been made in various reports and various forums are really important in terms of informing this process going forward. So when in the legislation it states that the LHINs must involve themselves in community engagement and public engagement, how do you see that best happening so that comments like "Integration doesn't mean amalgamations and mergers" don't get lost, that those comments continue to be made? How do you see that public and community engagement happening?

Ms. Meredith: I think it may be very important at this point to hold back on the implementation of the legislation. Once the legislation goes through—if it isn't amended and it goes through as it is, any community consultation after that point may not have the result that people would like it to have.

Ms. Wynne: Except that as the LHINs do their work and identify gaps and come up with the local plans, they're going to need to keep talking to people in all the different parts of the province. I guess I'm just asking you to think about it, because we're going to run out of time. But if you have suggestions about particular mechanisms you think LHINs should be using over time, that would be very helpful.

The Chair: Thank you very much for your presentation.

KENORA HEALTH COALITION

The Chair: We do have the Kenora Health Coalition on the line, so we are going to hear the presentation from Cassandra Moeller, co-chair. Cassandra?

Ms. Cassandra Moeller: Hi there.

The Chair: Good afternoon. Please start your presentation.

Ms. Moeller: Okay. Thank you very much. My name is Cassandra Moeller, and I'm the co-chair of the local health coalition here in Kenora, the Kenora Health Coalition. This is a community-based coalition. Our primary goal is to empower members of our community to become actively engaged in the making of public policy on matters related to health care and healthy communities. We seek to provide our community with ongoing information about their health care system and its programs and services. Through public education and support for public debate, we contribute to the maintenance and extension of our system of checks and balances that is essential to good decision-making.

We are an extremely collaborative organization, actively working with others to share resources and information. We are a non-partisan group committed to maintaining and enhancing our publicly funded, publicly administered health care system. We work to honour and strengthen the principles of the Canada Health Act. The Kenora Health Coalition has members who are seniors activists, union members and community members at large who are concerned with the state of health care and, worse yet, the apparent move away from the publicly funded, publicly delivered model of health care.

As a coalition, we lend our support to many other community health projects and groups. Some examples of our coalition's representation are the family council at the Kenora District Home for the Aged, our commitment to the Kenora Health Providers Group and the Kenora Seniors Coalition.

Health restructuring: This legislation appears to be a health restructuring act. Like the hospital restructuring act legislation brought in by the Conservative government, this bill increases the health minister's and their designate's power over health providers in order to facilitate restructuring. Like the Conservative government's restructuring, there are only a few, if any, checks and balances to ensure that population need and the principles of the Canada Health Act guide this restructuring.

There has been no evaluation of the consequences of the last round of restructuring, save the reports by the Provincial Auditor that expressed concern about the sequencing of restructuring, the lack of projected savings and the costs, which escalated to $2.8 billion over planned amounts. By the end of the last round of restructuring, hundreds of millions in operational funding was spent to close hospital beds, cut programs and lay off health care staff.

We strongly encourage the government to take heed of the effects of the former government's attempt and large failures prior to continuing to push through this legislation. During its tenure, the Conservative Health Services Restructuring Commission issued final directions to 22 communities, affecting 110 hospitals. These directions amalgamated 45 hospitals into 13, and closed 29 hospital sites. The worst years were from 1995 to 1997 and im-

mediately after, when the Conservative government withdrew approximately $900 million without warning from the hospitals, announced closures and amalgamations of dozens of community hospitals, and forced the cutting of 9,000 critical, acute and chronic care beds and the layoff of approximately 26,000 positions.

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Hospitals were thrown into chaos with amalgamations, bed closures, staff cuts, emergency room overloads, and serious backlogs for procedures and diagnostic tests. Hospitals drained their reserves as they attempted to cope with the serious funding shortfalls.

Community services did not exist to take the load of acute patients moved out of hospitals. Slowly, new long-term-care nursing home beds and home care took many, but in the process, support of home care services to tens of thousands of frail elderly seniors were cut, as they were pushed to the bottom of the priority list in a competition for scarce resources.

Ultimately, the Conservative government was forced to re-fund hospitals, but seniors' services in the communities—off-loaded hospital services such as physiotherapy, speech pathology, social work and others—have never been restored.

The new capacity in the health care system, new long-term-care beds and the extended home care program for acute patients were largely given over to for-profit companies. After spending billions, the last round of restructuring increased privatization, created massive labour disruptions, and reduced the scope of publicly covered services.

New powers: In Bill 36, the Ministry of Health and Long-Term Care has given itself, and essentially controlled LHINs, major new powers to order health system restructuring and contracting out. The main new powers include:

—the ability to order transfers of service, personnel, property and funding, with limited appeals and compensation;

—the ability to order closure, merging and transfer of all operations from many non-profits but not for-profit, service providers;

—enforcement of these new powers by court order;

—a new structure for the health system ruled by the health minister's strategic plan, set out unilaterally, enforced ultimately by court order;

—the ability to override protections and provisions in legislation covering civil servants, corporations, expropriations and the statutes act, among others.

This legislation appears to be a bill to empower the ministry directly and through LHINs to execute a new restructuring of the health system. The legislation confers powers that expressly override previous legislation that set out processes for the disbursement of charitable and non-profit property, the guidelines of the civil service compensation for expropriation of property or process for the enactment of statutes.

While this government obviously trusts itself with these increased powers, we wonder, would it trust a future government run by another political party with these powers? Despite claims by the ministry, this legislation does not set up regionalized health care to move control closer to communities. In fact, this legislation centralizes power rather than regionalizing it.

The LHINs are to be made up of government appointees, with the purpose of reorganizing the local health system based on targets and goals set out by the LHINs under the direction set by the minister. The LHIN boards are entirely undemocratic. They are appointed by cabinet and can be replaced at cabinet's will. The qualifications for these positions are biased towards business and administrative elites, and there are no provisions in the legislation for diversity, democracy or representation. There is no protection for equality-seeking groups. Cabinet is given the inexplicable power to exclude any persons or classes of persons from LHINs membership.

There are no protections in the legislation to prevent a revolving door between the for-profit health industry and the LHINs. There are no normal, democratic precautions and processes set out in the legislation. There is inadequate specification of an expected process for public notice of meeting. The bill simply requires that notice "be given in a manner that is reasonable in the circumstances." Most non-profit and other organized groups require a certain level of publicity for public notice of meetings.

There are no normal democratic protections against in camera or secret meetings. The bill gives cabinet discretion to regulate what will be in camera or not. This is not in keeping with the legislation covering comparable regional government organizations, such as school boards and municipalities, that are bound to short-term lists of items in legislation for which they meet in camera. Why does this government envision a system in which democratic rights regarding the health care system are less than they are in other sectors?

There are no public processes for access to timely information regarding restructuring proposals, and there is no process for public input or appeal. Even the Conservatives' health restructuring process allowed for public deputation. Anyone can make a submission. In this bill, the public will be able to access restructuring orders at the LHINs office after decisions are made. No patients or community members have the right to appeal.

There is no democratic process regarding the minister's strategic plan for health. Normally, a change in the strategic direction of the entire ministry, covering a vital service like health care, would include a white paper or similar document, setting out the intended strategic direction, issued publicly. There would be a broad consultation which would be on the record and available for public perusal. The result of this consultation would be used in the creation of legislation or directions flowing from the white paper. This legislation describes a process in which the minister, without any consultation process or any public input on the record, will set out the strategic direction for the entire health system and implement it, backed by court order.

Privatization: The legislation facilitates privatization in several ways. The LHINs may move funding, services, employees and some property of non-profits to for-profit agencies. Cabinet may order the wholesale privatization or contracting out of all support services in hospitals. Note that there is no definition in any Ontario legislation of what constitutes non-clinical services. Under this legislation, cabinet is given the power to define these services as broadly or as narrowly as they wish. The minister may close or amalgamate non-profits but not for-profit companies. It is not difficult to foresee a shrinking set of non-profit providers while the for-profits continue to gain new market opportunities as the system is restructured. There is nothing to prevent the moving of services out of hospitals, where they are covered by OHIP, into the community or other facilities where the government is allowed, by law, to make people pay out of pocket for them. There is nothing to prevent them from cutting services so that people must pay out of pocket for them.

The new use of powers contained in the legislation will likely become clear when the minister makes public his strategic plan for the health system. Under this legislation, the LHINs are required to execute their powers following the direction of the strategic plan set out by the minister. They will be bound to do so by accountability agreements with the minister. There is no process of public input or debate to precede the setting of that strategic plan. It will be publicly available once it is set. However, in speeches and interviews, the direction of the minister has become clearer.

Competitive bidding in hospitals is a major concern. It is the current direction of the ministry to expand a price-based competitive bidding system through acute-care hospitals. Thus, for example, the regional hospital that bids under a centrally set target price for the hip and knee replacement surgeries would get the funding for that region, and patients would be required to travel further to access health services.

Under this legislation, the LHINs would have the power to allocate funding, and therefore services, to hospitals that underbid others. While many civil-minded community members have been fundraising for generations to improve local access to services, the direction of this ministry is the opposite: to coordinate services into the hospitals that specialize.

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The ministry has also mentioned in several speeches and interviews the number of mental health community agencies. This legislation gives the LHINs and the government the power to order the amalgamation or closure of these agencies. This system of market competition that has been so destructive in home care is already being introduced in the hospital sector under the guise of "wait-time strategy."

The ministry surveyed hospitals to find out prices for cataract surgery. It then set essential targets and funded those hospitals that provide the surgery at that price. Reduction in the price target is the next goal.

The Chair: Thank you. Madam Moeller, you've used your 15 minutes already. Do you want to conclude, please?

Ms. Moeller: Of course. These LHINs are very worrying for the local area because our LHIN is so geographically large and serves such a diverse population. I request that the government take that into account and implement suggestions for more democratic input.

The Chair: Thank you. I understand that you are going to fax your presentation to us. We thank you for that and for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1781

The Chair: The next presentation is from the Canadian Union of Public Employees, Local 1781, Kenora: Judy Bain. Good afternoon, Ms. Bain. You have 15 minutes. Please start when you're ready.

Ms. Judy Bain: Hello. My name is Judy Bain. I'm an RPN and I work at Lake of the Woods District Hospital. I've worked as a nurse for 20 years. I'm the president of CUPE Local 1781, which represents the RPNs at our hospital.

I would like to start my presentation with a quote from George Smitherman, Minister of Health, from his speech to the Ontario Hospital Association, November 5, 2003.

"Restoring the pride and confidence of our front-line workers is an important test, and something I will treat as an early priority. And better working conditions are part of that equation.

"Health care is delivered by people—and it's our job to make sure that they have a safe and supportive working environment."

Well, Mr. Smitherman, those are pretty words, but this government hasn't restored any confidence in the front-line workers. All this government has done is it has broken promise after promise for health care workers. P3s, AFPs, more nurses—all empty words.

In regards to the LHINs, I'd like to say thank you for your 15 minutes of time, but it angers me that this standing committee is in Thunder Bay and not in my home community of Kenora. Many people would have liked to have a say here today, but to travel to Thunder Bay is a six-hour ride from Kenora or a $1,100 flight. Many seniors can't afford this. In our town hall meeting last Thursday, they had a lot of concern and a lot of questions. If this government was really interested in consulting the public about this, they would have put this committee in rural communities and not in urban centres. I think it's kind of ironic that the hearings are all in big centres. I have a feeling that this will be very similar to how the LHINs are run: Rural communities will suffer and lose their voices, and the urban centres will be just fine.

The only thing local about the LHINs is the name. Our LHIN is very big; it's vast and it's diverse. Northern Ontario has a hard time catching the ears of the government at the best of times, so having a LHIN this

big is very alarming. The boundaries have been formed based on hospital referral patterns, overriding municipal and provincial boundaries. This bill would grant very little real power to local communities and providers to make decisions that affect their communities. How can local hospitals stay connected and best serve the communities when they are mandated by LHINs? So it will be very difficult for people living within the LHINs to have a significant voice over the direction of the LHINs even if the board wishes to listen to them.

The LHINs will operate like regional ministries with awesome powers, heavy administration requirements and very little public accountability for improving the health care system. What is the role of the local hospital boards that are now currently elected? Now taken over by government-appointed and unaccountable people. The government will control the funding, and each LHIN will be required to sign accountability agreements with the government. How do we make the government accountable when they will unilaterally impose agreements if the LHINs don't agree?

If the government wants to restore confidence in the front-line workers, they could start by making the amendments needed to ensure our work will not be contracted out and privatized. Give us specific guarantees in legislation on competitive bidding and privatization. Also, employees should continue to be governed by their existing collective agreements and conditions of employment, and these must continue to be determined through central bargaining and HLDAA. Existing terms and conditions of employment set out in the collective agreements should be respected and not steamrolled by the government, with no respect for them.

The integration will remove jobs and services from local communities, hampering access. Support services will likely be the first to go, but I do believe clinical care will be under attack. There is no protection against OHIP service being cut. In fact, the LHINs may isolate the minister from political consequences of such cuts.

There are no provisions in the bill which ensure, require or encourage the LHINs, the minister or the cabinet to preserve a public, not-for-profit health care system. I believe these bodies will now be able, with legal authority, to privatize large parts of our publicly delivered health care system. An interesting note: The Liberals campaigned in 2003 on keeping health care public and stopping the creep of privatization that they cited and criticized during the days of Mike Harris. Well, Mr. McGuinty, it looks to me like you're turning blue.

Why weren't the health care act principles of comprehensiveness, universality, accountability, portability and public administration included? The lack of clear direction or principles to protect public interest is a deep concern, since recent speeches and interviews by the health minister indicated that his strategic direction is to centralize and consolidate hospital services and community health services.

Under the provincial wait time strategy, the minister is implementing a competitive bidding system for hospital services such as cataracts and hip and knee replacements. We have reason to believe that this will be even further expanded under the LHINs. This bidding system is structured to result in fewer hospitals delivering these services, worsening the inequities of local access to these services. We have just started doing eyes and knees in our hospital, and we don't want to lose these services. They are very important to the citizens of our community.

To sum up my thoughts, I believe this bill and the government's attempt to restructure health care needs to be rethought and move at a much slower pace, with more input from all sectors of health care and the consumers of this system. The rush to push this bill through has left many people wondering about the hidden agenda of the Liberal government, and that is where credibility is very fragile.

I now have some questions I would like to ask the committee. I would like you to define "community" for me.

The Chair: Anyone?

Ms. Bain: It doesn't matter.

The Chair: Does anybody wish to answer? Ms. Wynne?

Ms. Wynne: The way "community" is used? Are you talking about the section where we talk about community engagement?

Ms. Bain: Yes. I'm just curious when you say "community."

Ms. Wynne: It includes the community of people who are involved in health care as well as the public.

Ms. Bain: So the total LHINs.

Ms. Wynne: Sorry?

Ms. Bain: When you engage the public, are you talking—

Ms. Wynne: It's a requirement in the legislation that the LHINs engage the public, engage the community, in their processes, in their deliberations.

Ms. Bain: Okay. My second question is, do you see further amalgamations of the LHINs, going from 14 to 7 or—

Ms. Wynne: Well, in fact, there's a mechanism within the legislation that would allow more LHINs to be created. If it's determined that there are too few and there's a need for more than there are already, then that can happen. So that's an ongoing process.

The Chair: Before you go ahead, Shelley Martel, please.

Ms. Martel: Yes, there's a provision in the legislation that says that the minister can increase or also can dissolve some of the LHINs. So there can either be more or there can be less. The provision exists for both possibilities.

Ms. Bain: My third and final question is, will the referral patterns be a part of the written agreements to honour current practices? We do a lot of our transfers into Manitoba, and I'm just wondering if it's the intention of this LHIN to continue to honour those practices.

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Ms. Wynne: Yes, it's my understanding that those referral patterns, first of all, were part of what determined the way the LHINs were set up and that they would be ongoing considerations.

Ms. Bain: But will they be a written part of it?

Ms. Wynne: Will they be written into the legislation—is that what you're asking—or into the agreements?

Ms. Bain: Into the agreements.

Ms. Wynne: I can get that answer for you. I don't actually know. I'll get that for you.

The Chair: You may be able to double-check.

Ms. Martel, do you want to comment on this?

Ms. Martel: Yes, I do. Some of the referral patterns don't make any sense at all. We heard when we were in London that people from Sarnia, who would normally go to London for procedures at the hospital, are now told that their referring hospital is Windsor. So the referral pattern is completely different from the one they had been used to. The minister has said to people that you can still continue to go where you want to. However, we did have a presenter in London raise a scenario to say that she—and we don't know what context it was in because the question and the answer occurred at the end of the presentation. But she did say on the record that she had been told that because she was from Sarnia coming to London, she wouldn't be able to get that treatment because that was not the referral pattern that was envisioned when the LHIN was set up. We didn't get any more information. I can only relate to you what was on the public record.

I do know, though, from people from Kenora that there has been some sense that it's not clear that you can go to Manitoba. For example, your northern health travel grant might be at risk. I know that Howard's office has been getting calls from people who have been told that, albeit we haven't seen an actual piece of correspondence. I have asked Barb in his office, if she gets a piece of correspondence that actually says that, to give it to us because we would raise that immediately as a concern with the ministry. I gather that was something that came out of Closson's report. I don't know all of the details of it, but I can't imagine that the ministry would want to change that at this point, because so many people do go out to Winnipeg.

The Chair: There are two more answers to your questions. First is Ms. Wynne and then Mr. Ramal.

Ms. Wynne: As far as the referral patterns that you're talking about, many of those reside with OHIP and they will continue, they won't be part of the accountability agreements. Everything that will be included in the accountability agreements is still being established at this point.

The issue of—and I'm sorry, I had half an ear listening—whether people can go across LHIN boundaries to get service, absolutely they will be able to do that. The law will not allow people not to go across those LHIN boundaries. That's absolutely within the purview of the law.

Ms. Bain: I guess I just want to make sure that that's enshrined somewhere.

The Chair: Mr. Ramal, you still had something to add?

Mr. Ramal: No, Ms. Wynne answered.

Mr. Gravelle: Can I say one thing?

The Chair: Yes, Mr. Gravelle, and then I'll go around. Thirty seconds or so, please.

Mr. Gravelle: Just very quickly, I want to make reference to the fact that it would be great if we could be in Kenora. I think I probably speak for Mr. Mauro as well. We're always pleased to have the committee come to the northwest. I've always, for years and years—not just to our government, previous governments—said it would be great to be in Marathon, it would be great to be in Greenstone, it would be great to be in Kenora, it would be great to be in Dryden. We'll keep arguing it would be great to do these things but, quite frankly, it's a challenge. There are so many communities in the province that want to have access to public hearings. I just want you to know I hear you and I've been making that case for some time, but I'm still grateful that we managed to get to Thunder Bay.

Ms. Wynne: Teleconference.

Mr. Gravelle: And the teleconference aspect has been helpful, that's right. Still, in an ideal world, we'd be there.

The Chair: Why don't we have 30 seconds each? Ms. Martel, do you wish to make a statement?

Ms. Martel: Careful, to Mr. Gravelle. I did ask for the committee to go to Sioux Lookout and to Sault Ste. Marie and got voted down. That wouldn't respond to your problem in Kenora, but it might have been a little easier to get to Sioux Lookout versus coming to Kenora. We got some extended hearings but they were not in all the places that I had put forward as an opposition member for us to go to.

Just very quickly, one of your colleagues earlier from Lake of the Woods told us about a situation where Versa foods had run the contract for food and that the board of the hospital had decided after some time it was not very good and the contract wasn't renewed. My concern, of course, is in the legislation. As it currently is written, even if the board says, "We don't want Versa any more, we want it in house," the legislation very clearly says the minister can order that service to be contracted out to a for-profit company like Versa. So that absolutely has to change.

Mr. Ramal: Thank you for your presentation and for your questions. Definitely there are a lot of people we want to hear from and we, as a standing committee—and our party—pushed for seven days instead of four days, for more people and to have more input. Prior to this travel in the province of Ontario, we consulted as a government, the Minister of Health, with 4,000 groups, agencies, individuals and community groups in order to consolidate and come up with suggestions for the bill.

We're going to take your input and that of other people who have been speaking to us for the last four days, and hopefully we can make some kind of changes in order to achieve our goal, which is to consolidate health care in Ontario and have better delivery. As you know, as we speak today, health care in Ontario—yesterday the minister spoke to the London Free Press—is not as good as people think; it needs some kind of reform. That's why we are here.

You started your speech—I call it a speech because I have listened to many of your CUPE locals across Ontario. When they come to us, they come with a political speech, not suggestions. Anyway, that's fine; we'll take it.

I want to tell you something very important. When the Minister of Health was appointed, he had a commitment and a goal to achieve: to fix health care. That's why we got elected in 2003; that's why we are going to do it. Hopefully you will judge us on our results, not just by what you hear, what you have in assumptions and what you are being told. For you and many other people in Ontario, the result is the most important thing.

Mr. Miller: Thank you for your presentation. On that set-up, I guess I'll ask you—the government is heading down the LHIN path, obviously. They've hired the CEOs and a lot of the bureaucracy already and have the boards in place, and the legislation isn't even passed yet. My question would be, will local health integration networks improve our health care system? In the compendium of the bill, it says we're going to have "efficient management of the health system at the local level by local health integration networks." Do you think LHINs are going to improve the health care system, or what direction would you give to the government if they don't improve the health care system?

Ms. Bain: I think everybody who works in health care understands that there's a need for change, but we also think there's a big need for people to listen to us. We're the ones who deliver the care every day, and we don't think we're being listened to. We definitely understand that there has to be accountability, and we see not very good spending, but to move to this system, absolutely not. I think that health care is going to be very threatened. All we see is privatization and having care delivered by people who aren't accountable and maybe not regulated, and that concerns us very much.

The Chair: Thank you very much for your presentation.

THUNDER BAY AND DISTRICT INJURED WORKERS SUPPORT GROUP

The Chair: We are going to hear from Steve Mantis, an addition to the agenda. He is from the Thunder Bay and District Injured Workers Support Group. Please start your presentation. You have a maximum of 15 minutes.

Mr. Steve Mantis: Thank you, Mr. Chairman, and thank you very much for making the opportunity for us to present today. It is very special and unexpected.

We're here, really, as a group of people who receive medical treatment. We don't deliver it. That's not our job, though many of us were hurt in the health care field. We're certainly not experts on this bill, and we're not experts in terms of how the system works or doesn't work, other than from being on the receiving end. You can imagine that we may be one of those groups who are on the receiving end quite a bit.

Of course, if you're injured, you need medical treatment. But research shows that following a permanent injury, a permanent disability—in Ontario there are 300,000 workers today who have a permanent disability, so we're talking about a fair group of people. That group of people tends to have what one researcher called an injury cascading effect. Once you become permanently disabled, you start having a greater risk of reinjury—many of these people are injured a number of times, in the workplace and outside—and overall health issues deteriorate, so people begin to rely more and more on the health care sector.

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So there are a lot of people, and we use the system a lot. We come here, really, as consumers of the system. What we see—mostly we learn a lot about how systems deal with people, a lot of it looking at the compensation system, the Workplace Safety and Insurance Board. That system is structured in a way to look at certain aspects of people's lives: earnings replacement, physical health. The problem is that we're not just physical beings and wage earners; we're people with many different needs and emotions. In order to get people to fully recover, they need to be looked at on a number of levels: certainly the physical, which is most of what our health care is, but certainly on the emotional, mental and spiritual levels.

You guys have a heck of a challenge ahead of you trying to think about how you're going to integrate all these different things into a comprehensive health care system. I'm kind of glad it's not me. I know it's a tough thing.

But within that context, we see changes in our society, and we definitely see a change to more and more privatization on all levels. If you just talk to people in the community—I was talking to a fellow today in one of the government offices as we were waiting in line. We were talking about the roads—the maintenance for all the highways here has now privatized. He said, "You know, I worked for 40 years in construction out on the road, and if I was headed to Ignace," which is three hours west of here, for those who aren't local, "and it was in the middle of a snowstorm, I'd feel secure because the ministry was out on the roads plowing and patrolling. Now we get a few centimetres of snow and the highway is closed because no one is patrolling, no one is plowing regularly."

We start off with privatization saying, "We can save some money." Having worked for a number of years in construction, where you get your jobs by bidding, you get to know some of the tricks. You know how you can bid to meet the minimum requirements of the service, but are you really going to do a good job? If the homeowner, in

my case, doesn't know that six inches of insulation are better than four: "It doesn't matter. I'll just supply the minimum. It's cheaper." But 10 years down the road, you're going to say, "I wish I knew more when I was putting that bid out."

What we've come to see is that relationships that are established long-term are the ones you want to count on. I live outside of town. In our township, it's all done by bid now. It seems like every two or three months we have a new grader operator doing the roads. They don't know the roads. Twenty years ago, we had one guy who did it every year. He knew the roads, he looked after us, he cared, he lived there and he was committed to the environment and the neighbourhood, and we had much better service. The cheaper thing right at the beginning is not always cheapest long-term.

If we look at WSIB, which is beginning to contract out more and more, they've contracted out to private providers the rehabilitation services to help people get back to work. There's no accountability. These people are there and get paid a good buck, but there's no accountability to ensure that the plans they develop really work. So when we look at privatization, we say, "Slow down. The relationships here are more important than the immediate thought of savings."

I want to mention, too, in terms of the selection of the committee—we have these 14 committees or whatever, and the government says that, in the best interests, "We're going to select the best people," and in fact you may select the best people. But when the next government comes along, they get to select and they may not do the same thing. In fact in the last government—I know this personally; my partner has been involved in this area for 25 or 30 years—there was the Early Years initiative in the area of child care. The committee that the Conservatives struck was almost all Conservatives, and they were all mostly interested in making their government look good, not in really looking after kids from zero to six years of age. You may even start with the idea that, "We're going to do the best," but once you put in place a structure, you have to kind of balance it. Someone down the road is also going to have the same choices, and are they going to make the best choices, even if you think you are?

The last thing I want to mention, because I want to leave some time for questions, is that what we think is driving so much of this publicly is the expanding cost of health care. What we see from our members, injured workers, is that a whole lot of costs go into the publicly funded system that maybe should be paid for out of the workers' compensation system, the Workplace Safety and Insurance Board. I'll give you a couple of examples.

A lot of claims go into dispute. If an injured worker is denied entitlement, they may take five or 10 years to resolve that and finally win. All those health care costs for all that time are now billed to the public system. Down the road they realize, "Yes, it was work-related; yes, we're going to give you entitlement," but it is still all paid by the public system. We're saying that if the public system is underfunded and stressed, maybe we need to look at what some of the root causes are.

Another one we want to mention is the area of occupational disease. We're seeing that up to 40% of cancers may be occupationally related. Those are all covered under the health care system, and we need to look at where those costs are being generated.

I'll stop there.

The Chair: There's about a minute and a half left, 30 seconds each. I will ask Mr. Gravelle to start.

Mr. Gravelle: Thank you very much, Steve. It's good to see you. Your presentation is essentially handwritten; you just got on this afternoon. Are you prepared to put it together in writing? We've been working together on a number of things, but some of these things you and I haven't even discussed. We'd be grateful if you could find the time to put it down in some more formal fashion, and then I can make sure the committee gets it.

Mr. Mantis: As soon as the health care system can do a little cloning, I'm right on it. I'm a volunteer.

The Chair: Mr. Arnott.

Mr. Arnott: Thank you very much for making your presentation to us this afternoon. I think you've given us a number of ideas that hadn't been presented to the committee so far today, which will be very helpful as we deliberate on Bill 36. I look forward to reviewing the Hansard of your presentation.

Ms. Martel: Thanks very much for being here today. It's nice to see you again. I'm glad you focused on privatization, because of course there are sections in the bill that facilitate privatization of health care, contrary to what the minister said in his opening remarks and, quite frankly, contrary to the intent and spirit of Bill 8.

Section 33 gives the minister the power to integrate services in hospitals. It says "non-clinical service" right now, but those aren't defined, so what that means is pretty sketchy. But the minister certainly can tell a hospital to outsource its non-clinical services to a "prescribed person or entity." It remains to be seen who that is. It certainly doesn't say "not-for-profit provider or not-for-profit entity." The other place where that continues to concern me is section 25.

Third is the whole area of how the LHINs are going to acquire their services, because of course the legislation is silent on that. Many people have raised concerns that they're going to acquire services in the same way that CCACs do right now, through the competitive bidding model, which has been totally destructive. We have said to the government, "If it's not your intention to have LHINs acquire services through the cutthroat bidding model, then put that in the bill." We'll wait to see if the government does that. Part of the problem around privatization is (a) disruption to the service and (b) the lowering of wages that usually comes, but (c) if you've got limited health care dollars in the system, you want to make sure they go to patient care, not to profits for some of those for-profit providers in the system.

I'm glad you focused on privatization, particularly because there are lots of ways and means it can be done

through this bill, and we wait to see if the government is going to shut down some of those mechanisms that clearly exist right now in the bill.

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

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RÉSEAU FRANCOPHONE DE SANTÉ DU NORD DE L'ONTARIO

The Chair: The next presentation is from the Réseau francophone de santé du Nord de l'Ontario. There are two presenters: Diane Quintas and Diane Breton. Ladies, you have 15 minutes total for your presentation. If there is any time left, we will ask some questions. You can start any time. Bienvenue.

M^me^ Diane Quintas: Merci. Bonjour à tous et à toutes. Merci de nous recevoir pour entendre nos commentaires quant au projet de loi 36.

Mon nom est Diane Quintas. Je suis l'agente de développement pour le Réseau francophone de santé du Nord de l'Ontario pour la région du nord-ouest.

M^me^ Diane Breton: Bonjour. Je m'appelle Diane Breton. Je suis une des membres du conseil d'administration du réseau. En plus, je suis une consultante régionale qui travaille pour l'équipe provinciale des services de santé en français au ministère de la Santé et des Soins de longue durée en Ontario.

M^me^ Quintas: Permettez-moi de vous présenter le Réseau francophone de santé du Nord de l'Ontario. Le réseau a été créé en 2003. Il est un organisme sans but lucratif, géré par un conseil d'administration, composé d'organismes offrant des services de santé, de professionnels de la santé, de membres de la communauté et d'institutions post-secondaires offrant des programmes en santé. Sa mission est d'assurer aux francophones du nord de l'Ontario l'accès à un ensemble de programmes et de services de santé de qualité en français et qui répond à leurs besoins.

Le réseau n'est donc pas un prestataire de services de santé. Son rôle est essentiellement celui d'agent facilitateur, de leadership et d'appui en matière de développement des services de santé en français. Nos activités sont principalement le réseautage et la sensibilisation des intervenants de façon à créer les synergies nécessaires à l'atteinte de notre objectif.

Le territoire que couvre le réseau comprend les districts de Timiskaming, Cochrane, Thunder Bay, Kenora et Rainy River. Ce territoire représente plus de 680 000 km^2. Pour vous donner une idée, ce territoire est plus grand que celui de la province de Saskatchewan. Selon le recensement de 2001, le territoire couvert par le réseau compte plus de 60 000 francophones, soit près d'une personne sur cinq. Dans le district de Cochrane, les francophones sont même majoritaires.

En général, l'accès à des services en français est déficient dans l'ensemble sur notre territoire. Malgré le fait que plusieurs de nos régions soient désignées par la Loi sur les services en français de 1986, il est pratiquement impossible d'avoir accès à l'ensemble des services essentiels en français. Évidemment, le développement des services de santé en français varie considérablement d'un endroit à l'autre. Dans les régions où les proportions de francophones sont les plus élevées, les services de santé en français sont plus nombreux et l'accès est meilleur, mais dans les communautés où les proportions de francophones sont plus petites, l'accès aux services de santé est limité et souvent inexistant. De plus, notre région vie une double problématique. En effet, la pénurie de professionnels de la santé vécue partout dans le nord de l'Ontario se trouve accentuée dans notre région par la nécessité de recruter des professionnels capables d'offrir des services en français et prêts à venir pratiquer dans les régions isolées du nord de la province.

Ce qui est important pour les francophones, c'est de recevoir des services de qualité dans leur langue et qui répondent à leurs besoins afin d'améliorer leur santé et donc celle de l'Ontario en général. II est clair que pour que les services soient de qualité, il faut que les intervenants en santé et les institutions qui les abritent possèdent ce que l'on nomme la compétence culturelle. Partout dans le monde, il est reconnu que si un système de santé ne possède pas les compétences culturelles pour répondre aux besoins des patients, il est extrêmement difficile de poser un diagnostic de qualité et ainsi intervenir efficacement. La compétence culturelle est donc un déterminant fondamental dans la qualité des soins offerts. Ceci est particulièrement important dans les domaines des soins de santé primaire, du traitement des maladies chroniques et des services entourant la santé mentale. Dans ces domaines, la communication devient essentielle pour les intervenants en santé d'être aptes à proposer des interventions qui sont efficaces et qui donnent les résultats escomptés. De la même façon, on ne peut pas demander à une personne malade de clairement s'exprimer dans une langue qui n'est pas sa langue première. Même dans le meilleur des cas, il est souvent difficile de s'exprimer dans sa propre langue.

La compétence culturelle ne s'arrête pas à la connaissance de la langue mais aussi à la compréhension de la culture des gens que l'on traite ou avec qui on transige. Comprendre la culture, c'est aussi comprendre ce qui nous entoure, ce qui entoure les comportements qui déterminent la santé des populations. C'est de nous permettre d'interpréter ce qui est sous-entendu dans les paroles du patient. Reconnaître la langue sans la culture, c'est se mettre dans une situation où il est beaucoup plus facile de mal interpréter ce que dit l'autre. On pourrait ici donner de nombreux exemples de ces situations, mais là, ce n'est pas notre propos.

Le fait de ne pas posséder les compétences culturelles nécessaires fait en sorte que les services sont de moins bonne qualité, qui ultimement se répercute sur l'état de la santé d'une population. Il est intéressant de noter, à ce sujet, que le deuxième rapport sur la santé des francophones de l'Ontario, publié en décembre 2005, dénote les différences importantes en matière de santé entre les francophones et la majorité. Par exemple, les franco-

phones ont plus tendance à percevoir leur état de santé comme étant moins bon que celui des anglophones. Par ailleurs, les taux de certaines maladies chroniques sont légèrement plus élevés chez les francophones que dans l'ensemble de la population provinciale. On peut également décerner certaines différences dans les comportements de santé des francophones. Comparativement à l'ensemble de la population, les francophones font plus usage des services d'urgence.

Pour améliorer la santé d'une population, il faut donc développer des services qui adressent directement leurs besoins. Afin d'arriver à ce résultat, le projet de loi 36 doit inclure des changements nécessaires. L'établissement des RLISS fait partie de la solution pour les francophones.

M^me^ Breton: Les cinq principes qui guident le mandat et les responsabilités des RLISS sont des principes avec lesquels nous sommes entièrement d'accord.

Le premier : un accès équitable aux soins en fonction des besoins des patients; (2) le respect des choix des patients; (3) des résultats mesurables et tangibles, conformes au libellé de la politique stratégique à la planification des activités et à la gestion de l'information; (4) des services centrés sur le patient, axés sur la collectivité et au diapason des besoins en matière de santé de la population locale; et le dernier, une responsabilité partagée entre les soignants, le gouvernement, la collectivité et les citoyens.

Or, si l'on reprend ces principes sous l'angle de la francophonie : (1) non seulement l'accès équitable est nécessaire, mais l'accès doit être en français, tant au niveau des services directs que des services de soutien des organisations. (2) Le choix des patients, y compris celui de la langue de traitement, doit être respecté. (3) La communauté francophone exige que la loi 36 supporte des résultats à la fois mesurables et tangibles. (4) Pour améliorer les services centrés sur le patient, et au diapason avec les besoins en matière de santé des populations locales, il est nécessaire que les intervenants en santé possèdent les compétences culturelles requises pour desservir la communauté. Il faut donc que des services en français soient mis en place et que les institutions de santé possèdent les compétences culturelles indispensables à l'offre de services de qualité pour les francophones, et ce tant au niveau de la langue que de la culture. Or, la Loi sur les services en français, bien que nécessaire et importante, n'a pas donné les résultats escomptés dans ce domaine. Le dernier : la communauté francophone est prête et souhaite être coresponsable de sa santé et de la gestion des services qui en améliore l'état.

De ces principes, qui sont ceux des RLISS, on peut facilement comprendre ce qui selon nous améliorerait le projet de loi 36.

1510

M^me^ Quintas : Au-delà de la question des droits constitutionnels et légaux des francophones, et ayant fait le tour de la question, il faut maintenant clarifier nos attentes envers le projet de loi 36.

Le réseau ne possède pas les compétences légales pour proposer des changements précis à la loi. Il est clair que nous souhaitions que les RLISS aient dans leurs responsabilités, d'une façon claire et sans équivoque, la nécessité de desservir la communauté francophone à travers les organismes de santé qu'ils financent. Cette responsabilité doit inclure le maintien et le développement des services en français avec des institutions possédant les compétences culturelles nécessaires pour offrir des services de qualité. II faut que la loi soit claire et précise à ce sujet.

L'allusion à la Loi sur les services en français dans le préambule est, selon nous, insuffisante. De la responsabilité ajoutée au RLISS découle une obligation d'évaluer les services et ultimement de rendre des comptes à la province et aux communautés francophones. Ce n'est qu'ainsi que nous aurons l'assurance que l'ensemble des institutions et de leurs intervenants sera redevable d'offrir des services de qualité à la communauté francophone.

L'objectif du réseau est de participer à la mise en place d'un système qui donnera un accès équitable à des services de qualité pour les francophones, et nous croyons que les RLISS, établis avec les changements nécessaires dans la loi 36, contribueront significativement à l'atteinte de cet objectif.

Nous sommes heureux que le gouvernement considère la francophonie ontarienne comme un atout, et le Réseau francophone de santé du Nord de l'Ontario est prêt à participer avec tous les intervenants en tant que partenaire afin d'atteindre une meilleure santé pour les francophones de notre région et, par le même fait, pour l'Ontario. Merci.

The Chair: Merci. This is all of the presentation. Monsieur, une minute.

Mr. Arnott: Merci beaucoup. Thank you very much for your presentation this afternoon. We have heard, over the last couple of days, from time to time presentations from organizations representing the views of Franco-Ontarians on this issue. It's my belief that the government is going to want to be listening very carefully to the views you're putting forward to ensure that your constitutional rights are observed and protected as we move forward with Bill 36.

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

M^me^ Martel: Merci d'être venues cet après-midi. Vous avez raison : il y a une petite phrase à propos de la Loi 8 dans le projet de loi, et ça ne sert à rien après.

Hier, à Ottawa, il y avait quelques présentations en français, et nous avons appris qu'il y avait un groupe de travail sur la santé pour les francophones qui avait fait un rapport, et en ce moment ce rapport est aux mains de M. le ministre. Nous n'avons pas vu le rapport et nous ne connaissons pas les recommandations en ce moment. Selon vous—je ne suis pas sûre si vous avez participé à la construction de ce rapport—est-ce que vous pensez que les recommandations qui sont peut-être dans ce rapport vont répondre aux craintes et aux espoirs de la communauté francophone à propos de la santé?

M^me^ Quintas: Nous n'avons pas vu le rapport non plus. Il est encore confidentiel. Nous espérons que oui, en

effet, les recommandations qui vont être mises vont être pour et par les francophones. C'est un groupe de travail de personnes qui oeuvrent depuis bien des années pour améliorer l'accès aux services pour les francophones. En fait, j'imagine que oui, en effet, ce sera le cas, mais je ne peux pas vraiment répondre. Je n'ai pas encore vu le document.

The Chair: Ms. Wynne, s'il vous plaît.

Ms. Wynne: Thank you. I actually just wanted to know whether you were confident in the recommendations of that report. So you haven't seen the report. Just so you know, we are waiting to hear the results and what the reaction to that report will be, and we're confident that the minister is going to take into account the recommendations that were made to him.

Le Président: Merci. Monsieur Ramal.

M. Ramal: Merci pour votre présentation. C'est la même recommandation donnée par l'autre communauté francophone. Je pense que maintenant notre ministre, George Smitherman, travaille avec la communauté francophone et cherche un mécanisme spécial pour aider la communauté francophone de l'Ontario.

The Chair: Merci. Thank you for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 3634

The Chair: We'll move to the next presentation, from the Canadian Union of Public Employees, CUPE Local 3634, Kenora, Doug Kurtz and—hello again.

Mr. Doug Kurtz: We travel together.

The Chair: Yes, and that's fine. It's good to see all of you again. Sir, you can proceed any time you're ready.

Mr. Kurtz: Good afternoon. I'm Doug Kurtz. I work as a medical laboratory technologist at the Lake of the Woods District Hospital in Kenora. I am president of the paramedical group, Local 3634 CUPE. I am also co-chair of the Kenora Health Coalition. More importantly, I am a citizen and taxpayer of the province of Ontario.

Like most of the speakers here today, I am not a public speaker, and as you may have noticed, I am quite nervous, but this LHINs legislation to me is so ominous that I am compelled to state my views and not sit back quietly to let it pass without my voice.

Bill 36, or the Local Health System Integration Act, purports to acknowledge that the community's health needs and priorities are best developed by the community health care providers and the people they serve. LHINs purport to localize the provision of health services by enabling local communities to make decisions about their local health system. LHIN 14 starts in the east at Manitouwadge, goes west to the Manitoba border, starts in the south at the Canada-USA border and goes north up to Fort Severn. In an area this large, what is the definition of "local" and what is the definition of "community"? With only nine members being appointed to the LHIN's board of directors, it cannot possibly represent all the communities in LHIN 14.

The LHIN's board is appointed by cabinet. The chair and co-chair are decided by cabinet. Each member continues on the board at the pleasure of cabinet, and as such, can be removed at any time without cause. The LHIN is defined as an agent of the crown and acts on behalf of the crown. The LHIN must enter into an accountability agreement with the ministry, and if an agreement cannot be successfully negotiated, the minister may set the terms of the agreement. The minister controls the funds provided to LHINs on the terms and conditions that the minister considers appropriate. I feel that the LHIN's board will be nothing but a puppet for the government. If they do not follow the government's direction, the strings will be cut and a new puppet will be put in their place.

Under the provincial wait time strategy, the minister is implementing a competitive bidding system for hospital services such as cataracts and hip or knee replacements. I have reason to believe that this will be expanded by the LHINs.

At the town hall meeting that the Kenora Health Coalition organized in Kenora, a speaker said that there was really no change with LHINs, as the minister and cabinets have always had the power over hospital funding and services. My response then was, why are they putting in place a costly new bureaucracy? Are they using the LHINs as a shield against the public outcry that will come when services are cut in that community?

The only way to make the LHINs somewhat local and accountable is to have directors elected or appointed by individual communities to represent them, with the length of the term to be set out in the Legislature. Front-line workers, union and non-union, must also be appointed to subcommittees. If the intention is to allow community health care workers to set needs and priorities, they must be heard.

Another issue I have with the legislation is the amount of job loss that will follow with integration and amalgamation. As a citizen and taxpayer of Ontario, I would expect the government to try to keep jobs in local communities and not attempt to centralize them in another LHIN, as in the case of the NOBOS initiative, or the SOBOS initiative in the south, which is set to go as soon as this legislation is passed. Mr. Smitherman has stated publicly that hospital housekeeping staff get paid too much to push a broom. Is he planning to privatize the service to the lowest bidder? If this is not the case, then it should be put into the legislation that union contracts will be honoured, that legally negotiated contracts will be honoured. With the closing of the paper mill in Kenora, the hospital jobs are all the more important to our community.

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In closing, I would like to share with you the most prevalent concern that was expressed to me at the town hall meeting we had about LHINs. The majority of citizens of Kenora just wanted a family physician, a doctor to go to when they were sick instead of tying up the emergency department; a doctor who would renew

their prescriptions and do their medicals. Sad to say, I had to tell them that the legislation does not include doctors and does nothing to address the issue of orphan patients. This legislation is about saving money, not patient care. Our community of Kenora has just bought the medical clinic from the physicians. They feel that if they own the building and maintain the building and just charge rent to doctors, we will actually get a doctor to come to Kenora. That's pretty sad. I can't remember; is it 3,000 orphan patients that we have? That is quite a lot for a community of 10,000. My question is, why is the government not putting money towards buying this complex and trying to entice doctors to serve our community?

Why do I feel so strongly about LHINs? My 80-year-old dad was one of those people in Kenora who had no doctor. He was going to a chiropractor for back pain and the chiropractor suggested that he go to emerg, as it was something far more serious. After a four-hour wait in emerg and X-rays, it was discovered that the prostate cancer had spread to his spine and he was terminal. We were lucky enough to get a doctor to take over his care and monitor him so we could keep him at home until his last days. It was arranged that CCAC would come and do his medicine and arrange for his plan of care. This was in October 2001.

So we had a plan set up. CCAC came in and they were doing his morphine, they were doing his medication. Probably about halfway through it, they came to us and said they no longer could come, that they had gone over their budget and there were other people who needed this care. I do believe that this is the time that they were taken over by the province and they were put out for bid. We were left to take care of my dad, and I have to tell you that I did things to my father that I never thought I would be doing. I was giving him medication that I probably should not have been giving him, and to be in the bathtub with your father naked is not a good way to remember your father. That's probably more information than you want; sorry. In the end, we were forced to bring him to the hospital for the last two weeks of his life because even though there are 10 kids in my family, we could not take care of him around the clock, which was needed.

That said, I will not let this happen to health care. This legislation, the way it stands, opens the door for privatization and centralization. There must be changes and amendments made to this legislation. Amendments have been made by numerous people. As a citizen of Ontario, I'd like these to be looked over and decided on. Thank you.

The Chair: Thank you. We have about four and a half minutes. I'll start with Mr. Ramal at one and a half, please.

Mr. Ramal: Thank you for coming again and presenting before our committee. I guess we agree with you that we have a problem with health care. That's why I want to echo what the minister said yesterday: We are moving toward a system that is more efficient and better able to deliver the kind of health care Ontarians need and deserve. That's why we founded the LHINs. That's why we're working toward finding a mechanism to communicate with the people of Ontario. That's why we want to break that big, huge silo, huge ministry, humungous ministry, 6,000 people working in Toronto, and divide it into 14 units across the province of Ontario, based locally. Instead of going to Toronto, you go to Thunder Bay, you go to Ottawa, you go to London, etc.: 14 units across Ontario, in constant communication with the local people to have their input and to work with them.

I know from past experience that when the past government was in power and tried to reconstruct health care, what happened? Major layoffs, mayor hospital closures. But the minister said clearly in his opening remarks to this committee, "No hospital closures, no two-tiered health care, medication or hospitalization in Ontario. Yes to publicly funded Ontario health care for everybody, accessible for all." That's our message to you and to all the people in this province from this committee. I strongly support, 100%, publicly funded health care, accessible for all. That's why we got elected in 2003; that's why I'm going to continue advocating on behalf of the people who elected me and on behalf of the people of Ontario.

The Chair: Ms. Wynne, please.

Ms. Wynne: I've heard nothing in this legislation that will allow further privatization or expansion of competitive bidding. Section 33, which has been referred to a number of times, is a transitional section. There is a mechanism within it so that it will be repealed. There are some processes that are under way right now to amalgamate some office services to some hospitals around the province. When those are completed, the intention is that that piece of the legislation will be withdrawn.

I think everything that this minister has done so far since he's been in office has indicated his commitment to publicly funded medicare: Bill 8, the bringing back of private MRIs into the public system and the turning back of the Life Line vans at the border and not allowing them into the province. If actions speak louder than words—and there's nothing in this legislation that would expand privatization—I think we have to understand that that's the intention of the government. There is no secret agenda here.

The Chair: Thank you. Mr. Miller.

Mr. Doug Allan: Can we answer?

The Chair: Well, they made statements. I didn't hear any questions. When he's asked the question, you always have an opportunity to answer.

Interjections.

Interjection: We yield our time.

The Chair: You've got a minute and a half at least to answer.

Mr. Allan: That's interesting information, Ms. Wynne, but what we'd like to know is what services are going to be contracted out before that section 33 is going to be repealed. That would be the key thing. Right now, we've been told that 1,000 jobs will be contracted out, and they're just waiting—just waiting—for this legislation to be passed before 1,000 jobs go out. Services

within that are then going to be privatized. That's what they've told us. We're not making it up; that's what they've told us. This is what Hospital Business Services has told us—HBS, which is funded by the provincial government through Ontario Buys—and it's all been approved by Ontario Buys. The government's seen the same perspective that we've seen that says 1,000—actually, it was a little higher number at that time, but a few hospitals have pulled out; 20% to 25% severance payments are included in their budgets and privatization of services within that. That's pretty major privatization. We know that that's not—

Ms. Wynne: But that's not new authority that this—

Mr. Allan: But section 33 is a new authority. What's more, we're seeing that a lot of the powers that exist that are going to be facilitated by this bill already exist, and we're seeing it right now, as we were saying about the wait time strategies. We're saying stop the contracting out and stop those powers from happening.

Ms. Wynne: I don't think it's my time.

The Chair: No. Mr. Miller.

Mr. Miller: Thank you for your presentation. You said in the middle of your presentation that they have NOBOS and SOBOS ready to go; I think that's what I heard. Could you tell me what that is?

Mr. Kurtz: Northern Ontario back office systems. It's based out of Sudbury, which makes me concerned that maybe LHINs 14 and 13 are going to be amalgamated since Sudbury is actually going to chair this committee for NOBOS. Our CEO just went to a meeting last week in Sudbury about NOBOS.

Ms. Wynne: Would they be collapsed into one LHIN?

Mr. Kurtz: Well, why would you have a NOBOS that took two LHINs in, two separate LHINs?

The Chair: Sir, the floor is for Mr. Miller. He's asking the questions. Can you address him?

Mr. Kurtz: Sorry. I tend to get argumentative. You may have noticed.

The Chair: That's okay. Madam Martel will be next.

Ms. Martel: Thank you for coming back up. Because the Liberals have referenced section 33, I'm going to read it into the record, and you can tell me whether or not it sounds like this section is only for certain processes that are now underway, and once those processes are done, this section is going to be repealed.

Here's what it actually says: "The Lieutenant Governor in Council 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 on the prescribed date." And at the bottom, the repeal section, here's how clear it is. "(5) This section is repealed on a day to be named by proclamation of the Lieutenant Governor."

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I'm sorry. I don't see any specific reference to processes that are going on right now that, when they're finished, this section is going to be repealed. I see this as wide open. I don't even know what non-clinical services are, because they're not even defined in the act. So please, do not take any comfort from the minister or some of his folks saying, "This is only for specific processes, and when they're over, this is going to be gone." This is what the legislation says. If the minister or ministry have some other ideas, have something concrete that this has reference to, then put it in the legislation so we can see what it is and we can know when it's going to end.

Secondly, with respect to competitive bidding, you're darn right that's going to lead to increased privatization. If it's not the intent for LHINs to procure services through competitive bidding, then put it in the legislation. It isn't here. If the government means what it says, put it in the bill.

Thirdly, with respect to what the government campaigned on, I remember Dalton McGuinty saying "no private financing of hospital construction." Now we've got at least 16 privately financed hospitals on the go, which are going to cost taxpayers a bundle.

Interjection.

Ms. Martel: Yes, Mr. Ramal, we have quotes from before and after the election to the Ottawa Citizen saying categorically "no private financing of hospitals." That's exactly what your government is doing: private financing of new hospitals, at an enormous cost to the taxpayer.

Finally, with respect to competitive bidding, why do I think it's going to happen? Because the competitive bidding process established by that government in home care has been kept in place by this government. There has been absolutely no change, and the chaos that we saw in home care is going to continue in all other sections that LHINs have responsibility for unless you folks bring in an amendment to say otherwise, and I look forward to seeing you do that.

The Chair: Thank you for your presentation. We went just a few minutes over, but we thank you for your time.

ASSOCIATION DES FRANCOPHONES DU NORD-OUEST DE L'ONTARIO

The Chair: Next are Denyse Culligan and Angèle Brunelle. Their presentation will be in French. You can start any time you're ready, ladies.

M^me^ Denyse Boulanger Culligan: La traduction du document n'est pas prête. Elle va être distribuée lundi au plus tard.

Monsieur le Président, les députés Gravelle et Mauro et chers membres du comité, mon nom est Denyse Boulanger Culligan. Je suis la présidente-directrice générale de l'Association des francophones du Nord-Ouest de l'Ontario. Depuis septembre 2004, je suis membre du Comité consultatif provincial sur les affaires francophones pour la ministre de la Culture et des Affaires francophones. Pendant la dernière année, j'ai siégé comme une des trois représentantes de la ministre

Madeleine Meilleur sur le Groupe de travail provincial sur la réforme du système de santé présidé par M. Gérald Savoie. Le rapport du groupe de travail a été déposé en octobre 2005, et nous attendons impatiemment qu'il soit rendu public. Donc, si vous avez une question à me poser, je ne suis pas vraiment la personne qui peut répondre.

Les Franco-Ontariens et Franco-Ontariennes du nord-ouest de l'Ontario sont minoritaires dans la minorité. Dans le nord-ouest, nous ne parlons pas de la détérioration des services de santé en français, puisqu'ils sont quasi inexistants. Les droits légaux et constitutionnels de la population francophone n'ont pas encore été respectés après les 20 ans d'existence de la Loi sur les services en français de 1986. Comment pouvez-vous donc expliquer cette situation?

La communauté francophone du nord-ouest de l'Ontario partage les mêmes priorités que le gouvernement ontarien en ce qui a trait à la santé. Nous tenons à ce que l'intérêt public soit respecté; les francophones reçoivent des services de santé de qualité ponctuels en français; la santé de notre population s'améliore; et que les fournisseurs de services soient redevables. L'intérêt public implique le respect du principe fondamental du respect et de la protection des minorités linguistiques. La Loi 36 devrait le spécifier.

S'ajoute à tout ceci la protection des droits constitutionnels des Franco-Ontariens reconnus par plusieurs jugements de la Cour suprême et dans le jugement Montfort de la Cour d'appel de l'Ontario. Il est souvent dit d'un pays qu'il sera jugé par la façon dont il traite ses minorités. Le jugement serait très sévère envers l'Ontario si on devait le fonder sur la façon de laquelle notre province traite la minorité franco-ontarienne du nord-ouest. Nous sommes des laissés-pour-compte et perçus comme des citoyens de deuxième classe. Pourtant, nous sommes un peuple fondateur du Canada.

Ce n'est pas seulement une question de droits. L'absence de services de santé en français n'est pas la meilleure pratique et occasionne des délais, des diagnostics plus difficiles, des lits occupés plus longtemps, des patients plus vulnérables et malades, et engorge tout le système de santé. Un service de qualité en anglais, offert à une personne d'expression française, peut facilement devenir un service médiocre, pour ne pas dire dangereux, qui affecte non seulement la qualité du service de santé mais la qualité de vie du patient. Quand il s'agit de services de santé, l'importance de l'utilisation de sa langue de la part du patient et la compréhension de la culture de la part du fournisseur sont des éléments clés à la prestation de services qui répondent au besoin imminent et permettent l'efficacité et la ponctualité du traitement.

Je vais laisser la parole à M^{me} Angèle Brunelle, qui va se présenter. Elle va vous donner quelques exemples de ceci.

M^{me} Angèle Brunelle: Bonjour. Mon nom est Angèle Brunelle. Je suis directrice générale de l'Accueil francophone de Thunder Bay.

J'aimerais partager avec vous deux situations qui illustrent clairement comment l'incapacité de communiquer dans sa langue maternelle peut avoir des conséquences désastreuses.

Le premier exemple est celui d'un homme professionnel, unilingue francophone, d'environ 35 ans. En mai 1991, cet homme a subi un malaise et s'est rendu à l'hôpital de sa communauté. Le médecin, soupçonnant un infarctus du myocarde, l'a transféré aussitôt par hélicoptère à l'hôpital régional. Le spécialiste a administré au patient une batterie de tests.

Le lendemain, constatant que l'état du patient s'était amélioré, le médecin l'a renvoyé chez lui. L'homme croyait profondément qu'il avait subi une crise cardiaque. Cette conviction a eu plusieurs effets sur sa vie. Par exemple, à cause de son état de santé, il a eu de la difficulté à obtenir une hypothèque, ainsi qu'une assurance-vie.

Quatre ans plus tard, un médecin bilingue est venu s'installer dans sa communauté. Lors de sa première consultation, l'homme a informé le médecin de sa condition. Le médecin, prenant connaissance du dossier médical, a avisé l'homme qu'il n'avait jamais fait de crise cardiaque et que le problème en question n'était en fait qu'un ulcère à l'estomac. Quatre ans de stress pour lui et sa famille parce que personne ne pouvait lui parler en français; serait-ce acceptable pour un membre de la majorité?

Le deuxième cas dont j'aimerais vous parler est beaucoup plus tragique. Il s'agit d'un homme dans la quarantaine, ayant une connaissance limitée de l'anglais, qui a été admis à l'hôpital à cause d'un caillot sanguin à la jambe. Le patient a été informé qu'il devrait subir une chirurgie pour régler son problème. Il a signé le formulaire de consentement en pensant que le chirurgien enlèverait le caillot sanguin. Lorsque l'homme s'est réveillé après l'intervention, il s'est rendu compte qu'on lui avait amputé la jambe. Cet homme n'a pas eu l'occasion de prendre une décision éclairée, ni de s'adapter graduellement à sa condition.

Imaginez-vous simplement l'horreur de vous réveiller dans un lit d'hôpital avec un membre en moins. Vous n'étiez pourtant pas inconscient lorsqu'on vous a fait signer une formule de consentement. Votre seul défaut est de ne pas parler l'anglais.

M^{me} Boulanger Culligan: Comme vous voyez, ces deux situations auraient été traitées différemment si seulement les patients avaient pu communiquer avec des professionnels de la santé dans leur langue maternelle.

L'Association des francophones du Nord-Ouest de l'Ontario, avec ses 23 groupes membres et ses partenaires, travaille constamment pour contrer l'assimilation, empêcher l'exode de notre population, promouvoir une population et des communautés en santé, et revendiquer nos droits à une pleine participation dans la société ontarienne. L'utilisation de la langue française est implicite à cette participation. Notre diversité culturelle est une valeur ajoutée à la société. Malheureusement, l'attitude de la majorité envers notre histoire et nos droits se situe souvent entre l'ignorance et l'apathie. Nos droits

ne sont pas respectés par le simple fait que plusieurs d'entre nous pouvons nous exprimer dans une langue autre que la nôtre, et on nous reproche de vouloir utiliser notre langue maternelle. Cette excuse n'est pas valable, et encore une fois ne respecte pas nos droits.

1540

La transformation du système de santé proposée par le ministre nous est acceptable seulement si elle reconnaît que les décisions touchant les services en français sont prises par les francophones. La majorité a déjà fait la preuve que les décisions qu'elle prend en ce qui touche le développement de services de santé en français sont inadéquates. Il est grand temps que les déficiences du système soient rectifiées. Les difficultés que les Franco-Ontariens vivant en région géographiquement éloignée et en situation linguistique minoritaire ne sont pas insurmontables. Par contre, une volonté politique et une reconnaissance de l'esprit de la loi par le gouvernement et les institutions ne sont pas suffisantes pour répondre aux obligations constitutionnelles et légales majeures de l'Ontario envers la minorité francophone.

Nous sommes encouragés par la reconnaissance dans le préambule de la Loi 36 proposée du respect de la diversité et du respect de la Loi sur les services en français. Cependant, nous nous demandons pourquoi cette loi ne reconnaît pas le rôle de la communauté francophone, un peuple fondateur de notre pays, dans les décisions touchant les services de santé. La Loi 36 doit utiliser un langage clair qui protège suffisamment la participation active et permanente de la communauté francophone à la gouvernance qui dirige le développement, la planification et le maintien de services de santé de qualité en français.

Également, la reddition de compte doit être l'objet d'une attention particulière. Pour nous, la priorité est le développement de soins primaires en français. Ensuite viennent les services hospitaliers où il est inacceptable de ne pas avoir de personnel et de services bilingues. La situation des francophones dans le nord-ouest demande une collaboration avec les institutions de soins de santé à tous les niveaux et oblige que des indicateurs de rendement précis soient établis pour toutes les institutions où nous devons aller chercher nos services de santé.

Il est aussi primordial pour nous que la loi stipule que l'accès aux services de santé en français auquel nous avons droit soit assujetti à un système d'évaluation qui permettra autant la planification de l'amélioration des services par les francophones que l'imputabilité des institutions.

Soyez assurés que les francophones du nord-ouest sont d'accord avec les propositions d'amendements qui vous seront présentées sous peu et que nous sommes solidaires avec les recommandations soumises au ministre Smitherman par le groupe de travail Savoie. Merci.

The Chair: Thank you. Merci. We have about three minutes and we'll start with Mr. Arnott. One minute each, please.

M. Arnott: Merci beaucoup. Votre présentation est très intéressante, et nous écoutons votre idée.

Thank you very much for your presentation. That's the best I can do in French. I want you to know I believe that this committee is listening carefully to the views that are being put forward by Franco-Ontarians with respect to Bill 36, and I would hope that there's a desire on the part of the government members to take that message back to ensure that there are amendments to ensure that Franco-Ontarians receive the health care they are entitled to in their own language. So thank you very much for being a part of this process.

M^me^ Martel: Merci pour votre présentation cet après-midi, toutes les deux.

Vous étiez représentante sur le fameux comité. Je pense que vous avez travaillé si fort. Je pense aussi qu'il vous est interdit de parler à propos des recommandations. Mais est-ce que vous pouvez nous dire, si les recommandations sont acceptées par le gouvernement, est-ce que les craintes dont vous avez parlé dans cette présentation vont être réduites à propos du projet de loi? Il est bien clair que le projet de loi 36 parle seulement à propos du projet de loi, sans détails à propos de comment on peut protéger et aussi améliorer les soins de santé de qualité pour les Franco-Ontariens. Alors, avec les recommandations, est-ce qu'on peut avoir une amélioration dans la situation pour les Franco-Ontariens?

M^me^ Boulanger Culligan: Absolument. Nous avons formulé les recommandations exactement pour aider non seulement la population franco-ontarienne mais aussi le gouvernement à remplir leurs responsabilités constitutionnelles et légales envers notre population. Donc, oui, les recommandations sont très fortes et vont améliorer et être ancrées dans la loi si le gouvernement accepte les choses qui sont nécessaires.

M^me^ Martel: Deuxième question : je ne suis pas sûre à propos du nombre de recommandations—

M^me^ Boulanger Culligan: Il y en a cinq.

M^me^ Martel: Si le gouvernement met en place seulement une ou deux de ces recommandations, est-ce qu'on pourra vraiment avoir une amélioration de la situation, à votre avis?

M^me^ Boulanger Culligan: Ça dépend desquelles.

M^me^ Martel: Desquelles? Bon.

M^me^ Boulanger Culligan: Il y en a une ou deux qui régleraient les vrais problèmes.

The Chair: Thank you.

M. Ramal: Merci pour votre présentation, et merci pour vos pensées sur la transformation du système de santé proposée par le ministre, bien pour la communauté entière de l'Ontario, sauf pour les services en français. J'ai une question pour vous. Quelle recommandation pour la communauté peut améliorer la Loi 36?

M^me^ Boulanger Culligan: Est-ce que vous parlez des recommandations formelles qui ont été faites dans le rapport?

M. Ramal: Oui.

M^me^ Boulanger Culligan: Non, c'est confidentiel. Je ne peux pas les partager avec vous, et le gouvernement n'a pas encore rendu le document public. Donc, il faut attendre que le ministre fasse l'annonce.

M. Ramal: Si beaucoup de gens viennent parler avec nous des recommandations, pour que notre comité puisse comprendre, qu'est-ce que vous pouvez recommander pour le ministre et le ministère?

M^me^ Boulanger Culligan: Nous, on fait des suggestions. Ils vont avoir des amendements, des recommandations d'amendements, précis qui vont être présentés par l'alliance des réseaux. Je pense que c'est le 8 février. Donc, nous sommes d'accord avec les recommandations qui vont être présentées à ce moment-là, et j'attends qu'eux les partagent avec vous.

M. Ramal: Merci.

The Chair: Thank you, ladies, again.

KENORA CHIEFS ADVISORY

The Chair: The next presentation is from the Kenora Chiefs Advisory, Tania Cameron. Whenever you're ready.

Mr. Ramal, would you like to take the chair for a few moments, please?

Ms Tania Cameron: Good afternoon. My name is Tania Cameron. I'm with the Kenora Chiefs Advisory. I guess I want to start by introducing the Kenora Chiefs Advisory. We represent seven First Nations within the Kenora area. They are Wabaseemoong, Grassy Narrows, Ochiichagwe'Babigo'ining, Obashkaandagaang, Naotkamegwanning, Shoal Lake 39 and Shoal Lake 40. Within the Kenora Chiefs Advisory, we deliver health and social services, both federal and provincial programs.

I'd like to mention that in the spring of 2005, the province of Ontario announced an action plan, a new approach to aboriginal affairs. In it, the McGuinty government promised respectful relations with First Nations and aboriginal service providers. As well, the document stated, "Aboriginal people will have greater involvement in matters that directly affect their communities, including, where applicable, in programs and service delivery."

I guess that sort of leads off to where the Kenora Chiefs Advisory takes issue: that we weren't consulted in the beginning. We understand that there were workshops in November, December and then in January 2005 talking about the LHIN. We asked the First Nations if they received any of these invitations. They didn't. We do our best, if we receive these invitations, to forward them to our communities, and we've heard the tail end. We learned later that in LHIN 14, aboriginal issues were 11th on the list. It didn't even make the top 10 priorities. Given that within the LHIN 14 geographical scope there are a quite a number of First Nations, that was a huge concern to us.

1550

Our leadership, through the Chiefs of Ontario, held a meeting with Minister Smitherman in May 2005 shortly after this promise was announced to Ontario. We had concerns over the non-participation of First Nations people regarding this change and the new structure of the LHIN. This meeting was held. Our chiefs had requested LHIN 15, an aboriginal-specific LHIN, and that was immediately denied. What was offered was the task force and some dollars attached to it. The Chiefs of Ontario did agree with this, so the First Nations task force on the local health integration network was struck. I have sat as the technical rep for our Treaty 3 territory. Our objective was to identify potential impacts of LHINs on First Nations health and services. Our final report was submitted in December 2005.

What I wanted to mention is that, from the beginning, there were barriers. The first barrier I mentioned was that in LHIN 14, aboriginal issues did not make the top 10. Another one was that immediately, at our first task force meetings, we requested a number of documents from the health results team, one being the document on the need to integrate health so we can better understand where the integration was coming from. We requested a memorandum of understanding. We requested bylaws of initial LHINs. We also requested the training, design and orientation package for the LHIN board and staff to see if there was any aboriginal-specific orientation that was taking place. We never received those documents, and we had made numerous requests.

In August, we had asked Minister Smitherman eight specific questions that we felt we needed to know in order to address these potential impacts. We asked that in mid-August and we got it at the end of November. Our task force was mandated to serve until November 15, so that was very frustrating.

We asked right from the beginning to review draft legislation to clearly identify potential impacts of LHINs on First Nations and aboriginal organizations. Like I said, it was asked a number of times and, finally, late on November 2, we were told that we could get a PowerPoint presentation of this draft legislation, but we had to be there for November 4 for this meeting at 8:30 to 9:30 in the morning in downtown Toronto. Even just myself, with family commitments, work commitments, to ask me to go from Kenora all the way down to Toronto the next day to listen to an hour presentation, I couldn't do it. So I requested a teleconference and the PowerPoint presentation forwarded to me. Technical difficulties did not allow me—not on our end, on their end. We couldn't get the PowerPoint presentation, and we were told that it would be a one-way dialogue, so we couldn't ask questions. It was very frustrating and I thought it was a waste of time.

Like I said, we had the first meeting of our task force in July and they wanted a report by November 15. Of course, we were late because we didn't get a lot of the documents we'd requested, and when we did, it was within the last two weeks of the task force mandate. I wanted to state those frustrations with that.

In the short time, we met every day, through e-mail and teleconferencing, as a task force to try to come up with our recommendations towards the legislation. I brought this to our chiefs, who are the board of directors for the Kenora Chiefs Advisory. I brought it to the health directors in the First Nations, and this is the best we can do, I believe.

One, we wanted to address the governance and accountability. It is a priority that the LHINs identify First Nation citizens on and off reserve. The province must respect their legal obligations and co-operate with First Nation governments. The ministry should be dialoguing with all PTO representatives to define First Nation service providers on and off First Nation communities.

To ensure effective accountability, we recommend a minimum of one aboriginal seat on the LHIN board. Further to that, for the LHIN 14 board, we're hoping for at least two aboriginal seats on this LHIN. I know it's already been selected, but this is our recommendation.

Since there is a legal obligation to consult, and in this situation it was ignored, the province must fulfill its duty to consult in a government-to-government process.

The other one we identified was recommendations towards health system planning and evaluation. For the LHIN to be accountable to First Nations on- and off-reserve, there must be co-operation with First Nation governments to identify gaps and priorities by consultation and examination of existing structures.

An evaluation process needs to be undertaken in partnership with First Nation governments to safeguard against the closing or dismantling of services. This would also help determine the viability and success of programs, based on needs and evidence.

First Nations have the right to decide our own health criteria and needs. This may result in a First Nation performance management process being established.

The other one was service delivery coordination and integration. Services and programs must be developed by First Nations both on- and off-reserve which include planning, implementation and evaluation. This could be accomplished through consulting with local health planning authorities.

The human resources and staffing component: The province must be prepared to meet the human resource challenges in First Nation communities.

Ministry of Health and LHIN staff should also have specific training in aboriginal health and social issues. This is, again, what the task force had wished to identify.

Another one was the northern issues. LHIN 14 is not sufficient to meet the needs of such a vast geographical area. It is the largest area in Ontario. We recommend at least—I believe that was—two aboriginal seats on the LHIN, one of course from the Treaty 3 area and one from the other aboriginal PTO within LHIN 14.

Role of Health Canada: We wanted to make sure we stated this, especially in light of the Blueprint on Aboriginal Health. The Kenora Chiefs Advisory advises that Health Canada maintain fiduciary responsibility and that the federal government must be accountable to First Nations in the provision of services, regardless of collaboration with the provincial government. The best possibility is to use the intergovernmental process to bring the federal government to the table to negotiate with First Nations, the province and the LHINs. This must be a coordinated approach.

Community engagement: There must be engagement of individual First Nation communities on and off reserves, given the fact that each First Nations' rights and interests are unique. Joint decision processes must be developed and implemented to ensure that communications continue on an ongoing basis to fulfill the duty to consult.

The community engagement is very important. A lot of our First Nations didn't know that LHINs were happening, in the middle of LHINs being announced. So the task force prepared a fact sheet that was circulated to each of the First Nations on how we understood the LHIN to be going, LHIN expectations and First Nation participation in any of the workshops being held.

We of course recommend that LHIN 14 make effort to communicate with each of the First Nations in its area, to share information, and to just have continual dialogue.

One area that I had been concerned with is that the LHIN is already in place; the district health councils are out. The first funding announcement that I've seen was made, I believe, in July 2005 for home care and CCACs. I did the math: Across Ontario, 3.8% of these dollars went to First Nations and aboriginal organizations in Ontario. That, to me, is an indication of future funding announcements for other provincial programs, and it worries me.

That's all I had to present.

1600

The Vice-Chair (Mr. Khalil Ramal): Thank you, Tania, for your presentation. We have about a couple of minutes left. We can divide it among the three parties. First, Ms. Wynne.

Ms. Wynne: Thank you very much. Thanks for being here. Thanks for taking part in the process. I understand your point of view in terms of there having been barriers, and I think some of the language that's been used here is—going forward, it's certainly our hope that the recommendations that came out of that task force report will inform the final legislation. I mean, we can go back and forth about how many meetings there were, and whether it was enough or not. If the sense is that it wasn't enough, then my hope is that, going forward, we'll be able to take your concerns into account.

Ms. Cameron: It wasn't the number of meetings. It was the information that we weren't able to get, and that was very frustrating—to try to identify impacts for our people when we didn't have the information in front of us.

Ms. Wynne: I think for everybody involved in this process right now, it is an evolutionary one. We're trying to put in place a framework that's going to allow communities to figure out what the gaps are and coordinate the providers in their communities. I know communities are larger and smaller, depending on what part of the province we're talking about, but that's the evolutionary process, and it really is our sincere intention that those decisions be made at the local level in order to meet the needs of people and to deal with regional disparity. That's what we'll be trying to do at every step of the way.

Mr. Miller: Thank you, Tania, for your presentation. Often, it seems with First Nations their issues get lost among the various levels of government, as demonstrated this fall with the Kashechewan water crisis, when the provincial government didn't even realize they had a signed agreement with the federal government that made them responsible for declaring an emergency and evacuating people. That's in other issues, not necessarily health issues, but from my own riding I've seen that, where you can't get any solution to a simple problem because it's always complicated between the three levels of government. So I guess my question is, what advice do you have, with that in mind, to make sure that the First Nations' health issues don't fall through the cracks in this LHIN process?

Ms. Cameron: I guess that would be the promise in the document, Ontario's New Approach to Aboriginal Affairs. They sound like really good words. Let's use them. Just dialoguing with us, taking the time to say: "Okay. What are the aboriginal priorities? What are the aboriginal issues? How can we address them? How can we work with you?" That's pretty simple, but—

Mr. Miller: You need the federal government there too, because—

Ms. Cameron: And that's where I mentioned the Blueprint on Aboriginal Health.

Ms. Martel: Thank you for making the presentation today. I have a comment and then a question. I guess we all hope that things go better moving forward, but I think it goes without saying that it was a pretty poor start to a government-to-government process, especially when it followed on the heels of the government announcement that there was going to be a new relationship with aboriginal people. The first process out of the gate wasn't a very pleasant one and certainly wasn't a good way to start. I hope this is not going to be the pattern that we see then with other ministries. So let me just say that.

Secondly, would it be the position of the chiefs in Treaty 3 or of the Kenora Chiefs Advisory that the way to handle the situation now would be that a clause with respect to non-derogation be included in the legislation and, perhaps further, a clause that makes it very clear that on-reserve First Nations are exempt from Bill 36?

Ms. Cameron: I'm not sure how that would—I know the Chiefs of Ontario are going to be delivering a clear presentation. They're talking about exemption. They're talking about the non-derogation clause.

Ms. Martel: So we should look for that in their presentation in Toronto next week.

Ms. Cameron: Oh, definitely. I don't want to presume to speak on behalf of them. So I'll leave it to Angus Toulouse.

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

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 4807

The Vice-Chair: Now we have the Canadian Union of Public Employees, Local 4807, Riverside Health Care Facilities Inc.: Corinne Webb, president. Go ahead. You have 15 minutes for your presentation; you can start at any time.

Ms. Corinne Webb: Good afternoon. My name is Corinne Webb and I'm the president of CUPE Local 4807 at Riverside Health Care Facilities. I'm a health information management professional, I belong to the Canadian Health Information Management Association and I'm responsible for coding and abstracting of all medical records for data submission to CIHI, transcription of medical reports, and privacy and release of medical information. As the president of my local, I represent 230 hospital workers in Fort Frances, Emo and Rainy River, Ontario, communities that border the province of Manitoba and the United States. We are as far west as you can get in the province of Ontario.

Riverside operates one 60-bed medical surgical community hospital in Fort Frances and two small rural hospitals in Emo and Rainy River, 15 and 24 primarily long-term care beds respectively, serving a population of approximately 20,000 and employing over 400 personnel. Some of those personnel I represent include clerical, dietary staff, housekeeping staff, pharmacy technicians, health information management professionals, materials management staff, RPNs, paramedics and maintenance and trades.

A brief overview of the services we provide at Riverside, or just what goes on there: Our patients requiring tertiary care are transferred primarily to Manitoba for cardiac, urological and vascular services, as nine times out of 10 there are no beds available in the Thunder Bay hospital. We're smack dab in the middle of Thunder Bay and Winnipeg, four hours each way. Our patients are also sent across the US border for urgent CT scans. As Sister Judy Bain pointed out, I'm concerned that the legislation will change referral patterns and the ability of these patients to receive CT scans as quickly as they do now.

Our hospitals in Emo and Rainy River are primarily long-term care, allowing these patients to stay close to home. We have visiting specialist clinics in the Fort Frances hospital offering services in cancer care, orthopaedics, paediatrics, rehab services and orthotics. We have renal dialysis on-site in Fort Frances, we have mental health counselling in all facilities and we also have chemotherapy for cancer patients.

The members of my local, as well as those of the local representing our home for the aged, and community support and members of ONA are genuinely concerned with Bill 36, the Local Health Services Integration Act, and the effect it will have on how health care services are restructured.

The North West LHIN, LHIN 14, which we belong to, covers a huge geographic area, approximately 560,000 square kilometres, from the Manitoba border north to Hudson's Bay and east to Manitouwadge. The large, socially diverse areas covered by the LHINs also suggest that there will be significant conflict over resource allocation—what services a LHIN will provide in each area of the LHIN. Unlike the government, the LHINs will not

be able to increase revenue. Smaller communities, like ours, may be the first to see their services integrated into other communities.

Bill 36 paves the way for the government to restructure public health care organizations any way it chooses. Firstly, the LHINs have funding powers to facilitate consolidation. They also have accountability agreements with health service providers. You would think these tools would be sufficient for the government to restructure public health care; however, even more authority has been given to the LHINs, the minister 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. The bill gives the minister even more powers to order integrations directly. The minister may order a not-for-profit health service provider to cease operating, amalgamate or transfer all of its operations. For-profit providers are exempt from this threat.

The bill allows cabinet to order any public hospital to cease performing any non-clinical service and to transfer it to another organization. This means that the government can centrally dictate how all non-clinical services are to be provided by hospitals, including through privatization. The bill gives cabinet the authority to contract out these services despite the wishes of the hospital. There is no definition in the act of a non-clinical service, so this definition may be a matter of considerable controversy.

1610

If I could just take a moment here to ask a question of the panel: Can anyone tell me why the cabinet needs the power to contract out support jobs like mine over the objections of my hospital?

The Vice-Chair: Do you want to direct your question to somebody specific?

Ms. Webb: No one specific.

Ms. Wynne: The cabinet is not going to do that without the recommendation of the LHIN. I guess if you want to have a conversation about the history or contracting out of ancillary services, we can do that, because that practice hasn't begun with us. Maybe you want to wait until the end of your presentation?

Ms. Webb: Okay.

The government refers to this restructuring as integration, stating that the goal is the creation of seamless care and a true health care system. This is misleading: The LHINs restructuring will not unite hospitals, homes, doctors, laboratories, home care providers and clinics. The LHINs will set a price for services and then tender for them, awarding the contract to the lowest bidder. The LHINs purchaser-provider model will increase competition between providers.

There are no provisions in the bill which guarantee preservation of the public, not-for-profit character of our health care system. The government would now be armed with the legal authority to privatize large parts of our publicly delivered health care system. The LHINs will purchase services from the hospitals, homes and community agencies, and for-profit agencies will provide them. It's the same model that destroyed community-based, non-profit home care in Ontario, diminishing the continuity and quality of care provided to patients. Home care workers lost their jobs as providers lost contracts, or they left the sector because of low wages, few benefits and no job security.

The government plan is to regionalize hospital support services. With government support, dozens of hospitals across the north are planning to consolidate supply chains and office services by turning work over to the new employer, Northern Ontario Hospital Business Services, or NOHBOS. This is a major change that may have far-ranging consequences for workers and local communities.

An exclusive focus on support services wouldn't satisfy the cost savings demanded by the government. These savings will also require clinical cuts, i.e., the centralization of hospital surgeries. This raises the prospect of even more travel to multiple sites for health care services.

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

Wouldn't it make sense for the government to create surgical clinics in the facilities and organizations in which we are already invested? Hospitals have the infrastructure needed to support these surgical clinics. There's no need to duplicate human resources, stores, payroll, purchasing, cleaning, food, lab and other support services. Hospitals also have the resources to deal with any emergencies that may arise during operations, and this would actually help advance the seamless care this reform is supposed to create.

Like so much restructuring, these moves will have a major negative impact on hospital support workers. This certainly will not create seamless care for patients. Instead, they create more employers and bring in more for-profit corporations into health 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 make it easier for the government to implement these threats. We need a fundamental change.

The change in health care delivery contemplated by these reforms opens up possibilities for enormous changes in bargaining units, collective agreements and collective bargaining. Health care and social service workers have been through many rounds of restructuring already, and we were always assured the various changes were for the best. Too much of this restructuring simply consumed enormous energy and resources, exhausting

health care and social service workers, yet we face change on an even broader scale now.

My members have been through cutbacks and layoffs over the years. Our hospital is one of the largest employers in the area. Where are my people to go if they lose their jobs? Transfer to employers in a different community is not an option for many people. These local communities can be hours away—away from the families and friends we've chosen to stay close to. What of technical-professional members like myself, a health information management professional with 20 years of service and seniority? No one else in my community is in need of my qualifications. Where will I go if the LHIN decides to move health record services to another employer in another community? I made a choice to stay in my community, close to my family, and to pursue this career because the hospital would always be there. But this reform might change all that.

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

CUPE is closely examining the impact that Bill 36 and its use in some cases of the Public Sector Labour Relations Transition Act to deal with labour relation 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 that entity is not the provision of services within the health sector. This may allow the LHINs or the government to transfer work without providing health care workers the right to a union representation vote. We would also like to make it crystal-clear that this bill cannot override employment security protections in our collective agreements.

Some of my personal concerns about Bill 36:

—loss of care close to home for the residents of small communities, resulting in hardships to families and requiring travel in often undesirable conditions;

—decrease in level of health service provided due to a competitive bidding model and lack of preservation of a public, not-for-profit health care system;

—loss of job security for health care workers, both unionized and non-unionized;

—loss of support in non-clinical services or having these services contracted out to for-profit corporations; and

—creation of another level of bureaucracy to fight through for local health care issues.

For these reasons, I believe this bill and the government's attempt to restructure health care need to be rethought. I urge the government to take a considered and consultative approach. Consult with the local communities and health care workers and the public about how health care should be reformed.

Mr. Allan: If I can just add, to follow on Ms. Wynne's comments, which I appreciate: It is true that we have dealt from time to time with a desire by hospitals to contract out services, but what is new, what the government intends to do, is these new powers around Bill 36 which create a potential for contracting out on a much broader scale and with a level of government that we have a very difficult time dealing with.

We feel that we create very often with our employers a recognition that the work is done best in-house and that they feel very comfortable with that. In many cases, such as in this hospital, there is a very long tradition of keeping that work in-house, and that's a very warm feeling that exists and has been around for years. There's no question about that. But now these very hospitals are threatened with powers they can't control, for which that work could be contracted out, and we're now facing that, as I say, throughout the province. In many support areas, this is what we're looking at.

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

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.ON

The Chair: The next presentation is from the Service Employees International Union, Local 1.on. Is Barb Rankin present? Good afternoon. We did hear a presentation from another member of your group yesterday, I think. There's a total of 15 minutes. Please start whenever you're ready. Thank you.

Mr. Jeff Rooney: Good afternoon. My name is Jeff Rooney. I'm a union representative with the Service Employees International Union, Local 1.on, and with me today is Barbara Rankin, also a union representative with SEIU. Through our Thunder Bay office, we both service a wide array of health care members, which cover through northwestern Ontario, and we'll be sharing today's presentation.

SEIU Local 1 represents 40,000 health care workers in hospitals, nursing homes, home care, retirement homes and community support services across Ontario.

1620

We've heard complaints about the rising compensation and salary costs of health care budgets from the previous government. Mr. Smitherman has also recently alluded to the same fact. Let's face it: We're dealing with a service-oriented sector, which invariably involves people. It's not abnormal to spend 80% of the budget on human resources. Our members in the hospital setting earn approximately $33,000 to $35,000 per year. Our members working as personal support workers in home care average approximately $26,000, which is exceedingly close to the poverty line. Can we refer to these salaries as being excessive? I think not, particularly not if we compare these salaries to some of the CEOs of these hospitals, who may earn in excess of $700,000 per year.

The previous government's attempts at containing health care costs resulted in the implementation of the health tax, whereby health care workers, our members, are now subsidizing their own wages up to $900 per year.

If you want to contain costs or trim fat, don't take blood from a stone. Our members or the front-line workers are not the cause for rising health care costs.

The Honourable George Smitherman, in a speech to the standing committee on Bill 36 on January 30, 2006, stated, "Reshaping, fundamentally changing, improving: That's what we set out to do with Ontario's health care system with this bill."

It wasn't difficult to conclude, after reading the bill and with the interpretive assistance of several lawyers, that Bill 36 definitely was "reshaping" and "fundamentally changing" Ontario's health care system, the negative effects of which are only as limited as the creator's imagination. What we don't understand is how these changes are going to improve the current health care system.

One of the best strategies to combat your opposition is to beat them to the punch; in other words, prepare your audience for what to expect while defending your own position at the same time. That is exactly what Mr. Smitherman did when addressing the standing committee. After forewarning the standing committee on what to expect throughout these presentations regarding Bill 36, Mr. Smitherman urges you to ask the following questions: "Where does the bill do that? Where in the bill does it say that?"

We suspect that this committee has the foresight and aptitude to deflect the rubbish which Mr. Smitherman has delivered. Weasel words won't confuse the educated. Remember, Bill 36 has been carefully and cleverly crafted, and we're not surprised that the bill doesn't specifically say, and I'm going to quote, "Local health integration networks are going to extend the competitive bidding model to the entire public health care system." We're not surprised that it doesn't specifically say, "Local health integration networks will result in patients having to travel further" distances for health care, or that it doesn't say, "Local health integration networks will mean lost jobs and lower wages," or even "Local health integration networks are not going to close hospitals."

The bill, as written, provides the ability or has the desired momentum for these outcomes to flourish. That's the problem. It's also what the bill doesn't say that scares us and those who are aware of this bill.

In determining whether the bill provides the opportunity or has the effect for these devastating changes to occur, we urge you to ask yourself the more appropriate question, "Does the bill prevent these situations from occurring?" The answer to that question simply is no.

In Smitherman's speech, on more than half a dozen occasions, he referred to decisions being made by people closer to the action. Although we are hopeful that the composition of the LHINs will be comprised of local individuals, we're concerned that these same individuals are being appointed by cabinet as opposed to being elected.

These LHINs have taken the appearance of a pawn—created, hand-picked and controlled by the player. In this case, it's the government.

Smitherman has stated that decisions would be "based on priorities set in communities" and taken at open public meetings.

Our region of the province has been labelled the North West LHIN. The boundaries of this LHIN are from the Manitoba border, which is approximately 600 kilometres west of Thunder Bay, to White River, which is approximately 400 kilometres east of Thunder Bay. This LHIN's boundaries span 1,000 kilometres if travelled in a relatively straight line. However, let's not forget the communities north of Thunder Bay and the distances involved in reaching them, i.e. Nakina, which is roughly 400 kilometres north of Thunder Bay.

Section 9 suggests that LHIN meetings are to be public. Let's be realistic. Making meetings public is one thing; making them accessible is another. Being a citizen and living in northwestern Ontario, we often struggle with the ignorance associated with the vast size of our region. Let's be clear: We will demand that, if this bill is passed, these LHIN meetings be conducted in each community that may be affected by a decision.

Expecting someone to drive upwards of 1,000 kilometres to attend a local meeting hardly seems appropriate. I'm sure you realize how many communities are situated in our region and how many days or weeks it may take to conduct these meetings. I once again refer to Mr. Smitherman's comments: "priorities set in communities" and more responsive "to the needs" of the community. How can the government be more responsive or set priorities for a community if they don't allow an opportunity for the communities to provide their input?

The LHIN legislation is nothing more than the Ontario government's attempt to control health care costs by privatizing non-clinical services and integrating other services, meaning patients will have to travel hundreds of kilometres.

Forestry is the mainstay of many of our communities. Over the past few years, we have seen mill closures and drastic layoffs, with more anticipated. The effects to our local communities have been devastating. Many would believe that little has been done by way of government intervention, and what has been done has been too little, too late. Now it appears as though we will be facing another round of job losses and demolition of our communities.

The smaller communities within our geographical region will likely be affected the most, with services being moved to larger communities. If services are removed, undoubtedly it will result in job loss. It doesn't become an issue of moving from one employer to another or from one location to another; it's a matter of removing decent-paying jobs out of communities which have already been teetering on the brink of existence. Without decent-paying jobs, existence becomes futile. Individuals will be forced to abandon their communities and relocate to metropolitan centres such as Toronto or to another province. It's already occurring daily. We simply can't afford another blow to these communities.

Once jobs are gone, the residents will follow suit. What do you think happens to the community? It

naturally moves closer to extinction. We understand that it's hard for Ontarians living outside of northern Ontario to believe that houses are typically sold for $20,000 to $40,000 in some of these smaller communities. Who wants to move to a community that has nothing to offer? It's not even as though you could live in one community and commute to another because odds are that the community beside you has nothing to offer either, not to mention the significant distances between communities. Having said this, houses often do get sold. Americans and southern Ontarians buy and use these houses as summer getaways or vacationing destinations. After all, the hunting and fishing is superb. Neither Smitherman's recent speech nor Bill 36 protect loss of jobs in communities.

Once these services are moved to larger communities, they run the risk of being privatized. Remember, LHINs will be forced to contain costs, given their predetermined amount of money to provide services and an inability to run deficits. So now, our decent-paying jobs of $33,000 to $35,000 per year would be shifted to the for-profit private sector. The government may argue that the result is simply a shift in employers. But let's not forget: The private sector will not be bound by the collective agreement our members once enjoyed. Now they may only earn $7.75 per hour, which is the most current minimum wage, which represents approximately $16,000 per year—not acceptable.

The government is moving this legislation forward without having a strategic plan in place for the delivery of health care in Ontario.

The legislation is flawed because its premises are based on cost containment of health care services and not on ensuring that Ontarians have equal access to quality public health care services.

In effect, Bill 36 is nothing more than the Ontario Liberal government's cost containment strategy. Privatization schemes that will reduce human resources costs are the route the government has chosen.

Ms. Barb Rankin: My name is Barb Rankin.

The Chair: There's one minute left for your presentation.

1630

Ms. Rankin: Okay. I've been working with members of the service employees union for over 20 years, and one of the first meetings that I attended was a meeting with the government about restructuring health care. We sat down at that meeting and said, "We realize what you're doing." At that time, they were trying to move patients out into the community. We said, "You know what? We understand what you're doing, but there are some concerns and some issues." We laid them all out; we said, "For one thing, you don't even have the people in the community to take care of these individuals that you're going to move out, and secondly, we're concerned about how those members who are working in the hospitals," at that time making relatively decent wages—what was going to happen to them, because they would end up working for the private sector. We raised all those concerns and we were told, "You know what? We're not going to privatize. Everything's going to be okay."

We know that everything's not okay. We know that those individuals working in the home care communities are making less money. They are, at times, we want to say, subsidizing health care for people who are receiving care in the community.

We're raising these issues because we see the same thing happening again. We see you putting forth this legislation and we think it's the same thing. It's a layer of bureaucracy, but what's that layer going to do? We don't see that it's going to help provide doctors or better health care or anything along those lines. Back then, we said, "There are some problems here. You have to go back and talk to people. You have to talk to the stakeholders and listen and get into the nitty-gritty." These meetings that you're having here are fine, but you're not having the nitty-gritty discussion that you need to have with the people we represent and many of the other unions as well.

I'm probably going past my one minute. I think we underestimated our time a tad. But we thank you for listening to us. There is more information in the brief. We are appealing to you to stop this legislation and go back to square one.

The Chair: Thank you for your presentation. Yes, we do have the materials. They will be part of the pile.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 3253

The Chair: The next one is a teleconference. I believe Diane Atkinson is on the line.

Ms. Diane Atkinson: Yes.

The Chair: Ms. Atkinson, would you please start your presentation? You have 15 minutes.

Ms. Atkinson: Okay; thank you. My name is Diane Atkinson. I am a Marathon citizen who has worked as a front-line social worker for the past 21 years. I provide addiction, problem gambling and mental health services in Marathon. I am the president of CUPE, Local 3253. I am an elected official who sits on the CUPE, Ontario division, social services workers' coordinating committee, representing community agencies.

I'd first like to take this opportunity to thank you for providing this public hearing and making available the possibility for me to speak in standing before your committee using teleconference. As I mentioned in my request to stand, Thunder Bay, where the public hearing is being held presently, is 320 kilometres away from my community. In driving hours, that's approximately three and a half hours of straight driving. In winter weather in our district, highway closures are simply a way of life. In any season, travel is always a worry and a concern to those who are well. Just imagine if you have a health care need or if you suffer from mental health or addiction problems.

At first glance, when I referred to the local health integration network's geographical boundaries on the

website, all 14 areas appeared approximately the same. As northerners, we know that the first step to any geographical reference is to examine the legend and the scale used. I would first like to point out that the geographical area for the North West LHIN is extremely vast, and its scale is 150 kilometres to 45 millimetres. Only one third of our geographical boundary is accessible by road. The remaining two thirds of the map can only be accessed by plane. Many First Nation communities are not accessible all year round. To call the northwestern integration network "local" is misleading and negligible, to say the least. Further, to suggest that our small communities, or even more remote, that a citizen from within the northwestern integration network can have a significant voice in being heard or give direction at the LHIN board level is also misleading.

The power of the government in this proposed bill is far removed from allowing community input and continuing to provide community-based services. A LHIN is defined as an agent of the crown, and it acts on behalf of the government. LHINs are governed by the board of directors appointed by cabinet and paid at a level determined by cabinet. The government determines who will be the chair and the vice-chair of those boards. Each member continues on the board at the pleasure of the cabinet and may be removed at any time without cause.

The government will control LHIN funding, and each LHIN will be required to sign an accountability agreement with the government. Indeed, the government may ultimately impose this, even if the LHIN does not agree to the agreement.

In addition, the LHINs' integration plans must fit the provincial strategic plan, so LHIN boards will be responsible to the provincial government rather than communities. This is in contrast to a long history of health care and social service organizations in Ontario that, as a rule, are not appointed by the provincial government. Our hospital boards, for example, are not appointed by the provincial government. They are elected by the citizens of their communities, those very people who live, work and use the services, the people who are there to advocate for community health care needs and who understand their community needs, and in our case, the reality of our geographical area.

Recently, however, the government has found a way to blunt criticism of underfunding and privatization. The key was to replace community boards with government-controlled boards. This, unfortunately, is the model of the LHINs. The result of this experiment in community care access centres, otherwise referred to as CCACs, suggests that it is a very poor model for LHINs to follow.

CCACs were taken over by the provincial government in 2001. CCACs immediately ceased pointing out to the public their need for adequate funding. The result: The funding was flatlined for years, and home care services were cut back dramatically. With these cutbacks, my clients—those receiving mental health and addiction services who are also in need of home care services from CCACs—saw their eligibility for services cut: baths cut from twice per week to only once, or even eliminated. The time allotted for workers to spend with clients was significantly reduced, their homemaking services decreased or totally severed, and their isolation from their communities was further entrenched, leading them to more complications with their mental health. Now, clients complain of continued changes of workers, since workers are paid at lower rates of pay and the retention of quality workers is a problem.

Government-controlled regional agencies are a poor model for health care and social service reform, yet this is what we're facing. The LHINs structure puts up significant barriers to local community control for health care. Conflict between communities within our LHINs are likely, with small and very remote communities pitted against one another, and their already scarce services threatened or eliminated.

These serious problems suggest that another direction must be investigated. We need to provide for a democratic election of LHIN directors by all residents in the LHIN geographical area, with selection of the chair and the vice-chair by the elected directors. Local members of provincial Parliament should be ex officio directors of the LHINs. There should be a requirement in the bill for extensive public consultation on existing geographical boundaries of the LHINs. We need a ministerial obligation to meaningfully and fully consult the communities prior to imposing an accountability agreement on a LHIN. We need a requirement that each LHIN must establish a health sector employee advisory committee made up of union representatives and representatives of non-unionized employees.

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

The bill gives the minister even more powers to order integrations directly. Specifically, the minister may order not-for-profit health service providers to cease operating, to amalgamate, or to transfer all their operations. For-profit providers are exempt from this threat. The government refers to this restructuring as integration, stating that the goal is the creation of seamless care in a true health care system.

A key goal of this reform is to constrain costs by integrating services, but this also raises questions about cutting services in local communities. Community mental health services and addiction services are already integrated in our district, to a level where often accessibility is affected.

1640

In recent years, mental health and addiction services in our district have seen underfunding, budgets frozen, and

services amalgamated. Our district services already cover a vast area of 80,000 square kilometres, with community offices having been shut down and clients made to access services in neighbouring communities. Agencies have reduced worker travel and put in place restrictions on workers to provide the services to those in need due to high travel costs to small and remote communities such as ours, which service such a large geographic area. This may as well be the elimination of services, since many communities do not have the luxury of public transportation. Add to this the population that we serve. These are citizens facing mental health and addiction problems where often poverty and/or the very essence of their illnesses create isolation. To add travel to a nearby community to access services would only make their task insurmountable.

As a front-line worker, I service a population at their most vulnerable state, with few supports and options, often too unwell to have a political voice and be heard while decisions such as these are being made. These amalgamations have meant that clients have gone without services or have seen their services reduced to the point where one would question their effectiveness. Jobs and services have been cut, with workers being laid off, their positions eliminated or just left vacant. Integration will remove jobs and services from local communities, hampering access. Community services are under attack. Reduction in community control and provincial government accountability will make it easier for the government to implement these threats.

We need fundamental change. Provide in the bill that 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. You must 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 has been served if integration creates a new class of 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.

There are no provisions in Bill 36 which ensure, require or even encourage LHINs, the minister or cabinet to 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. Competitive bidding is already doing damage in social services. With the introduction by Human Resources and Skills Development Canada, the new bidding process has, in the first round of proposals, disrupted over a third of the long-standing arrangements with community organizations. Laid-off social service workers are being forced to apply for their same jobs at a lower rate of pay and benefits.

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. Specialization will increase inconvenience and travel for patients. In our district that creates far-reaching challenges for community citizens, with little or no access to public transportation, extremely long distances to travel, unsafe road conditions and continuous road closures.

The institution of the purchaser/provider split and the expansion of privatization in health care and social services should not be part of health care reform. Again, we need to rethink this reform. Health care and social service workers have been through many rounds of restructuring already, and we were always assured the various changes were for the best. But too much of this restructuring simply consumed enormous energy and resources, exhausting health care and social service workers. Yet we face change on an even broader scale now.

As the workers faced with this change, we deserve at a minimum a fair process that will provide reasonable employment security and protect working conditions, collective agreements and bargaining unit rights. The Canadian Union of Public Employees is closely examining the impact that Bill 36 and its use of the Public Sector Labour Relations Transition Act to deal with the labour relations issues raised. These concerns have most certainly been presented to the hearing by other committee members, and it has been made clear that employment security protection in our collective agreements cannot be overridden by this bill.

For all these concerns, this bill and the government's attempt to restructure health care needs to be rethought. We urge the government to take a considered and consultative approach. 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 democratic process.

I'd like to thank the committee for listening to the concerns of those I represent and to the suggestions I've put forward.

The Chair: Thank you, Ms. Atkinson. You took exactly 15 minutes, so there is no time for questioning.

Mr. Gravelle: If I may, Mr. Chair, I'd like to say hello to Diane. It's Michael Gravelle, Diane.

Ms. Atkinson: Hello, Michael.

Mr. Gravelle: Thank you very much for your presentation. I appreciate it. How are things going with the North of Superior programs?

Ms. Atkinson: Not too bad.

Mr. Gravelle: I'll come and see you soon.

Ms. Atkinson: Okay.

Mr. Gravelle: Thank you.

The Chair: Anybody else?

Thank you very much for your presentation.

THUNDER BAY AND DISTRICT LABOUR COUNCIL

The Chair: The next presentation is from the Thunder Bay and District Labour Council, Evelina Pan, president.

Good afternoon, Ms. Pan. You can start whenever you're ready.

Ms. Evelina Pan: Thank you so much. Thank you for the opportunity to present our concerns to the hearings on LHINs this afternoon.

The Thunder Bay and District Labour Council, for those of you who don't know—Michael and Bill do—represents some 9,000 union members in and around Thunder Bay, who work in every aspect of the economy, from manufacturing to mining, from service and retail to media, and of course in the public service.

We were very concerned when we first learned about the LHINs process last year, and the more we find out about LHINs, the more alarmed we have become. We're sure you've heard many of these concerns articulated all day today here in Thunder Bay and in the other communities that the committee has been to. We won't go through all the issues that cause us concern, but we'll highlight just a few.

Regional inequalities: As you've heard all day, only 14 LHINs will control most aspects of health care in Ontario. Do you have any idea how big the northwest LHIN is? Even the Ontario government's own website takes a page and a half—it looks like this—to list the communities, and it says, "This list is intended as an overview and may not be complete." Here's a map that gives a more graphic representation of just how big our LHIN is. Ours is the part that I've pinked in. The rest of the province, I've done the outline in pink. It takes up pretty well half of the territory, the land mass, of our province. As other presenters that I've heard since I got here after work have said, it's 1,000 kilometres this way, there are many communities north. Well, this is what it looks like. If you've spent any time here in northwestern Ontario, you'll know that during the winter, roads can be treacherous to drive on, and if you drive the speed limit, the six-hour drive from Thunder Bay to Kenora can take up to eight or nine, or more, hours, especially if the Trans-Canada Highway is closed for whatever reason—and that happens. It's not a big surprise when that happens.

There is some fear that with the development of centres of specialization, people in already underserviced communities will be forced to travel many hundreds of kilometres to get the services that they were once able to access locally. For many seniors and others who live on small fixed incomes, the cost to travel from their home to another community might result in them not getting the care they need. The northern travel grant would have to be increased to include not only the patient, but someone to travel with them.

I just want to tell you a little story. I've written here a little story that's very sad, but true, that happened to somebody in northwestern Ontario not that long ago. A woman who was sick had to go to Toronto for treatment, so she and her husband flew down. He was also covered, because he had to accompany her. Unfortunately, she died. The government was so callous and uncaring that they said he didn't qualify for the travel grant on the return trip because he wasn't accompanying anybody.

Further, smaller communities may lose their hospitals because they won't be able to compete with larger hospitals, which can make purchases cheaper due to economies of scale.

1650

The next concern that we'd like to highlight is the responsibility of the LHINs. According to the government's website, the LHINs will be responsible for public and private hospitals, including the divested provincial psychiatric hospitals, community care access centres, community support service organizations, mental health and addiction agencies, community health centres and long-term-care facilities. At the same time, not all health care programs or all services will be covered. The not-covered ones include doctors, ambulance services, labs, provincial drug plans, independent health facilities and public health. It absolutely defies the imagination to understand how LHINs can purport to create an integrated health system without the inclusion of these major parts of primary health care.

If we also look at the Ontario government website, the list of programs and services takes four full pages to list. Again, there's a disclaimer at the bottom that the list may not be complete. So we're looking at addictions, children's treatment centres, community care access centres, community health centres, community support services—the list goes on and on for four pages, which I'm not going to read.

The competitive bidding model: We wonder if public health care providers will have to compete against each other for contracts, as is currently the case with the CCACs, and further, if for-profit health companies, including those from the United States, will have an increased presence in our Canadian system of medicare. We demand assurances that health care services won't be provided by the lowest bidder who wins a contract. We've seen the destruction of community-based not-for-profit home care in Ontario, along with increased private for-profit delivery, and the diminished level and quality of care provided to patients through this process. We are absolutely fed up with the health care model that orients itself on short-term financial goals at the expense of people and patients.

Workers' futures: In the home care sector, the competitive bidding model, which is proposed for the LHINs, has resulted in less care and a lack of continuity of care for patients as providers change when they lose contracts. What will be the impact on workers' wages and benefits, health and safety, and job security? Will health care workers have to reapply for their own jobs at a lower rates of pay and inferior benefits if the employer they work for loses a contract to an even lower bidder? How will workers' morale issues be addressed? What about workers' union membership and protection? Health care should never—never—be dictated by a race to the bottom.

Public accountability: This is something that I've heard a number of presenters talk about just in the hour or so that I've been here. As it currently stands, the LHINs legislation doesn't seem to allow for community

input or control, unlike school boards and municipalities, where the members of these bodies are democratically elected from the communities they represent. The LHIN board members are political appointments, with the chairs and vice-chairs being appointed by cabinet, resulting in their primary loyalty being to the government and not the local community.

Without some major changes to this legislation, we see the LHIN process destroying local control of health services, while creating a new massive and expensive bureaucracy that has no ties to local communities. The only beneficiaries are political careerists and predatory private health care corporations with absolutely no loyalty to patients, employees or communities.

Patient care: The McGuinty government prides itself on supporting our public health care system, but from what we can see, the LHIN system will actually undermine medicare by opening the door to increased private health care delivery through competitive bidding. How does it help patients when their health provider changes because they lost the job to a lower bid? For those of you who have family or friends who have faced this situation, you'll know that it takes time to develop a relationship between a patient and a caregiver, and part of the healing process is that good relationship.

A health service provider that is party to a decision by a LHIN may request reconsideration if they disagree with the decision. The LHIN has the power to make the final decision. Patients, community members and anyone who is not a party to the decision may not appeal. That is another patently unfair aspect of this legislation.

In conclusion, we ask the government to re-evaluate and review the plans for the LHINs and, instead, create an integrated health care system that emphasizes stability over chaos, fair treatment for all health care workers, democratic and accountable decision-making, and publicly funded, administered and delivered health care services.

Market-based health care is a proven failure in every jurisdiction it's been implemented in, especially as we can see in the United States, but also in Great Britain and New Zealand.

There's no public demand to undermine and dismantle the Canadian and Ontario community-based public health. What is required from the Ontario government is a sincere commitment to build on healthy foundations and to ensure proper funding for the health care system we cherish and demand. The McGuinty government has no mandate to complete the undermining of public health care that was initiated by the Harris government. Thank you.

The Chair: Thank you. We've got a couple of minutes, one minute each. Mr. Miller.

Mr. Miller: Thank you very much for your presentation, Emily.

Ms. Pan: It's Evelina. There's a typo.

Mr. Miller: Oh, I'm sorry.

Ms. Pan: But I'll actually answer to Emily. It's okay.

Mr. Miller: Thank you for correcting that.

And thank you for the sad story about the northern health travel grant. I'm afraid nothing surprises me about that, as I've had many experiences with trying to assist people who have been turned down. It seems to be one of the most bureaucratic programs there is in the Ontario government. Thank you for that story.

My riding is Parry Sound–Muskoka, so we're served by two LHINs, one being the North East LHIN, which I thought was pretty big because Parry Sound and James Bay are in the same LHIN. We have some fairly unique integration in our health system in the Parry Sound area right now. I'm concerned we're going to lose it with this process we're in right now, because with our hospital, the West Parry Sound hospital, we actually have the hospital, long-term care, the CCAC and nursing stations all under the same roof. Under the LHIN model, actually you move to less integration, I guess you'd say, because the six nursing stations that are under that umbrella, for some strange reason, are not under the LHIN.

I've certainly learned many of your objections. Do you have any suggestions for improving integration or suggestions for improving health care in the province?

Ms. Pan: I think the simplest answer would be to make things truly local, because when you take the decision-making outside of the community—and I know that Dr. Whitfield and the others on the LHIN are local people, but I don't recall anybody asking me if I would support that group. I don't recall any process by which the group was selected. In order for health care, education or municipalities to run in a sane and sensible way, there has to be accountability, and that gets to your question about any suggestions. There needs to be accountability. There needs to be—and you heard this this afternoon; even I heard it this afternoon and I've only been here for an hour—the participation of everybody who's involved in health care. And in order for that to happen, there needs to be a little bit more democracy in the process.

The Chair: Thank you. Monsieur Gravelle.

Mr. Gravelle: Evelina, it's good to see you, as always. You have very strong comments and I appreciate them.

In terms of the northern health travel grant story, it's a very true story. I was very involved in it and eventually we got the government to pay for the—

Ms. Pan: But it didn't just happen in—

Mr. Gravelle: It's a terrible story. That was a reflection of the lack of flexibility of the program, and I'll make my pitch now that I think we need to review the northern health travel grant and to build in some more flexibility.

Ms. Pan: Absolutely.

Mr. Gravelle: I know all my colleagues, but particularly Bill, support me on that.

My quick question, though—and Kathleen Wynne would like to ask a question too. You make reference to smaller hospitals closing. I think what we're going to be able to do as a result of the LHINs is actually enhance the services at the smaller hospitals in order to provide

better. You're going to have representatives who are going to be able to make the real case for why the McCausland Hospital, Wilson Memorial, which was recommended to be a district hospital—I see that scenario as being certainly as much of a likelihood as the one you're painting. Can you accept that possibility that I might be right?

Ms. Pan: I'd be very happy to accept that you would be right. But I could only accept that—

Ms. Wynne: He's usually right.

1700

Ms. Pan: He's often right. He's very often right. But I would accept that only if there could be assurances written into the legislation—cast in stone—that there would be sufficient money to make all these things happen. My worst nightmare is that money will be doled out January 1. Each LHIN will get X number of dollars to spend on the health care services that communities need, and come November 3, there ain't no more dough. People are still sick, people still need cancer treatment and people's elderly families still need care. What are we going to do? I don't see anything in the legislation that says there will be sufficient funds. One of the points that I tried to make in the presentation—but I guess I didn't do it very well—is to say that money should never be the guiding force by which health care, education or any other public services is delivered. If we deem the service to be important—and I don't think that there's a Canadian alive—maybe Stephen Harper aside, and Ralph Klein, certainly, but there aren't very many Canadians who would actually open their mouth in a public forum and say that the Canadian system of public health care is not one to be lauded, to be emulated, to be proud of and to be enhanced.

Ms. Wynne: Thank you very much for your presentation. What we're trying to do is to take powers and control that now reside in Queen's Park in Toronto and get them into the community. You noted that John Whitfield is from Thunder Bay. The other people who are on the LHIN so far—Janice Beazley from Fort Frances, Ennis Fiddler from Sandy Lake, Marlene Wong from Kenora, Kevin Bahm from Terrace Bay, Bob Ritchat from Atikokan—all of those people are much more connected to the community than ministry bureaucrats at Queen's Park. So I guess my question is, does it not make sense to you that those people are going to be more able to determine how the coordination of services should go in this area than people at Queen's Park?

Ms. Pan: Well, I don't know any of the other individuals. I do have an experience with Dr. Whitfield and I know that he spent a good number of years at Lakehead University. I don't think that he taught in health care; I could be mistaken. At the time that I had an experience with him, he was dean of—I don't even know what it was. I was in the library technician program at the university. That was before he became the academic—

Ms. Wynne: But would they not have more information? Even if you don't know them, would they not have more information than my friend who lives in Mississauga who works in the ministry? Would they not know more about the community?

Ms. Pan: I'm not convinced of that, because you need to know the community, and that's why we're asking for the members to be democratically elected or at least selected from a pool, because for all the wonderful things that Dr. Whitfield and the rest of them have done, this is not their area of expertise. I don't think it's fair to put on his shoulders and the rest of the committee the responsibility of knowing all the health care issues in anybody's given community.

Ms. Wynne: I know I'm running out of time and the Chair's going to cut me off, but what we're also trying to do is learn from other jurisdictions. In Quebec, in Saskatchewan and in Alberta, where there were elected boards, there were not people stepping forward to take the positions. There wasn't a competency base and there weren't people willing to take it on. We're trying to learn from that and get the competency that we need on the LHINs.

Ms. Pan: Why can't we learn from the school board and municipalities model? That seems to work.

Ms. Wynne: That's another conversation I'd be happy to have.

The Chair: Thanks very much.

HELENE KELLY

The Chair: The next presentation is from Helene Kelly. It's a teleconference. Ms. Kelly, are you on the line?

Ms. Helene Kelly: Yes, I am.

The Chair: Would you please start your presentation, and thank you.

Ms. Kelly: My name is Helene Kelly. I am a registered psychiatric nurse working as a community mental health worker in Marathon.

I feel that if passed, Bill 36 will give government and the LHINs new and troubling power to restructure public health care and social services. The LHINs are local in name only and the bill would grant little power to the local communities and providers to make decisions. Rather, it transfers control to local community-based providers, the ministry and cabinet and their agents—LHINs—thereby centralizing rather than localizing control over health care 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. It distinguishes the reform from regionalization in other provinces, as LHINs will not directly deliver services.

The LHINs cover vast and very diverse areas. The proposed LHINs are not local. They are not based on communities and they do not represent communities of interest. My community falls into the boundaries of the

northwest Ontario LHIN, number 14, which covers a vast demographic area and will create unique situations in regard to travel and increase stress on patients and families in their time of need. So it will be very difficult for people living within a LHIN to have a significant voice over the direction of that LHIN, even if the LHIN board wishes to listen.

The autonomy of the LHINs from the government is very modest. With this bill, cabinet may create, amalgamate and dissolve LHINs. LHINs are governed by a board of directors appointed by cabinet and paid at a level determined by cabinet. The government determines who will be the chair and vice-chair of these boards. Each member continues on the board at the pleasure of the cabinet and may be removed at any time without cause. The government will control LHIN funding and the LHIN will be required to sign an accountability agreement with the government. Indeed, the government may unilaterally impose this even if the LHIN does not agree to the agreement. In addition, the LHINs integration phase must fit the provincial strategic plan. So LHIN boards will be responsible to the provincial government rather than to local communities.

This is in contrast to the long history of health care and social services organizations in Ontario, which as a rule are not appointed by the provincial government. The previous government attempted to cut hundreds of millions of dollars from local hospitals, but when local hospitals helped to point out to their communities the problems this created, the government reconsidered. The cuts were reversed and the hospitals were allowed to continue to provide decent care. Recently, however, the government has found a way to blunt criticism of underfunding. The results of this experiment in community care access centres suggests a very poor model for the LHINs to follow. The CCACs were taken over by the provincial government in 2001 and the CCACs immediately ceased pointing out to the public their need for adequate funding.

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 2001 to April 2003 and a cut of six million hours in service, a 30% drop. Many of my clients' services were reduced or declined by this reduction, and many were refused on the basis that they had family living in the community and therefore their family could provide the care. Unfortunately, mental health and addictions clients do not have strong bonds with their families or are being put in the position of being abused both physically and emotionally by having a family member provide personal care to them.

Government-controlled regional agencies are poor models for health care and social services reform, yet this is what we are facing. LHINs will insulate government from decisions to cut back or privatize services by creating another level of bureaucracy that will catch much of the flak. The government will control LHINs, but the LHINs will actually implement decisions. They will be the first targets for popular discontent, even if their actual autonomy from government is more imaginary than real.

1710

The large, socially diverse areas covered by LHINs also suggest that there will be significant conflict over resource allocation. What services will be provided in each of the LHINs? Unlike government, LHINs will not be able to increase revenue. Smaller communities may be the first to see services integrated into other communities. The LHIN structure puts up significant barriers to local community control of health care. Conflicts between communities within a single LHIN are likely, with small communities particularly threatened. Likely, the provincial government will respond to complaints by stating, "It was not our decision. It was a decision of the LHIN," yet the LHIN will largely be unaccountable to the local communities. These serious problems suggest another direction to be investigated.

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

We also need a requirement for real public consultation when government proposes to amalgamate, dissolve or divide a LHIN. We need a ministerial obligation to meaningfully and fully consult with the community prior to imposing an accountability agreement of a LHIN. We need a requirement that each LHIN must establish a health sector employee advisory committee made up of union representatives and representatives of non-union employees. We need to eliminate cabinet's authority to enact regulations closing LHIN meetings to the public. We need to ensure the right to seek reconsideration and for full judicial review by any affected person, including trade unions, of any LHIN, ministerial or cabinet decisions or regulations.

Bill 36 gives LHINs and the government a wide range of tools to restructure public health care organizations. First of all, the LHINs have their funding power to facilitate consolidation. They also have the accountability agreement 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.

The bill gives the minister even more power to order integration directly. Specifically, the minister may order not-for-profit health service providers to cease operating, amalgamate or transfer all of the operations. For-profit providers are exempt from this threat. The bill allows the cabinet to order the public hospitals to cease performing any non-clinical services and to transfer them to another organization. This means that the government can centrally dictate how all non-clinical services are to be pro-

vided by the hospitals, including through privatization. The bill gives cabinet the authority to contract out these services, despite the wishes of the hospital. There is no definition in the act of "non-clinical service," and so this definition may be the matter of considerable controversy.

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

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

We need fundamental change:

(1) Provide in the bill that cabinet, the minister and 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.

(2) Provide in the bill that LHINs, the minister and the cabinet cannot order or direct integration nor approve/disapprove integration. The power the LHINs have to withhold funding is power enough to encourage consolidation. The LHIN, the 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.

The Chair: Thank you for your presentation. You're already over the 15 minutes, but if you have any closing remarks, we'd be happy to hear them.

Ms. Kelly: I just want to thank you for the opportunity to speak. I feel strongly against this. I feel that we're just leading to a two-tier health care system, and I find that frightening.

The Chair: Thanks again for your presentation.

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.ON

The Chair: The next presentation is from the Service Employees International Union: Deborah Menzies and Maria Turco. Please have a seat. You can start whenever you're ready. There's 15 minutes.

Ms. Maria Turco: Good afternoon. My name is Maria Turco. I am a member of Service Employees International Union, Local 1.on. I have been working in clerical support at St. Joseph's Hospital here in Thunder Bay for the past 34 years. In this time, I have seen many changes. In my opinion, some were good and some were not so good.

I am here today to speak to you not only as a health care worker but also as a concerned citizen. There has been much talk about the government not wanting to privatize health care. If this is the case, then why are there private hospitals and P3 hospitals running in Ontario right now?

Almost $200 million will be spent to set up a new LHIN bureaucracy. This will not add a single family doctor, specialist or direct, hands-on care provider to Ontario's health care system. As we know, doctors are not even included under the LHIN legislation. It is almost impossible to find a family doctor. How are LHINs going to address this shortage?

How can spending this much money make health care better and easier to access for any ordinary citizen? Section 33 will allow the government to cease performing any prescribed non-clinical service and to integrate the service by transferring it to a prescribed person or entity. This section of Bill 36 gives the government the right to privatize more health services, particularly non-clinical services; for example, dietary, laundry services, housekeeping services and clerical services can all be contracted out, as these are considered non-clinical services. The broad definition of services and the right of the LHIN to move any non-clinical service means only one thing: the devolution of these services to for-profit providers. Therefore, this bill will be used to contract out non-clinical services, which will result in thousands of health care workers losing their jobs. Once jobs are lost, workers will not be able to file grievances through their collective agreements.

The Public Sector Labour Relations Transition Act will not apply where the Ontario Labour Relations Board issues an order declaring that it does not apply. In other words, the government wants to remove the protection of current collective agreements from health care workers. Displaced non-clinical service workers will have no right to transfer their union contracts to the for-profit private provider of non-clinical services.

1720

We have said that the Ontario government wants to use Bill 36 to control health care costs through the privatization of health care workers' jobs. These workers, I want to remind this committee, are the least costly component of the health care system, yet we provide essential services that result in the smooth operation of a hospital. Even something as simple as not providing the proper diet to a patient could result in death or severe medical complications. Health care workers must be assured that our jobs, our wages and benefits, and our pensions are protected.

LHINs have already resulted in 42 district health councils being closed down and packages being offered to those displaced workers. Many of these workers will probably be hired in the new LHIN offices, of which there will be only 14. Are you telling me that all the displaced workers in 42 district health councils will be

given jobs in the LHIN offices? How will this save money? The only way I can see this happening is by cutting down services to the public. We are already waiting up to two years to see specialists and obtain much-needed services. How are LHINs going to effectively take care of this problem?

I do not think that anyone is averse to change when change will improve services; however, I do not see anything in the LHINs that will improve services. We still do not have enough doctors, wait times for tests and procedures are anywhere from six months to two years, and we now have to pay for eye doctor appointments, visits to the chiropractor and physio visits that are over and above the ministry's cap. How can we say that LHINs will be helping us when the services we had in the past are being cut? Will theses new LHINs make health care more accessible and faster? How? These are some of the problems in our health care system. Where in Bill 36 do we see a plan for improving these issues?

Travel for people in the north is also a problem. How to get to an appointment, or a place to stay if undergoing tests, is a problem. We offer a service, but the costs of getting there and day-to-day living expenses are not the LHIN's problem. Some people have to travel anywhere from two to six and one half hours to obtain health care. What are LHINs offering people: publicly funded health care services or services that will cost thousands of dollars they do not have?

Mr. Smitherman said in his speech, "Not a single hospital is going to close on my watch. Period." If this is the case, why is this in Bill 36:

"Integration by the Minister

"28 (1) After receiving advice from the local health integration networks involved, the minister may, if the minister considers it in the public interest to do so and subject to subsection (2), order a health service provider that receives funding from a local health integration network under subsection 19(1) and that carries on its operations on a not-for-profit basis to do any of the following on or before the date set out in the order,"

And the very first one is,

"To cease operating, to dissolve or to wind up its operations."

If Mr. Smitherman is not thinking about closing any hospitals, why have this paragraph in the bill to begin with?

In closing, I do not feel that people react badly to change; people just react to bad change.

Ms. Deborah Menzies: My name is Deborah Menzies. I am a member of Service Employees International Union Local 1.on. I work at Thunder Bay Regional Health Sciences Centre as an SPD operator. An SPD operator processes of instrumentation for surgeries that are performed at the hospital and provides sterile supply procedure trays to the rest of the hospital. I've worked at the hospital for 35 years in this capacity.

In preparing for this presentation, I looked at and pondered a number of issues and all sorts of different things that I could address, but I felt that others, certainly more eloquent than I, would talk at length about the effect of this legislation on the delivery of health care, the status of current collective agreements and the social and economic effects on communities in Ontario. I felt that maybe it might helpful and more appropriate that I talk to you about the experiences of myself and my co-workers in the health care system over the last many years.

Before I actually give you a flavour of what it is, and has been, like working in the health care system in the last many years, I want to comment on the whole process of how one deals with proposed legislation and discussions around that. I've noted that the government, in particular Mr. Smitherman in his presentations to this committee recently, talked about people who had different opinions than he and the government had with regard to LHIN legislation, that they were making an "attack" on the legislation. In my experiences in my work at the hospital, in my work as a steward and my benefits work, when we have a disagreement—whether it be a particular clause in a contract, the interpretation of that clause, or in regard to benefit issues where we're dealing with whether a person is deemed to be totally disabled or not—we have a discussion and a dialogue with regard to those issues and keep an open mind with respect to the folks whom we may not agree with, and at the end of the day we come to some type of resolution.

I'm offended that Mr. Smitherman would characterize someone not agreeing with his position or the government's with regard to LHINs as an attack on this whole piece of legislation. People have a right to make their position known, and the government has an obligation to hear that position and take into consideration the positions that are put forth, so that at the end of the day, the legislation crafted is the best legislation possible, legislation that will enhance the quality of health care of the citizens of Ontario.

Now I'd like to address some of the experiences that I and my fellow workers have had over the years in health care. One thing seems to be never-ending and repeated over and over again when they talk about health care: We in the support services areas—that is, housekeeping, dietary, SPD, laundry, RPNs etc.—feel like we're always being blamed for all the problems in the health care system because our wages are too high, and that everything can be solved by contracting out our services and reducing our wages. We don't feel we are the problem in the system. We feel that we provide a valued service to the system, whether it be the housekeeping aide who has helped develop a cleaning protocol for C. diff cases that has helped keep an infection rate down in our hospital, or the dedicated dietary help that prepares the meals for the patients in the hospital with care and with love and serves those very meals with care and with love.

The loyalty and dedication of those workers to the institution and to the health care system is immeasurable. Reducing our wages and putting the money in the pockets of contractors is not going to resolve the problems in the health care system. Governments have had difficulty addressing the problems in the health care system, problems that have existed for years, whether it be the escalating cost of medication, the cost of medical

equipment and medical devices, the physician shortage or the lack of accountability of the physicians in the system. Those very difficult issues are not seriously addressed by whatever the government of the day is. In fact, if they do make some type of effort with some of the problems, once there's any type of opposition or roadblock, particularly with regard to any issue related to physicians, every government in the past many years has backed down and left the docs for another government to deal with.

Something else that we in health care feel we've faced over the years is the issue of change, change in the system. Mr. Smitherman indicates his concern that people are resistant to change. We're not resistant to change. I can reassure him that we've seen change occurring in this health care system for as long as I've been in the system, working for my 35 years, particularly over the last 10 or 15 years. Yes, change is difficult, but people are open to the changes. What we get concerned about is that you don't change for change's sake. We've seen constant restructuring, where titles and names change over the years, over and over again. The question is: Is it any better at the end of the day after these changes? In most cases, no, because they're not addressing the real problems that are in the system.

Here's an example of changes at my hospital, Thunder Bay Regional Health Sciences Centre. In 1995, the two sites were merged, the McKellar site and the PA site. At that time, there was a whole restructuring of upper and middle management, and people were provided severance packages. At the end of the day, as time passed, what we saw was people being hired for these positions with a changed title, and the same people would end up coming back to the workplace with a different title. We then had to deal with the move to the new hospital, where there was the melding of the two different cultures into one workplace. The transition has taken place over time. Further, each department has since had to work at settling into a new work environment, with reconciling the differences between processes that came from each of the former sites. Add to that the constant updating of legislative requirements and various ministry directives and regulations. It has resulted in a constant state of change in an already stressful environment.

So we have been through and are constantly experiencing change, and there's not a resistance to it. Workers believe that there should be a positive outcome, something that would enhance the health care system. We look at the LHINs legislation and what we see is the government making changes that won't address the issues and the problems within the health care system. It's really frustrating for us, because we don't see it enhancing our quality of work life or improving the quality of care that the patients receive in the hospitals where we work.

In some cases, we see folks working in the health care field who have gone through their second round of severance packages because of the changes that this and previous governments have made in the health care system. From our perspective, it is wasting money, money that should be spent on hands-on patient care. The LHINs legislation is not enhancing health, but instead is creating another layer of bureaucracy.

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I'd like to share with you now a story about my work in SPD over the 35 years. I was working at the McKellar site for most of the 35 years, until we moved to the new hospital. The department had SPD trays that go up to the floors; for example, chest aspiration tray, bone marrow, thoracentesis, paracentesis and closed chest drainage trays etc. Those trays were at the front of the department. Over 35 years that I worked, we had many supervisors and managers. The above-noted trays were moved around the department each time the manager or supervisor had a reason for moving them. As time went on, they were moved again and again, so by the time we were leaving to move to the new site, the Thunder Bay Regional Hospital site, lo and behold, they were right back to where they started 35 years earlier, right at the front of the department. It struck me at the time when we were leaving how ironic this was. Every manager and supervisor had their reason or rationale for changes they made. Did it make anything any better?

The Chair: Ms. Menzies, we want to hear you. Just slow down.

Ms. Menzies: Did it make anything any better? No. Did it enhance the service provided? No, it just moved those trays around. The point I am trying to make, and the question we have as front-line workers, is, what we see is the government with the LHINs initiative changing names, changing titles, but at the end of the day, the things you have proposed will not enhance nor improve the quality of health care in Ontario.

Something else that health care workers face, and have faced for many years, is the instability in the system because of all the proposed changes that governments make. In this particular case with LHINs, in the past there has been restructuring or whatever. It seems as if there has been restructuring for 35 years that I've worked in health care. This is disconcerting to people working in that system and very much a concern for the quality of the health care that's provided because of the uncertainty that the workers have with regard to their future, whether it be their jobs or the kind of work they're going to be doing, who they're going to be working for, what union is going to be representing them—all sorts of different things. This is disconcerting to patients because of the effect of these constant changes to the quality of their health care.

From my perspective in working as an SPD operator, the uncertainty we have does not help me to do the best job I can and being the best I can be, because somewhere in the back of one's mind, one is going to wonder, what's next; what's going to happen next? It's not any comfort to know that Mr. Smitherman, bless his little cotton socks, can say that nothing is going to happen, because we've noted that in the past these things have occurred in spite of what government officials may say. A politician or the government of the day will say one thing and sometimes something else will happen. As a SPD oper-

ator, I'm trying to pick my instruments and I should be focusing on that alone so that I can be the best I can be, that I can provide the service, that I can make sure the instrumentation I'm picking is the right instrumentation, that I'm putting everything together properly, that I'm making sure all the instruments are in the proper order, that they're in the proper working order, that they're clean and that they're sterilized properly. It is important that I be able to focus on that so the patients, when they're having surgery, have the best outcome possible.

This particular legislation creates the instability or uncertainty in the system. I've seen Rae days, I've seen health restructuring, but I've never seen anything that worries myself and my fellow workers more than this LHINs legislation because of the uncertainty and the instability it has caused and is causing in the health care system.

Is LHINs legislation a value added to the health care system? What is the true cost of this extra layer of bureaucracy called LHINs? Does the Liberal government believe in the public health care system? You note that I am asking, do they believe in a public health care system? I'm not saying do they believe in a publicly funded health care system, but does the Liberal government believe in a public health care system? Does the Liberal government respect the various collective agreements that have been negotiated by the union groups over the many decades?

In closing, I leave with you something to ponder. It's from a book called Somebodies and Nobodies: Overcoming the Abuse of Rank, by Robert Fuller. Who are the nobodies? Those with less power at the moment. Who are the somebodies? Those with more power at the moment. Power is significant by rank in a particular setting. Somebodies hold a higher rank than nobodies in that setting, for that moment. A somebody in one setting can be a nobody in another, and vice versa. A somebody now might be a nobody a moment later, and vice versa. Abuse of power inherent in rank is rankism. When somebodies use the power of their position in one setting to exercise power in another, that's rankism. When somebodies use the power of their position to put a permanent hold on their power, that too is rankism.

Dignity is innate, non-negotiable and inviolate. No person's dignity is any less worthy of respect or any less sacred than anyone else's. Equal dignity requires equal opportunity. Rankism is an indefensible abridgement of the dignity of nobodies and a stain on the honour of somebodies. As once and future nobodies, we're all potential victims of rankism. As would-be somebodies, we're all potential perpetrators. Securing equal dignity means overcoming rankism.

Who are nobodies? They are every man, every woman and every child. Each of us dreams of becoming someone new, something more. The nobodies are us. Therein lies our power. Nobodies of the world, unite. We have nothing to lose but our shame. Respectfully submitted.

The Chair: I don't think there is any time left of the 15 minutes. We thank you for both presentations, ladies.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 715

The Chair: The last presentation for the evening is from Dave Gibbons. Good afternoon. Thank you for coming. You may start anytime, sir.

Mr. Dave Gibbons: Good afternoon, Mr. Speaker. My name is Dave Gibbons. I'm a biomedical technologist at Thunder Bay Regional Health Sciences Centre and I repair medical equipment. I'm also the president of Ontario Public Service Employees Union, Local 715.

I represent approximately 360 hospital professionals and about 30 maintenance workers. The workers I represent, and I'll give you just a short list of some of them, are registered laboratory technologists, registered diagnostic technologists, social workers, biomedical technologists, psychologists, kinesiologists, dietitians, electrocardiology technicians, registered respiratory therapists, morgue attendant technicians, ultrasound technologists, nuclear medicine technologists, electroencephalographic technicians, child care workers, speech therapists, electricians, plumbers, physiotherapists and pharmacists etc. There are a lot more in this group. In this capacity, I have been able to hear the concerns of hundreds of health care workers about these LHINs. I am pleased to share with this committee some of the views these workers have.

Health care professionals are opposed to the regionalization of care when it involves the movement of hospitals from public to private and from near to far.

I'll give you a quote from Ian Urquhart of the Toronto Star: "What the government has in mind here is the consolidation of services now being offered in many hospitals in a region—say, cataract removals or hip replacements—into just one hospital or even a doctor-owned clinic....

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

As my sister from SEIU stated, I was also involved in the amalgamation of the McKellar General Hospital and the Port Arthur General Hospital in 1995. I can tell you that there is still resentment about a forced amalgamation, and it will take generations before that disappears. The new hospital, the Thunder Bay Regional Health Sciences Centre, was probably the best solution for that amalgamation.

In the Thunder Bay district, the biomedical technology area has provided biomedical services for regional hospitals for about 16 or 17 years. This service was taken over by the hospital because a private contractor could not provide satisfactory service. I know this for a fact because I was the manager at that time. I instituted the service. The big complaint was that they were only getting one or two hours a day of service because they did not have enough time to repair medical equipment. As the manager, I promised that we would give them a full eight-hours-a-day service, and that was provided by the Port Arthur General Hospital at that time.

With LHINs, this service could disappear back to a private contractor. This results in a constant turnover of service, a lack of continuity, low wages, shortages of skilled workers, high cost and a shift to for-profit delivery.

1740

Just before Christmas, the union, OPSEU Local 715, was notified that there were layoffs in different departments. It seems that Thunder Bay Regional Health Sciences Centre is being compared with hospitals in southern Ontario. I believe that this is wrong because of the vast differences in distance between towns in southern Ontario and the northwestern Ontario region. If someone from Kenora needs a routine procedure, that patient may have to drive 6.5 hours to receive that procedure. As Evelina Pan pointed out, try that in the winter in the middle of snowstorm. Travel costs will effectively create a two-tier system: Those who can afford to travel will receive timelier health care.

In the north, hospitals are a major part of the community. The community's tax dollars went to build these hospitals, and these tax dollars are provided with the belief that each hospital will provide for full service. Services in the area hospitals with the LHINs will be rationalized and moved around. With LHINs in place, this will happen more and more frequently as LHINs are forced to rationalize and centralize services and contract out to the lowest bidder.

A good example of this is the Northern Ontario Business Services project. This project is under way so that hospitals may share resources and reduce costs. The areas that are being looked at are: information technology; biomedical engineering, which I work in, or clinical technology management; human resources; payroll; and scheduling and PACS, which is picture archiving and communications systems. This project may have some merit, but it's hard to imagine a biomedical engineering department in Thunder Bay being managed by a manager in Sault Ste. Marie.

Ironically, the sector repeatedly targeted by the Minister of Health is the hospital sector. It's ironic because the hospital has been the star performer in Ontario's health care system. Ontario has fewer hospital beds per capita than any other province. The Hay Group's March 2004 study also said that Ontario's hospitals are more efficient than others in Canada. The report showed that Ontario hospitals have a lower potential for finding additional savings than others in Canada—a reminder of the efficiency measures already taken by our hospitals.

Now, once again, our members are being asked to cope with chaos created when the whole system is amalgamated, merged, rationalized and bent every which way in the interest of trying to squeeze every last possible dime out of the system. I see shades of 1995 and the hospital mergers.

This system will have a negative effect on skilled labour. Look at home care and how it has been devastated. Home care is simply not a career option anymore thanks to the competitive bidding system put in place by the Mike Harris government. We do not want to see the same thing in hospitals.

We wonder if this is integration or something else you may call it. While the government presents LHINs as a solution to the integration problem within the system, essential parts of the system remain outside this model. These include physicians; ambulance; private laboratories and specimen collection outside the hospital; public health, despite the lessons learned from SARS; independent health care facilities; homes for special care; provincial drug programs; psychiatric hospitals still under direct control of the Ministry of Health; and defined specialists such as podiatrists and optometrists. In southern Ontario, the regional laboratory known as EORLA, which is 16 labs that have been downsized to one, and other similar structures are out, although they provide services to all the hospitals. This service will eventually make its way to Thunder Bay. How do you integrate a system when so many important services are outside?

This inconsistency will mean more fragmentation for small communities, such as Nipigon, Terrace Bay, Atikokan and Marathon, than presently exists. Ironically, the LHIN legislation actually encourages transfers to these organizations that are outside the LHINs—or was this really the intention? However, for those workers affected, there are many huge questions that have not been sufficiently answered.

In the last round of hospital restructuring, the Health Services Restructuring Commission recognized the need for human resources adjustment plans to be negotiated with the unions. This time, there is no human resources strategy at all. The majority of hospital professionals believe that this is a priority, and still it is ignored in the legislation. There is already a huge retention and recruitment problem for all health care professionals and others, and this legislation is going to make it worse. Try to get summer holidays when there is insufficient help for summer replacement. When I have talked to others, some have said, "If I had to choose a career all over again, I would not choose a career in a hospital."

We, the hospital professionals, are already wondering who will do the work in a few years' time, when so many of us are eligible to retire. Many of the schools for hospital professionals have been closed over the past 10 years. With so many couples where both are working, who is going to relocate to another community? My wife has worked for the hospital for 35 years and I've been in it for over 20 years. In a lot of these cases, you'll find that there are couples who both work in the hospital. What's going to happen when these departments are broken up?

The province must negotiate a human resource adjustment plan and it should be willing to substantially fund these plans. These human resource plans should include: layoff as a last resort; measures to avoid a layoff; some voluntary exit opportunities; some early retirement options; pension bridging; retraining options; and more classroom space for more students. A transitional fund

should be put in place and a health service training and adjustment panel should be resurrected.

This legislation should not go forward without a human resources plan. Without health care workers, you have no health care.

That's the end of my presentation.

The Chair: Thank you for your presentation. Does anyone want to ask a question?

Ms. Wynne: Sure. A couple of things. I just wanted to comment that the Ontario Hospital Association is supportive of this change, so it's interesting to me that the support of hospitals is coming from people who I guess are not in sync with what the hospitals themselves are saying about the need for this kind of coordination in the system. That's one piece.

The other piece is the whole issue of privatization, which has come up over and over again over the last four days, and I'm sure will continue to come up next week. There's nothing in this bill that says we're interested in increasing the privatization of the system. There just isn't anything there. There's a section 33 that is a transitional section. When we talk about non-clinical services being contracted out, that's not new in the system. As far back as the NDP government in 1991, 1992, 1993 and 1994—St. Thomas-Elgin General Hospital, Trillium Health Centre, Halton health centre, Joseph Brant Memorial: In all of those hospitals, ancillary services were contracted out.

What we're talking about is nothing new, and I guess the benefit of this system, to our minds, is that there will be an opportunity for people at the local level to have access to a discussion about planning that they do not have access to now. That's the point of this legislation, to give people access to a planning process that nobody in the province who's not in the ministry at Queen's Park has access to right now.

That's all I wanted to say, but I hope that message can get through because that is the intention of this minister in putting this legislation forward.

Mr. Gibbons: Excuse me; you didn't introduce yourself to me.

Ms. Wynne: I'm sorry. I'm Kathleen Wynne. I'm the member of provincial Parliament for Don Valley West in Toronto and I'm a member of this committee.

Mr. Arnott: I just want to express my appreciation to you for your presentation this afternoon. You've added a great deal to the discussion. Thank you very much.

The Chair: That's Ted Arnott. He's also a member of provincial Parliament.

Thank you. That takes us to the end of today's meeting.

We will adjourn until Monday at Queen's Park, when we will continue three additional days of deputations.

We thank you for joining us in beautiful Thunder Bay.

The committee adjourned at 1750.

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