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Mardi 28 janvier 2014

Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur l'intégration du système de santé local

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 28 January 2014

Mardi 28 janvier 2014

The committee met at 0900 in the Centre Ballroom, Sheraton Hamilton Hotel, Hamilton.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): Good morning. We'll call the Standing Committee on Social Policy to order. We're here at the great Sheraton hotel in Hamilton to review the Local Health System Integration Act and the regulations made under it as provided for in section 39 of that act. We're doing the public consultations on that, and we welcome all of the people in the audience.

HAMILTON NIAGARA HALDIMAND BRANT COMMUNITY CARE ACCESS CENTRE

The Chair (Mr. Ernie Hardeman): Our first delegation this morning is from the Hamilton Niagara Haldimand Brant Community Care Access Centre: Melody Miles.

Mr. Mike Colle: Point of order.

The Chair (Mr. Ernie Hardeman): Yes?

Mr. Mike Colle: Mr. Chairman, I just thought it would be helpful for me, and maybe other members of the committee, if we could have some employment data as relates to the LHIN areas to see how many people actually work in the health care fields, like in the hospitals and in the CCACs, so just the number of people employed in health care—publicly funded, in other words—for this LHIN here.

It doesn't have to be done today, but as we go, I'd like to have this background material of how many jobs we're talking about in these LHIN areas.

The Chair (Mr. Ernie Hardeman): Okay. I thank you very much, and the staff will take that into consideration and prepare that, but I guess it doesn't relate to the public presentations today. We are here today to hear from the public, not to talk to the public.

Mr. Mike Colle: No, no. But I have the right to ask for research material.

The Chair (Mr. Ernie Hardeman): I'm not questioning your right at all. I'm just saying that we will deal with that, but we have to hear the public now.

Mr. Mike Colle: Okay. I'd like to get that research material, so I'm going to give this to the researcher.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have Melody Miles, chief executive officer, and Dilys Haughton, director of client services operations and professional practice lead. Welcome, ladies. I'm happy to have you here this morning. You will have 15 minutes to make your presentation. You can use all or any of that. If there's time left, if it's less than four minutes, we will have just one caucus ask questions or make statements. If there's more than four minutes left, we will rotate it and divide the time evenly for everyone here. With that, welcome, and the floor is yours.

Ms. Melody Miles: Thank you. Good morning, Chair and honourable members of the committee. My name is Melody Miles, and I'm the CEO of the Hamilton Niagara Haldimand Brant Community Care Access Centre. I am a nurse by profession and have held executive leadership positions with a variety of community-based health care organizations in the home care and public health sectors.

With me today is Dilys Haughton, director of client services operations and professional practice lead for the CCAC. Dilys is a nurse practitioner and is the clinical lead for a number of our programs. She also has an active caseload and provides care to some of our most complex patients.

We are very pleased to have this opportunity to speak with you this morning. We work closely with the LHIN and others to support the delivery of care in this region, which is home to more than 1.4 million people.

We believe this review process provides an important opportunity to gather feedback from local stakeholders. The Ontario Association of Community Care Access Centres, our provincial association, will be providing a written submission with a detailed series of recommendations from our sector. Rather than repeat those, we will be using our time today to provide the local perspective and focus on the following: how the legislation sets a framework for local health system planning, funding and accountability. We'll profile some recommendations for consideration, provide an example of the importance of the role of the LHIN in our system and, finally, we'll share a patient story to illustrate the impact, at the individual or patient level, of the LHIN's leadership and investment.

On balance, we believe that LHSIA is a fundamentally sound piece of legislation that sets out a solid principle-based framework for local health system planning, funding and accountability. Regardless of the way the

health system is structured, the functions of LHINs—planning, funding and accountability—must be carried out. Given the size, complexity and diversity of Ontario's population and geography, we believe these functions are best carried out at a regional level. Ultimately, it is the relationships that are key to making the system work for patients.

LHINs carry out local system level planning and funding, and are accountable for health system performance in their regions. They work with health care providers to organize, plan and deliver health care services to meet the needs of the populations. Although we share the same geographic boundaries as the LHIN, the work that the CCAC does is different.

CCACs work with individuals to help them get the care they need when and where they need it. CCAC care coordinators are regulated health professionals: nurses, social workers, physiotherapists and others. They work with patients and their families to understand their care needs and goals, and to develop individualized care plans and link them with services. They help people to remain at home, avoid hospital admission, access support upon discharge from hospital and explore long-term-care options.

Last year, HNHB CCAC provided care to more than 75,000 individuals across our region. Each month, the CCAC helps more than 3,600 hospital patients transition home with CCAC services, as well as admits 1,900 patients directly from community. We also help 250 individuals transition to long-term care.

The patients we serve vary in age and complexity of need. Last year, we served half of all seniors in this region aged 85 and older. Some 12% of our patients were under the age of 20, and nearly 30% were between the ages of 20 and 64.

CCAC care coordinators lead the delivery of home care services in collaboration with our service providers and system partners. We are in every hospital, including every emergency department. We work with every school and every long-term-care home, and are sited with many primary care providers in the region.

Care coordinators meet with people in hospitals and in their homes, to understand and support their care needs. This may include the provision of nursing, personal support or therapies, and access to community services such as adult day programs.

The package we have shared with you includes a page highlighting our linkages with patients and partners.

We know the importance of working hand in hand with primary care providers. We are full partners in the development of all 11 health links in our region. We're very proud that, for many years, the HNHB CCAC and its predecessors have had care coordinators attached to and sited with primary care providers. Currently, we have 77 care coordinators with formal attachments to 258 family physicians across our region.

We recommend that LHINs be enabled to continue to work with a range of system providers, including primary care, public health and emergency medical services. These partnerships are critical to building a system that supports healthy aging and chronic disease prevention and management.

Some of our patients living at home have very advanced care needs, and the interventions and supports they need are more complex than ever before. This trend underscores the need for clinical care and expert coordination of health care services in our communities. It also speaks to the reality that all of us, no matter how complicated our care needs are, would prefer to be in the comfort of our own home with supports, rather than in any other setting.

Down the street from here is Hamilton Place. It's one of the region's main concert venues. You've likely heard the saying that "No one can whistle a symphony. It takes a whole orchestra to play it." That was Halford Luccock.

The LHIN brings partners together and leverages their strengths and resources to support coordinated, effective and efficient services. In a sense, it is the orchestra conductor of the health care system symphony. The legislation speaks to this role and, through the LHIN's Integrated Health Service Plan, with input from the CCAC and others, sets directions and priorities for the region.

One of the key system imperatives is to enhance coordination and transitions of care. In our region, the LHIN has convened a system flow steering committee, which is co-chaired by leaders from Hamilton Health Sciences and the CCAC and includes representation from long-term care, community support services, and other partners. It has supported the development of innovative models of care, including assisted-living hubs and a rapid response transition team; and has enabled development of a secure web portal, delivering an integrated electronic health record, linking records for primary, acute and home care, and it's called ClinicalConnect.

Together, we've made some remarkable achievements, including a significant decrease in the number of alternate-level-of-care days. In 2012-13, there were 54,000 fewer ALC days than there were two years earlier. The bed days that were saved are the equivalent of a 149-bed hospital, at 100% occupancy, being made available to patients in our system each and every day.

The rapid response transition team, a precursor to the rapid response nursing program that is now established in all CCACs across the province, is an example of how the planning and funding role of a LHIN enables improved coordination of local system resources and improved patient outcomes.

We understand that presenting numbers provides only part of the picture, so Dilys is going to share a story about one of our patients who experienced this type of care.

0910

Ms. Dilys Haughton: Good morning. As Melody indicated, our patients have benefited from having the LHIN as the orchestra conductor. The LHIN has brought partners together and has enabled us to leverage our expertise and assets to improve patient care.

As background, a couple of years ago, the LHIN approached several partners, including the CCAC, to develop innovative programs that would support patients at transition points and continue to improve system flow. Following research and consultation, we proposed a program for some of our most complex patients that would provide a more expanded home care team at the point of transition to include rapid response nurses, nurse practitioners and pharmacists; access to in-home laboratory tests; bridge system gaps by providing primary care in the short term and assisting connection to primary care in the longer term; supporting medication reconciliation and management; and providing health teaching.

The LHIN identified that one of our hospital partners, Hamilton Health Sciences, was also looking at this issue from the hospital perspective and brought us together to leverage our shared expertise and resources to support this specific group of patients. I'd like to share a story of one of those patients. Let's call her Marie.

Marie was a 75-year-old woman living in a retirement home. She had just come home from the hospital and had been identified in the hospital as a patient requiring additional support. Her acute care needs had been met but there were some concerns about her ongoing health and ability to manage independently. She had been in and out of hospital many, many times over the last year. She had several chronic conditions, including emphysema, heart failure and diabetes, and from her diabetes, she had kidney and nerve pain complications. She also had a number of other health conditions, including hypothyroidism, hypertension, osteoporosis and osteoarthritis, degenerative disc disease, gastroesophageal reflux disease, diverticulosis, venous stasis ulcers in her leg and sleep apnea. Marie is similar to many other complex patients that we see in our program, and she is among some of the most complex patients in the health care system.

Marie had difficulty getting in and out of bed due to being deconditioned following her hospital stay. She was short of breath and using oxygen. She was gaining weight and her diabetes was not under control. She also reported very severe pain in her legs, the worst possible imaginable, at 10 out of 10. Her most important wish, however, was to stay out of hospital.

The CCAC's nurse practitioner began to work with Marie to address her care needs. Leg pain due to diabetic neuropathy was Marie's most pressing issue. The nurse practitioner worked with our pharmacist and her family doctor to add medication to help with this. Within only one week, Marie was already starting to feel better and her pain was reduced to seven out of 10.

We worked with her respirologist and retirement home staff to better recognize and manage her COPD flare-ups. We involved physiotherapy and occupational therapy to help her manage more independently. We involved a dietitian to work with Marie and to build capacity in the retirement home staff to address her nutritional needs and get her diabetes under better control. As the nurse practitioner got to know her, she identified depression as an issue and started medication.

The outcomes were remarkable. Within only one month, Marie's self-reported pain was only two out of 10. She was more mobile, losing weight, and her diabetes was under better control. As Marie said, "I haven't felt this good in 25 years." I am also pleased to report that we helped Marie stay out of hospital, with not one hospital admission in the year following our involvement.

This story highlights how, through the provision of quality, patient-centred care, coordination between providers and increasing provider capacity, we are improving patient outcomes, reducing costs by using health care resources appropriately and ultimately improving the patient's care experience.

In your package, you will find a few patient journey stories, including one entitled "Jack's Journey," which is about another patient, similar to Marie.

Ms. Melody Miles: Dilys has told you the story of just one patient we have cared for with innovation and support from the LHIN.

Last year, we provided care to one out of every 18 people in this region. We don't do this alone. We do this in concert with our many system partners, including service providers, hospitals, primary care providers, emergency medical services, long-term care, school boards, informal caregivers and others. Many of these partnerships come about as a result of building relationships over time and working together.

We recognize that having these types of integrated programs will support patients and caregivers. At the same time, we know that we need to better understand and plan for future system capacity. Our provincial association has launched a series of discussion papers which expand on some of these key issues.

I thank you for leading this important dialogue. We know the system and services will need to continue to evolve, grow and adapt. We are particularly grateful for the recent focus and importance being given to home and community care. Going forward, we will need to continue to have solid leadership and system planning to fully utilize the capacity of our human technology and other resources as we provide preventive, healing and palliative care for the residents of our region.

I thank you for your time today. We would be pleased to respond to any questions you may have.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It was very well done. You've timed it within seconds of 15 minutes. We'll take it into consideration as we move forward with this review.

ST. JOSEPH'S HEALTH SYSTEM

The Chair (Mr. Ernie Hardeman): Our next presenter is St. Joseph's Health System: Kevin Smith, president and chief executive officer; David Higgins, president of St. Joseph's Healthcare Hamilton; and Tony Valeri, director of St. Joseph's Health System. Kevin, you look somewhat familiar.

Dr. Kevin Smith: It's true, Mr. Chair. I'm not stalking you.

The Chair (Mr. Ernie Hardeman): The instructions for your presentation today will be the same as the instructions were yesterday. We welcome you back, and the floor is yours.

Dr. Kevin Smith: We thought we'd come back till we get it right, Mr. Chair.

Dr. Higgins and I are pleased to be with you here today. Obviously, we're going to talk a little bit about St. Joseph's Health System as it plays within the LHIN.

St. Joe's is one of Canada's largest and most comprehensive health care organizations and, perhaps most importantly, the first in Canada of the academic health science centres to consolidate across multiple LHINs and all of the continuum of care, from primary care through to palliative care, including academic teaching hospitals.

Our experience with the LHIN in developing that model has been nothing short of remarkable. The local leadership of the LHIN has been a key partner in allowing the management of the continuum to evolve and, increasingly, for a focus on primary care and specialty services, home care services and community-based services, as well as social services to be well integrated in the complex needs of complex patients.

Clear strengths of this LHIN:

—a very well-articulated patient-first focus;

—significant support and respect for the contributions of local provider organizations and local governance;

—creating a culture of co-operation and team-building; and

—support for enhancement to community-based programs through the Ministry of Health and Long-Term Care, community and social services and numerous philanthropic organizations.

I think the other key strength of the Hamilton Niagara Haldimand Brant LHIN is engaging local physician, clinician and administrative leadership in bringing solutions to complex problems. That includes those who do the work on the front lines being very engaged in the solutions.

I've mentioned our integrated continuum-of-care project, which I won't dwell on here today. It's in your package. It has been a novel journey for us, moving from the mindset of a hospital to the mindset of a systems manager across the continuum of care, working with our funding partners, and community and social services partners as well. We'd be happy to expand on that should there be interest later.

I think the other potential opportunities for the LHIN, which was one of your key questions for today, are the engagement of the gatekeepers in primary care, particularly primary care physicians, nurse practitioners, community health centres and others—a key and important ingredient going forward; a greater emphasis that continues the development of partnerships and continuity, particularly focused on vulnerable populations, those who are the highest consumers of care and often those who are most economically and, at times, genetically disadvantaged. Health links is a very good start to this program.

The LHIN has advanced the model of robust business planning so that economics and clinical quality are well matched and the importance of data and data application in decision-making can continue to be refined.

0920

In closing, our focus really, increasingly, will be on the model of care that allows us to procure health care and the model of care that allows us to deliver health care. By creating a strong relationship between those who purchase the service and those who provide it, respecting the respective roles, and also recognizing that the funder—it's very legitimate and important to focus on "what," and the provider must be permitted to focus on "how."

Perhaps I'll stop there, in the interests of time for questions and dialogue.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We will start the questions. We have about 11 minutes left, so with that, we'll start with the third party.

Miss Monique Taylor: Hi. Nice to see you again.

Dr. Kevin Smith: Nice to see you again.

Miss Monique Taylor: Thank you so much for wanting to participate today and being present here, and for putting together a summary of what's happening with St. Joseph's Healthcare. My question would just be about how we're finding our wait times coming within our region.

Dr. Kevin Smith: Yes, we are making some significant progress. We have some significant areas for improvement to continue. The region has done a remarkable job in improving access to diagnostic services.

Similarly, the LHIN, working with the ministry, has freed up some resources. You may have seen last week in some media a focus on cataract care, that there was a gap, and the LHIN and the ministry did a very, very good job, I think, of coming back on that.

That having been said, a lot of work is being done on wait times that also allows us to get better information. I'll just give you an example that Dr. Higgins has been working on: When is the appropriate time for an intervention with a procedure like a cataract? So, when is the cataract appropriately ripe? It's very difficult to evaluate across the province, so I think our next steps in wait-times management will be better data, better criteria and better models of clinical judgment in comparison. I'll ask Dr. Higgins if he wants to add to that.

Dr. David Higgins: Thanks. Yes, I agree. I think that the challenge we're looking at in cataracts is an example of how do you create a more standardized and effective manner for assessment of patients, because not all patients are the same; we know that. A good example we sort of use is if I was a marksman, my objective feat for having surgery might be different from maybe Dave Higgins who's simply a hospital executive. So I think that we need to balance out the patient's needs versus the wait time and understand the acuity and intensity. That's one of the things we want to work on. What the LHIN has helped us do is focus on a LHIN-wide focus on understanding the assessment processes more effectively.

Going forward, then, with the LHINs who [*inaudible*] plan driving on quality, patient experience and quality is going to be a key focus on how to manage that in the context of wait times.

Dr. Kevin Smith: Ontario has gone from worst to first in wait-times management.

Miss Monique Taylor: Worst to first?

Interjection: Yes.

Miss Monique Taylor: Where are we sitting with cataract surgeries? Because that's a really good point that's been raised. I know myself, in my office, hearing from people who are saying that they're waiting for such a long time just to get one done, and then having to wait the exact same amount of time to get the other one done. So it's become a serious issue.

Dr. David Higgins: We agree with that, and I think that we need to have a more clear understanding of those factors within our region, and also, then, to ensure there's fairness and equity across the region. Our minister has very clearly said, "Patients need to have choice." And where patients can be offered surgery in a more rapid fashion, we want to help engage that, too. It's complicated, but I do think a more transparent approach to this from all—from the patient's perspective, the provider's perspective—will be an important first start, and then driving to quality as well to ensure equity, that we manage resources appropriately.

Miss Monique Taylor: Thank you.

The Chair (Mr. Ernie Hardeman): One more minute.

Miss Monique Taylor: Community urgent care centres: Where are we sitting on that? There's large growth in my riding, specifically in the Mountain, which covers Glanbrook, Ancaster, all of that area which I believe does not have enough urgent care. What are your thoughts on that?

Dr. Kevin Smith: It's a great discussion, and the number of urgent cares, as you know, is a rapid debate around the province of Ontario. I think the future is more about 24-hour access to primary care, with appropriate primary care coverage, and then rapid transport for those truly urgent or emergent things.

Again, I think one of the opportunities for the evolution of the LHIN is getting a little more involved in and being given the authority to do so in primary care planning. I don't believe we're going to see more free-standing urgent care centres as the solution. When we look at the number of providers available, we may be better positioned to look at how we do after-hours care with primary care providers.

Miss Monique Taylor: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We now will go to the government. Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Chair. Dr. Smith, I was interested in your comment that St. Joseph's, as an academic health science centre, has provided some leadership and coordination across several LHINs. Many of us actually represent ridings in the GTA, where we have a number of different LHINs, and I think that—again, on behalf of our constituents—we have noticed that there is tremendous disparity in some of the services provided between the LHINs.

How have you at St. Joseph's been able to use your academic health science centre to reach out or to coordinate or to suggest best practice? Can you sort of fill us in on how you played that role?

Dr. Kevin Smith: Sure. The first model, I would say, is that we've tried to focus on where the burden of illness exists: Is there a real need and a problem? Secondly, what's the data and what's the information or published literature that suggests improvement is possible? Lastly, and most importantly, is talking to those who deliver the work directly and those who receive the service about what "better" might look like.

I think we've done a reasonable job within the two LHINs that we work in. I would say that the opportunity to spark innovation across LHINs is still an opportunity to be further exploited in the future.

Again, you've heard this from me recently: Where the LHINs have autonomy or greater autonomy, and where they should have less autonomy, I think, is something that the Ministry of Health and Long-Term Care and the government of Ontario can help define. At the moment, I think that's still a little broader, and perhaps what you're experiencing across jurisdictions is as a result of that.

It is a fine balance. We want things like health links to be flexible and responsive to the population but, equally, we want to be able to say that Ontarians have similar access to appropriate services. I think that engaging the LHINs in a discussion about where autonomy is appropriate, and perhaps where less autonomy would be better at a systemic level—and the ministry being clear with that—would be helpful.

Ms. Helena Jaczek: Just as a follow-up, we've heard a number of suggestions that physicians should be somehow brought into the LHIN structure. We know community health centres are already part of that. Do you have any practical suggestions or some feelings as to whether, in a structural way, we should incorporate physicians or physician groups in some way?

Dr. Kevin Smith: Sure. Let me start, and then a practising respirologist can disagree with me. The focus, I think, increasingly has to be about integration, and it's folly to suggest that you can talk about health service delivery and leave physicians, the principal providers of direct medical services, within their scope of practice.

I think it's increasingly about how you engage physicians. I would say that hospital-based physicians are more engaged in this process by the nature of their work, because the hospital is so engaged with the LHIN process. My belief is that it is somehow better integrating primary care, and being perhaps clearer with the LHINs and with the primary care community as to what the relationship might be, should be and could be.

While I recognize that the Ontario Medical Association is the only negotiator on behalf of physicians in Ontario for compensation issues, I think the LHIN can play a very significant role in the design-and-delivery

model—again, the "what"—and then challenge the field back with the "how."

Lastly, I would say, do we have the right fora where we're actually getting the continuum of care at the table to talk about a system-wide solution, as opposed to, "We're going to solve a cataract problem"—which I'm not diminishing, but a cataract problem in isolation with a patient who's also diabetic—as Ms. Miles and her colleagues were talking about, with the very complicated Marie—I think that's a place where we need to engage physicians much more actively and be clearer about what LHINs' roles, responsibilities and accountabilities are with physicians.

David, do you—

Dr. David Higgins: I think the community is key to the future of the health care system, and primary care is a huge part of that. It's fundamentally and critically important that that becomes part of the conversation and part of the overall structures.

The Chair (Mr. Ernie Hardeman): Well, thank you very much. Ms. McKenna?

Mrs. Jane McKenna: Thank you so much, Dr. Smith. It's a pleasure to see you again today. I think my first question is—I see the relationship that you have with my CEO, Donna Cripps, is working and is great. I know that with my office, as MPP, she has been a phenomenal support for us.

Dr. Kevin Smith: Absolutely.

Mrs. Jane McKenna: But all those resources that you have here—I think we found, numerous times, that all 14 don't actually flow together when there's information given to each other, and there is a massive disconnect between one and the other. How could we solve that so one hand's talking to the other, instead of each one being in their silo?

0930

Dr. Kevin Smith: I'll maybe go on a theme—the data theme—yet again. I'm hoping that we'll see—and I know that Hamilton Niagara Haldimand Brant and other LHINs are working towards a systemic scorecard. We've done a lot of work, particularly in hospital-based or surgical procedures, which are easy to measure: "Did I or didn't I get what I said you'd get on time?" But I think the investment in a system-wide scorecard by LHIN, with targets and improvement statistics being very, very clear—I think, then, somehow engaging the Ministry of Health and its various arms, like Health Quality Ontario, for the mechanism of standardization helps. What we learned in wait times 1 and 2 was very clear: that data, money and embarrassment are very powerful tools for change.

Mrs. Jane McKenna: Yes. I do recognize, though—it is the Minister of Health, right? If you have leadership in that area, it does filter down to the rest, right? Because clearly there is, in the meetings that we've had here, a disconnect right from one to the next. So that's great, because we're here to fix those situations ourselves with the information that you give us.

The next question I have is, you measure your success by the success of your patients. So how do you measure those outcomes? I realize that Ms. Miles was here giving us some of those stories, but those are your job description of things that you should be doing on a daily basis. As an MPP—I won't speak for anybody else—we have a lot of people who come in who are not, clearly, getting those services at all. So how do you measure the success of the patient so we can actually make the system better?

Dr. Kevin Smith: As you know, it's an incredibly complex issue, and you're measuring want versus need, at times. We know that in many rationalizations of health services, what people want may not be well aligned with the best evidence. We know that when we try to consolidate services and when consolidation of services increases quality in certain domains, we still don't necessarily have communities say, "Great. Why don't you take that away from me and move it over here?" even though the evidence, the data, is extremely clear. So I think we have to continue to come back and talk about how we communicate with people with very complex clinical evidence.

I think the latter part is engaging the public in what the appropriate standard of care is and increasingly being clear about what we are able to afford to do with the limited resources we have, and perhaps what we're not able to do. I know that's a very, very difficult task for all of you who have elected positions to represent the people of Ontario, but I think, in a rational system, we'll increasingly be talking about what our priorities are and what is, in our language, a strategic plan.

Sadly, when limited resources exist, we also have to make some decisions about what we won't do, or, perhaps, more impressively, what we'll do in a less costly way, often by people who are less costly.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. I do want to point out that I mentioned that we saw you yesterday.

Dr. Kevin Smith: Yes.

The Chair (Mr. Ernie Hardeman): It was representing a different group of people.

Dr. Kevin Smith: It was. Yes.

The Chair (Mr. Ernie Hardeman): So we weren't hearing the same presentation.

Dr. Kevin Smith: No. It was Niagara yesterday and Hamilton today.

The Chair (Mr. Ernie Hardeman): Thank you very much.

BOARD OF NORTH HAMILTON COMMUNITY HEALTH CENTRE

The Chair (Mr. Ernie Hardeman): Our next presentation is the board of the North Hamilton Community Health Centre: Elizabeth Beader, chief executive officer, and Kim Rynn, board chair.

Thank you for being here today. We very much appreciate you taking the time. As with other delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for the presentation. If there's any time left over, if it's less than four minutes, it will go

to one caucus. If it's more than four minutes, we will divide it evenly among all three caucuses to give everybody an opportunity. With that, the floor is yours. Thank you very much.

Ms. Kimberley Rynn: Thank you. Good morning, Chair and honourable members of the Standing Committee on Social Policy. My name is Kimberley Rynn. I am the board chair of North Hamilton Community Health Centre. With me is Elizabeth Beader, our CEO. We're very pleased to make this submission to your committee on LHSIA.

I want to start by giving a little bit of context about North Hamilton. It's an organization where I've had the good fortune of having a role as a volunteer governor for over 13 years, so I have a lot of passion for the organization.

North Hamilton Community Health Centre is one of seven CHCs across our LHIN, Hamilton Niagara Haldimand Brant. Our vision is: no obstacles to health, and our mission is: enabling health through healing, hope and wellness.

CHCs are primary health care organizations that outreach to individuals and communities who have barriers to the health care system. CHCs are the only primary care model accountable to the LHIN.

The overall aim of the Hamilton Niagara Haldimand Brant LHIN is to dramatically improve the patient experience through quality, integration and value. The HNHB LHIN's three key strategic directions flowing from this aim are, first off, to dramatically improve patient experience by embedding a culture of quality throughout the system; secondly, to dramatically improve the patient experience by integrating service delivery; and thirdly, to dramatically improve the patient experience by evolving the role of the LHIN to become health system commissioners.

It is the intent of our submission to take advantage of the LHIN's full potential in enabling improved health outcomes at the best possible cost. With that, I want to hand it over to Elizabeth, who is going to review our submission.

Ms. Elizabeth Beader: North Hamilton Community Health Centre has experienced good results in the relationship between a regional funder—our LHIN—and our local community needs. The regional body understands our regional perspective, our unique realities and the distinct attributes of our communities in which our LHIN is situated. The local realities of quality, performance, funding and evaluation are well understood at the local level.

One of our key issues that we wanted to bring forward around the legislation is that the LHINs do not have jurisdiction over other models of primary care under the current legislation. CHCs provide excellent primary health care services to 2% of Ontarians. It is acknowledged—and we've heard from the previous presentations—how primary health care is the foundation for the health system and therefore essential to reform.

It's critical that the entire primary health care system fall under the accountability of the LHIN as an enabler to a high-performing health system. This means that all models of primary health care, including family health teams, family health groups, solo practitioners and all other models currently funded by the Ontario Ministry of Health and Long-Term Care must be accountable to the LHIN for quality, performance, funding and evaluation.

Just to highlight that, the LHIN's ability to achieve results is curtailed due to scope limitation in that they do not have jurisdiction over other primary health care models.

The second point that we wanted to make was that the act should be enhanced to support illness prevention and wellness initiatives to prevent more and treat less. The act should expand to include objectives related to health promotion and illness prevention. The act should expand to include a strong focus on the broad determinants of health. Performance indicators related to health promotion and illness prevention should be developed, and all primary care models and other health service providers, along with the LHIN, held accountable for those results.

The third point that we wanted to make was that a balance between local approaches and standards across LHINs should be evaluated. The regional body, as said before, understands the regional perspective, unique realities and distinct attributes of our communities. Solutions and funding those solutions, we acknowledge, are regionally distinct. However, there are certain standards, such as percentage increases to budgets, rules regarding accessing surplus and commitments to keeping surpluses within the community health sector, to name a few, that need to be standardized across all LHINs.

Finally, a commitment to health equity is crucial in dramatically improving the patient experience through quality, integration and value, ensuring that there are no obstacles to health. We are recommending that all LHINs have a health equity indicator or target included in all of the SAAs as a starting point to begin understanding the local issues related to reducing health inequities. We are recommending that the health equity impact assessment tool that has been developed by the Ministry of Health and Long-Term Care be used in regional planning and province-wide initiatives.

We're ready for questions, if you have any.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do have about nine and a half minutes left, so we'll start with the government side. Mr. Colle.

Mr. Mike Colle: First of all, I want to commend you for volunteering for 13 years to serve on the board of your local community care centre. Thank you very much for that volunteer service. I know that there are a lot of volunteers who work in the community health centres that make it so good. I'm a great fan of the community health centres. I have two in my riding, and I think they are the best kept secret in health care. The newspapers never talk about them; the media is not interested.

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Anyway, I just wanted to ask you: The one key point I think you made is that the community health centres are

under the LHIN. Then you provide primary care with your nurse practitioners and your doctors, right? Yet, you mentioned that the rest of primary care providers are not under LHIN jurisdiction. Are you inferring or are you trying to state—and I'm not trying to be confrontational—that maybe more primary care providers should be under the LHIN? Would that help you and others in getting access to better service if LHINs had more say in primary health care delivery?

Ms. Elizabeth Beader: I think what we're saying is that our relationship with the LHIN and our accountability to the LHIN has proven that the solutions that are system-wide and include primary health care can happen in partnership. But when you have a key group of individuals—who I would say are the gatekeepers to the system—not under the LHINs, the ability—

Mr. Mike Colle: You're saying the doctors, right?

Ms. Elizabeth Beader: The physicians, yes, in different funding models are not accountable to the LHIN for volumes, for initiatives across the sector. I think that the LHIN has done a phenomenal job in pulling that primary care group in to have conversation, to be part of the health links, to be part of those initiatives. But they are not accountable to the LHIN, and we believe that the entire primary care arena needs to be under the LHIN's purview so that the creative and innovative solutions that the Hamilton-Niagara-Haldimand-Brant community has developed in partnership with the LHIN can occur and have some accountability around it.

Mr. Mike Colle: Yes, and you mentioned the importance also of looking at the broad determinants of health, in other words, poverty, lack of housing. Could you give me a specific example of how, if we spend more time looking at that and their relationship to health that that would help deliver better health care and better outcomes?

Ms. Elizabeth Beader: There's a lot of evidence that shows that if somebody is homeless or under-housed or is hungry or is unemployed that they are going to be sicker than somebody who isn't hungry or does have a home or does have friends or does have employment. There is all kinds of research out there that shows that. What a community health centre does is try to understand those broad determinants of health in developing a care plan for an individual and then using that full understanding of the client in developing what will make that individual healthier.

It might mean that we need to have a client advocate that links that individual who may have extremely complex health issues, like diabetes with a comorbidity of heart disease and may even have asthma, and understand that they're living in either substandard conditions or living on somebody's couch with carpet, so their breathing is going to be an issue with their asthma. They're not able to follow up with their prescriptions—

The Chair (Mr. Ernie Hardeman): Okay.

Ms. Elizabeth Beader: Okay, sorry. I'm going on.

The Chair (Mr. Ernie Hardeman): Thank you. Mrs. Elliott.

Mrs. Christine Elliott: Good morning. Thank you very much for presenting to the committee today. I'm also a big fan of community health centres, and I think that your efforts do go unnoticed and they shouldn't be. I think it's a great service you provide to many marginalized people in our communities. I think your presentation really reflects that unique perspective that you have, and has raised a couple of questions. One of the questions I have relates to evolving the role of the LHINs to becoming health system commissioners. I'm wondering if you could expand on that a little bit about what you mean by an enhanced role of the LHIN?

Ms. Elizabeth Beader: We've put that in because that's a goal of our LHIN, and so I think that they would speak more closely to that.

Mrs. Christine Elliott: Okay. We'll have a chance to speak about it.

The other question I had was, standardizing the experience of the LHINs across the province. Do you feel that the LHINs are receiving the leadership that they need from the ministry? Do you think it would be helpful if the goals of the ministry might be more clearly articulated to the LHINs in order to allow them to provide enhanced services in the areas they represent?

Ms. Elizabeth Beader: I really wouldn't be able to speak to that point. What I can tell you is our experience as community health centres across the province. We have provincial initiatives across all community health centres.

There was an experience that happened a couple of years ago when the LHIN was given a certain percentage increase for budgets. Some LHINs gave the full increase to CHCs, some gave partial and some gave none. What that creates is a discrepancy across the system of CHCs. At that time, some CHCs could give, for instance, salary increases to staff and could expand services that were greatly needed to clients and to patients, but others couldn't. So then there becomes a bit of a competition between CHCs, which we don't want. Questions arise out of process, so attention gets focused on process rather than the delivery of excellent service and the support of fantastic employees. So that's where that's coming from. That's just one example of where it would be important to have some standardization, understanding that there are regional issues that each LHIN has to attend to.

The Chair (Mr. Ernie Hardeman): The third party?

Miss Monique Taylor: Thank you so much for your presentation. You've raised some absolutely wonderful points, talking about prevention, being proactive in health. That is something that, especially in your area of the city, we need.

I would like to know how you find that your community centre is looked at compared to other areas of the city and what the differences are between them. You talked about the standards in treatment. Are you getting treated the same? Are you finding that there are problems between your centre and others?

Ms. Elizabeth Beader: Other community health centres or other primary care models?

Miss Monique Taylor: Other community health centres.

Ms. Elizabeth Beader: No. I think, actually, that our community health centres with our Hamilton Niagara Haldimand Brant LHIN are a very strong group of leaders in primary care. We meet on a monthly basis. We work together with our LHIN. In fact, the LHIN comes to our monthly meetings to have discourse around quality across all CHCs, around opportunities for funding initiatives that are across the LHIN.

I'll give you an example. We noticed that our no-show rate at North Hamilton Community Health Centre was high due to the kinds of clients and patients that we outreach to, and so we delivered a proposal amongst all of the community health centres to the LHIN regarding a reminder call system. Through the data and the analysis of the need, that was funded across all community health centres, which created efficiencies in terms of purchasing power—one RFP instead of seven, better buying power and less training required. That's an example of how all of the CHCs work well together.

The Chair (Mr. Ernie Hardeman): Just half a minute left.

Miss Monique Taylor: Thank you for your presentation. Thank you for the work that you're doing.

Ms. Elizabeth Beader: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate you taking the time to come in.

ONTARIO NURSES' ASSOCIATION

The Chair (Mr. Ernie Hardeman): Our next presentation is from the Ontario Nurses' Association, represented by Linda Haslam-Stroud, the president. Thank you very much for coming in this morning and helping us with our review. We look forward to your presentation. You will have 15 minutes, and you can use any or all of that for your presentation. If there's less than four minutes left, it will go to the third party for questions. If there's more than four minutes left, we'll divide it equally among all the caucuses. With that, the floor is yours.

Ms. Linda Haslam-Stroud: Thank you, Chair. My name is Linda Haslam-Stroud. I'm a registered nurse, and I've provided care through St. Joseph's hospital here in Hamilton, with Dr. Kevin Smith as my ultimate boss, for some 35 years.

I'm also the proud president of the Ontario Nurses' Association, which represents some 60,000 registered nurses, registered practical nurses and allied health professionals. We're providing care, along with our 14,000 nursing student affiliates, across the health care system.

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I'm very proudly here today to talk not about the HNHB in particular but about LHINs. My focus is going to be on some logistical, operational and administrative types of recommendations that we think could enhance the LHINs' operations. In particular, we're looking at improving and safeguarding the professional interests and practice of our nurses, and protecting the delivery of quality care.

Our starting point for that is effective integration of health care services, which we believe is fundamental. There is still work to be done. Effective integration should be coordinating access to quality care and comprehensive services, in order to provide a seamless continuum for our patients in the health care system.

Minister Smitherman, when he enacted the LHINs some time ago, talked about it being "a comprehensive system of care that is shaped with the active leadership of communities and driven by the needs of the patient." He went on to say, "LHINs are going to help us build a system that has patients at its centre," and that they should be prioritized using the needs of our local patients and communities. I suggest to you that some of our decisions must be guided first and foremost by patient access to a comprehensive health care system, and I think we have a little bit of a ways to go.

Concepts fundamental to integration of health care, such as quality patient care and transparent decision-making made in the public interest, based on our priorities, should be front and centre in the decision-making process. I would suggest to you, rather, that right now integration is understood really exclusively in the blunt language of the act: "transfer," "merge," "amalgamate," "cease," "dissolve" or "wind up" the services or operations.

That's what we're seeing. The focus seems to be on cost-cutting and reducing government expenditures rather than principally reforming the system in the public interest. With due respect to Kevin, there are hard decisions for all of us to make with the limited health care dollars, but the research is out there, very clearly, on how we can invest the appropriate dollars to get the best health outcomes for our patients.

One approach that we're suggesting to refocus the LHINs is through accountability agreements between the Ministry of Health, each LHIN and the service providers. You'll see some recommendations in our submission. What we see as missing from both levels of the accountability agreements is a focus on creating the conditions which are going to provide that quality of care.

The research is evident that quality care is dependent on appropriate registered nursing staffing and safe practice conditions. We know that this is going to improve outcomes for our patients. We believe that there are presently some fundamental oversights in the accountability agreements, which could hopefully improve.

In the submission, you will see some disturbing data that shows that the health care sector has one of the highest rates of illness and injury. If you look at some of the costs, even to the Workplace Safety and Insurance Board—and these are actually the surcharges. This isn't even the premiums that our health care providers are paying.

For three years in the hospitals, how much did it cost in penalties because of the injuries that took place? It was $50.5 million. Those are dollars that we could be

reinvesting in our patients and having our nurses on the front lines be healthier. For long-term care over two years, it was $36.5 million, my point being that we have money in the system and better ways of doing things so that we hopefully could reinvest those dollars, to the benefit of our patients.

The accountability agreements do not have any of these kinds of requirements presently regarding health and safety for nurses and other health care professionals, and that is ultimately impacting the quality of the care that we're able to provide. We're recommending that there be health and safety indicators in accountability agreements.

We're also recommending that there be a health human resource plan in the accountability agreements with the LHINs and the providers, and the LHINs to the ministry. I cannot believe that we have the highest number of regulated health professionals caring for patients, clients and residents across Ontario—the nurses of Ontario—and there is not any health human resources plan, either at the provider level with the LHIN and/or the accountability agreements with the LHIN and the government. That is another suggestion that you will see in our submission.

It's embarrassing, actually, that Ontario has the second-lowest number of RNs per patient. I hate to say that, but we need to ensure that it is consistently reminded to you, the decision-makers, that we need a health care system that is going to provide those kinds of high-quality health outcomes for our patients.

The other thing I'd like to suggest to you is access to information in the actual LHINs. You will see that it is basically somewhat of a dog's breakfast. There are different accesses through the 14 LHINs. If you were to look at any one of their websites, you wouldn't be able to really find the information that you require—and I'm sure that in your review, you're probably finding that out yourselves. But I would suggest to you that health care funding announcements, decisions and information should be made available in multiple and consistent ways through the LHINs and certainly through the websites. We believe that right now there is inconsistent access to information. It really is imposing a very difficult task, if you're really looking for input from stakeholders and the patients that we serve. There are improvements in access, consistency and transparency of the LHIN information and of, actually, the LHINs' board decisions, especially around health care funding. We believe that's absolutely critical for public engagement, monitoring of and the involvement of local decision-making.

Because of the multiple funding streams for health care providers, such as in the hospitals, it's really extremely important that we have some way of being able to assess whether the appropriate funding is being provided for our patients on the front lines. Therefore, we're recommending that reports to and decisions on funding and other decisions for every LHIN board meeting should really be easily accessible on the website.

We also are suggesting that to ensure a focus by the LHINs on a quality agenda in the public interest, the hospitals must actively consult with and provide a strong voice with their fiscal advisory committees for front-line input. We're talking about input to make the system better. So we are also recommending that a requirement in relation to front-line nursing input be part of accountability agreements.

The last thing I want to talk to you about is the integrating of the independent health facilities, and that's a new act, as you know. We are very concerned that the integration of independent health facilities and local planning and the funding of health care under the LHINs is going to be extremely problematic for us as front-line nurses when we see that the extensive body of literature and evidence raises quality concerns where services are delivered in the for-profit sector. We know that consistency and lack of fragmentation of services is to the benefit of our patients, and we don't want to see us going down a road of further fragmentation. We are recommending that enabling LHINs to tender contracts for the movement of clinical services from the hospitals to the private clinics should stop now. A recent one here is looking at the ophthalmology services that we provide very well here in the HNHB LHIN. It also means that we should also be maintaining our community care access centres, and I personally have had the privilege, over the last five years, of having those CCAC care coordinators coordinating care for my two elderly parents—82 and 85 years old. They normally would have been in a long-term-care facility many years ago. They're coordinating everything for my parents to be able to live healthily in the community and in their home together, after 60 years of marriage, so I also wanted to acknowledge the CCACs.

Finally, it is our view that a quality agenda in the public interest requires equality across the sectors. You will know—or maybe you don't know—that unlike other provinces that have parity of wages and benefits for the nurses in the province, we have a piecemeal system and a lack of parity for the nurses that are working in our community. If we want to support the community, we need to attract the nurses into the community, and certainly wage parity, pensions and benefits would be important as well.

I urge the standing committee to seize the opportunity to refocus the LHINs on what matters most to our patients, and that is the delivery of high-quality care. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for the presentation, and we're right on the border here, so we do have to circle around. We'll start with the official opposition. You all have about a minute and a quarter.

Mrs. Christine Elliott: Okay. I'll speak quickly then. Thank you very much for your presentation. I gather that you've made specific recommendations for the improvement of the LHINs, so I'm assuming you support the concept of LHINs generally, or I'm wondering if your association has considered any other model as an alternative to the LHINs.

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Ms. Linda Haslam-Stroud: We, as nurses—I've been a nurse for 35 years and a leader in health care for 35 years—are used to change. I would suggest to you that the LHINs could work. Certainly, our LHIN here in the HNHB area is probably a better example of how LHINs can work for the benefit of our patients, but I still believe there are a number of improvements that we could be making.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. The third party: Ms. Armstrong.

Ms. Teresa J. Armstrong: Thank you very much for your presentation. I found it quite interesting that you gave a lot of feedback on ways to try to help improve the system that's there now. One of the items that you mentioned was the WSIB cost and health and safety. Could you just give a little more expansion on how you see nurses playing a role in that contribution and how that financial piece could be mitigated so that we can leave the funds where they're needed?

Ms. Linda Haslam-Stroud: The Occupational Health and Safety Act, which all employers are under, is a strong piece of legislation. We need to reduce violence in the workplace. I don't even want to show you the pictures of our nurses with pummelled faces from violence of patients in the emergency departments across Ontario. But the fact is that there are ways to flag patients, to reduce violence in the workplace, to ensure we have a safe system, to reduce injuries, working together—the nurses, the unions in the province and the employer—so that we can mitigate those costs and reinvest them in our patients.

Ms. Teresa J. Armstrong: You feel that nurses, obviously, can contribute to that conversation in order to make—

Ms. Linda Haslam-Stroud: Absolutely. We've had some really great, positive results. Actually, at the Toronto East General Hospital, working with Rob Devitt, the CEO there—I don't know if you know him or not—where ONA, the Ontario Nurses' Association, and the CEO and the employer have worked together to try and mitigate those kinds of costs.

Ms. Teresa J. Armstrong: Okay. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek.

Ms. Helena Jaczek: Thank you so much for your advocacy and your passion on behalf of the nursing profession. It's much appreciated. Certainly, I'm very aware that those issues of health and safety, particularly in the long-term-care sector, are very, very important.

Your recommendation number 3, which relates to the inclusion of public health within the planning mandate of the LHINs: As a former medical officer of health, I just have to ask you to expand on that. As you know, boundaries are totally different—they're based on municipal boundaries—and also, municipalities contribute 25% of the funding for boards of health. I'm just wondering if you could expand a little bit here and tell us exactly what you mean by that.

Ms. Linda Haslam-Stroud: I understand that there are some barriers, but I think any problem is resolvable in relation to the funding formulas.

If you want to really look at the extensive integrated health care plan, the prevention of disease and the promotion of health are the public-health-principled focus. If we are working together, along with the providers, dealing with the disease, I believe that the public health could work more closely with all the service providers to actually prevent disease, which is going to keep health outcomes more positive for the people of Ontario and reduce health care costs, and we would then have a fully serviced plan.

Public health has been out of the LHINs for too long. We've restructured the CCACs and we still have a way to go, but we're working with those. I believe that the public health, working integrated in the health care system, in the LHINs, would provide better health outcomes for our patients.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's very informative. We appreciate you coming in.

Ms. Linda Haslam-Stroud: Have a great day. I know it's a long one, so thank you very much. Take care.

DEMENTIA ALLIANCE

The Chair (Mr. Ernie Hardeman): The next one is Dementia Alliance: Mary Burnett, chief executive officer. Thank you very much for coming in this morning and helping us with the review of the LHINs. As with the other delegations, you will have 15 minutes to make your presentation. Any or all of that may be used for your presentation. If you don't use it all and there's less than four minutes, the questions will go to the third party. If there's more than four minutes, we will divide it equally among all the parties. With that, the floor is yours. Thank you very much.

Ms. Mary Burnett: Thank you very much. I have packages that are being distributed to all of the members of the standing committee.

Good morning, Chair and honourable members of the standing committee. My name, as you know, is Mary Burnett. I'm the chief executive officer of an interesting organization called Dementia Alliance.

In my presentation today, I want to speak a little bit about who we are and how our formation as an alliance relates to this legislation. I want to talk about the value of local engagement, some of the limitations of the legislation we have experienced, and then end with some concluding comments.

First of all, who we are: The Dementia Alliance is an alliance of the Alzheimer societies of Brant, Haldimand-Norfolk and Hamilton-Halton. We were three small, non-profit organizations that were providing similar services. For example, we provide services to those affected by

dementia and their care partners in our communities with very little infrastructure. Each of our organizations had an ED, but we did not have financial expertise, human resource expertise, and we were very concerned about our ability to address the rising tide.

Given that it's Alzheimer Awareness Month, in your package you will find information on dementia, but if you're not aware, in Canada today, 750,000 Canadians are living with some form of dementia, and that number will double over the next 20 years. One in 11 over 65, and one in three over 85, have some form of dementia. It is the third most expensive disease in Canada, and one that we desperately need a national dementia strategy for.

From a governance perspective, we recognize the need for more strategic management, financial capability, clinical services and fund development.

We also recognize that the LHIN had increasing expectations of our organization from both a reporting and an accountability perspective. So what did we do? We formed a new organization called Dementia Alliance, which is made up of three board members from each of the local societies, and it became the umbrella organization, which is funded by the LHIN.

Some of the benefits we experienced when we integrated—since a lot of this legislation is about integration, I thought I would share with you. Most importantly, in the first few years, we were able to more than double the number of individuals we served without comparable increases in funding. We were much more effective. We were able to look at best practices in each of our communities and borrow those ideas and implement them in others.

We do have more flexibility and we are able to respond at the local level. For example, in a community like Haldimand-Norfolk, which is very rural, we're able to have our staff go into the homes to provide counselling support.

In Hamilton, we now have staff located at the North Hamilton Community Health Centre, which is an area that has its own unique needs.

We have a broader and more diverse staffing pool that can help address some of the unique communities in our LHIN. We have aboriginal staff. We have francophone staff. We have individuals from multiple ethnic backgrounds who speak many languages. Because we now cover a large area, we can call on those resources when needed.

We were able to standardize our practices and improve our performance management. Now we have a director of operations who has developed quality tools, and quality is a big discussion today. I'm pleased to say we now have a quality improvement plan and we're moving towards accreditation. We could not have done this as standalone, little Alzheimer societies.

In terms of the actual legislation, I want to share with you an interesting story. When we went to become a voluntary integration—as you know, you have to apply to the LHIN to become voluntarily integrated. So we went through all of the process; we did all the paperwork. We did everything right, and then what was so strange to both myself and my board members was that the legislation speaks to—the LHIN has the power to oppose an integration from proceeding, but it doesn't speak to anything about supporting integration. That's something you might want to think about when you're looking at the legislation. The letter we got back was, "We're very pleased to tell you the LHIN will not stop the proposed integration," which we thought was a little bit funny.

Now I want to speak a little bit about the value of local engagement in this LHIN. I'm from a relatively small community organization that covers most of the LHIN. In the past, we were not included in planning tables. The hospitals would get together and the community agencies would get together, and the community health centres. Now we have forums where all of these different players and our citizens are coming together to plan for our health care services.

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I was part of the steering committee for the last integrated plan, the action plan, and we had representation from public health, from school boards, from citizens' groups. More and more, the community agencies, which were never included at the tables, have a voice.

So we have a patient flow steering committee that's looking at alternate-level-of-care issues in the hospitals. Thank goodness everyone has realized that community agents have to be a part of the solution, because these people need to come home to the community, and the community is going to be the answer for many of our health care issues in the future.

I also want to share a very exciting process I was involved in with the Behavioural Supports Ontario initiative. We were looking at how we were going to implement services at a community level. There's a long-term-care initiative, but this was at the community level for individuals with cognitive impairment who have responsive behaviour.

So we got together, and a group of community providers met every week for six months. We involved citizens' groups. We involved consumers. And we identified a need for service that was very different than any of us had ever thought we would have generated: There was nothing for families after hours or on weekends. So now we have a community outreach team that's located in our existing mental health crisis teams. We built on existing services, and we're helping to enhance their capacity. So we're very excited about how bringing all these great minds together does make a difference at the local level.

What we are seeing as an organization—you've heard it in spades, I'm sure—individuals want to stay in their homes, particularly older citizens. Recent investments in community care are helping with this, and they're certainly helping to relieve some of the pressures on our hospitals and our emergency departments, and we know that it's more affordable to invest in community care. But our community sector is really struggling these days. We've had frozen base budgets.

For my organization alone, while we've had new services funded, we have to raise $700,000 every year of

our $4.2-million operating budget to deliver LHIN-funded services, and I am not unique. There are many other charitable organizations across the province that are in similar situations.

In conclusion, I think the principles of the act are good. We believe strongly in local planning and accountability, community integration and co-operation, but let's not forget that coordination and engagement require time and resources. That's a tough thing to do in times of diminishing resources. I don't know how you're going to do it, but we need to do that work, particularly at the local level, but it takes time and human resources.

We also need to emphasize prevention and health promotion more. I support many of the submissions you've been hearing about the inclusion of public health. We know, I know, as an organization, that if we put money in the front end of the services, and we do more on the health promotion, individuals are slower to develop dementia—we have exercise programs—or they live a better quality of life with chronic illness.

One of the other things I meant to mention is LHIN boundaries. I'm an organization that crosses three LHIN boundaries. That's not easy, and the LHIN boundaries really don't make sense to me. I'm sure they do to you—

Mr. Mike Colle: Oh, they do?

Ms. Mary Burnett: I know there was a reason—hospital discharge planning—but communities think about geopolitical lines. We are the county of Norfolk, or the Halton region, and it's very hard when you're split—Burlington is one LHIN, and north Halton is another, and Norfolk county, God bless it, has a whole corner that's off with London. It's very difficult.

Everybody has the best intentions. Our LHIN, the Hamilton Niagara LHIN, has been very supportive, but it's hard to coordinate services or communicate across LHINs. I have to tell you, I'm a pretty assertive person, and I haven't been successful in really raising the needs of the people in the outlying LHINs as well as needs to happen.

Last, but not least, I want to put in that I think that local solutions are essential in times of diminishing resources. Dr. Sinha certainly told us about the need for strong communities. There's some cool work being done in palliative care that's looking at compassionate communities.

All of that, though, needs also, I think, an investment in volunteer coordination. Nobody talks about that. I want to put a plug in here, because I think the answer for many of us in the future is going to be creating natural systems of support and building communities that wrap services around us as we age.

In your package, you have lots of information on Alzheimer awareness. The Alzheimer Society serves people with any form of dementia. Please take a moment to look through those, and I will entertain any questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about five minutes left, so we will start with the third party. Ms. Taylor.

Miss Monique Taylor: Good morning. Thank you so much for your presentation. Thank you for the work that you're doing. Hamilton has the largest population of seniors for the LHINs, right?

Ms. Mary Burnett: Yes.

Miss Monique Taylor: —and a growing population, right?

Ms. Mary Burnett: We do.

Miss Monique Taylor: Absolutely. We're aging quickly, and we're going to be coming into what I see as a crisis period.

Then you mentioned that your base funding has been frozen. What are the talks about coming into the future and the need of your society?

Ms. Mary Burnett: I'm sorry. The first part of your question was, what are the—

Miss Monique Taylor: What are the talks that are happening with the LHINs, with the problem of your base funding being frozen and the deficit that you already—I mean, you're fundraising $4 million a year?

Ms. Mary Burnett: No. We're fundraising $700,000 of our $4.2-million budget.

Miss Monique Taylor: Oh, sorry. Okay.

Ms. Mary Burnett: I'm not unique. Many organizations across this province—hospitals—are in the same situation. But I would argue that the community support sector never received the infrastructure funding that larger organizations did. Many of us were voluntary, volunteer-led; we were funded by donations. But now, the needs that have shifted to the community sector are much higher, so we now have all regulated health professionals working for our organization.

Ten years ago, we were more of an information and referral—we were more upstream, as you say—but as the needs of individuals in the community increase, so do the needs for our services.

We continue to fundraise. We have a fundraising professional. We meet with the LHIN. We identify new needs. But I don't think I'm unique in saying that we have a pressure, from an infrastructure perspective.

Miss Monique Taylor: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Mr. Flynn?

Mr. Kevin Daniel Flynn: Thank you, Mr. Chair, and thank you, Mary. Good to see you again. Thank you for coming again. It's good to see you here.

Ms. Mary Burnett: Nice to see you too. Thank you.

Mr. Kevin Daniel Flynn: You've done a great job. Your organization has done a great job alerting the decision-makers to what's going to happen in the future if we don't come to grips with this in a strategic way.

If you can get beyond the boundaries—and sometimes the boundaries make sense strategically and sometimes they make you scratch your head, so I agree with you on that. If you can get beyond that with the LHINs, they seem to be a vehicle where we could make some of the changes that you're asking us to make for your specific issues, for Alzheimer's and related dementia. How could you see us improving that process?

Ms. Mary Burnett: Absolutely. I think that we are going to have to continue to plan at a local level, so it's

really at the community level where we're seeing the biggest gains. When we start to come together as organizations, as faith groups, as neighbours, to support the aging population, we will—I think there's a lot more that we can do, but I think we need to invest in volunteer management—volunteer engagement, not management. We have a huge seniors population that's healthy and well, as Dr. Sinha reminded us. We need to get them engaged in being part of the solution.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation, Ms. Burnett. It's really interesting, and I'd like to follow along with what you were just commenting on. I really believe in the power of local volunteers as well and their ability to support people with Alzheimer's. You're doing great work in the community.

One of the things where I think there's an area for additional support is in respite services. I think there's a lot of volunteer work that could be done there. I'm wondering if you could expand a little bit on how you see volunteer engagement could be very supportive to your organization.

Ms. Mary Burnett: Absolutely. We have respite services that are offered through a volunteer visiting program. We also are building circles of support. When we meet families at the front end of this disease, we tell them, "Don't expect that you're going to get 24/7. You need to start thinking about how you're going to come together to support your family member with dementia, because there aren't going to be enough health care resources."

But I think we need to invest in good volunteer coordinators who can go out and recruit, train, thank and support our volunteers in our communities. All of our clients want more respite, and they want in-home respite, and they need consistency of respite.

1020

Mrs. Christine Elliott: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It was very much appreciated.

I want to say that, even through the snowstorm last Saturday, our Walk for Memories was a great, successful event. Thank you.

Ms. Mary Burnett: Thank you very much.

VON CANADA

The Chair (Mr. Ernie Hardeman): Our next presentation is VON Canada: Linda Lopinski. Linda is the manager of external relations with VON. Welcome to our committee meeting this morning. Thank you very much for taking the time to come. You will have 15 minutes to make your presentation, and you can use any or all of that for your presentation. If there is less than four minutes left over, we'll go to the third party; if there's more than four minutes, we will divide it equally, starting with the government side.

Ms. Linda Lopinski: Thank you. Good morning, everyone. My name is Linda Lopinski. As has been mentioned, I'm manager of external relations for the Victorian Order of Nurses for Canada and the HNHB LHIN. We are a LHIN-funded health service provider here and in many other jurisdictions in the province of Ontario, as well as being a national charity.

Prior to joining VON, I was with the Waterloo Wellington LHIN as their senior consultant for community engagement. In that capacity, I had the opportunity to work with the Ministry of Health to develop the current LHIN community engagement guidelines and tool kit, and also to conduct many conversations with health care consumers.

It is with that background and experience that I offer my comments today, and I would like to thank this committee for providing me with the opportunity to do so.

As a community engagement practitioner, I applaud the committee's commitment to hearing from a broad range of stakeholders. I come with no new data for you today, but rather to provide you with some street-level perspective that I hope will bring additional context to the data that others have assembled for your consideration.

In following the dialogue in previous sessions with this committee, it appears that there are running themes to the presentations and to the questions. One of those themes is, are the LHINs achieving the integrated health system that we want for ourselves, as Ontarians?

It's no surprise that the review of LHSIA has become a review of LHIN performance. Performance reviews are a valuable way for an individual or an organization to understand the way in which they can refine or improve their work. As such, it's important to see this as an opportunity to review the performance of our entire health service provider community, with the LHIN playing a leadership role.

The LHIN is but one entity within the local health community, and LHSIA also created expectations for us as funded health service providers. That's not to minimalize the importance of the LHINs' role in leading the integration of local health.

To understand what we have achieved as a service provider community, it's important to reflect on where we started. Change in health is a big order, and we don't have the option of shutting down the plant to retool. That means that we have to both change service and offer service simultaneously. This requires that our local health service provider community be in a constant state of "plan, do, study and act." It requires that we maintain a culture that is in constant movement and prepared for change. Some may recognize that as the Deming cycle, one of many change-management theories, but one that has demonstrated significant success in other sectors.

It's also important to acknowledge the scope of change that is required to see us achieve our collective goal for an integrated system, and also to recognize that change and process improvement must be continuous.

VON is one of a hundred community support service agencies in this LHIN; add to that 10 hospital corpora-

tions with multiple sites and somewhere in the neighbourhood of 86 long-term-care facilities.

Prior to regionalization under the LHIN structure, each agency worked their own plan, set their own agendas and essentially proposed measurements for their own performance, although they may have additionally contributed to informal networks with no authority to act in concert. However, we are evolving as a service provider community. Since authority for local health service provision was delegated to the LHINs through LHSIA, service providers are required to share plans, partnerships, goals and objectives in an unprecedented manner.

Partnerships and planning that were unheard of even five years ago are happening, including cross-sector conversations. Hospitals are talking to community support service agencies, with greater awareness of the shared responsibility to alleviate the pressures on things like ER services, for example. Agencies are forming partnerships with non-traditional health partners such as social housing and developmental service agencies.

Although we have not yet reached our goal for an integrated health system, shared planning, shared goals and objectives are foundational to achieving this. This can only be accomplished when a local authoritative body such as the LHIN sets expectations for a shared agenda.

As an agency that has invested a number of years in this collaboration, we support the need to continue this dialogue. If it was not to be a LHIN in its present form, the local leadership and coordination role would still be critical to the change agenda. The not-too-distant history supports this. Some excellent work was done by the old district health council: lots of great research and planning. But with no authority to direct health service providers, we moved no closer to an integrated system.

More recently, if you look at the seniors' exercise initiative that was rolled out in 2013, we see an example of what happens when funding is distributed centrally but without the benefit of local intelligence. Kudos to the province for taking steps to better control the investment in seniors' exercise, but this initiative would have benefited from more direct local involvement in the planning process and avoided significant frustration for seniors and their residential care providers.

Although there continue to be concerns and criticism of the LHINs and the health service providers for the manner in which we have fulfilled our obligation for community engagement, I would offer, as a community engagement practitioner, that we are now achieving some aspects of true engagement, because true engagement is not episodic, although events are an important tool for gathering information. True engagement happens when the dialogue is regular and ongoing, and we have seen it develop amongst the service providers and the LHIN.

We have work to do in the area of better engagement with the consumer public, but this is still, in many ways, a developing art and the subject of study and dialogue in the world of professional networks for community engagement practitioners like myself on how to better involve the consumer community, achieving that ongoing, meaningful dialogue while providing individuals with realistic expectations for how their feedback can influence decisions.

I say "can" because "needs" are sometimes synonymous with "wants" with the consumer public—and, in truth, for the health service provider community as well, who are eager to assist by jumping to solutions. However, like individual agencies, one voice does not always reflect all voices, and input can only be informed by our own experiences. Collectively, our goal is a client- or patient-focused system. In such a system, both wants and needs carry weight in the decision-making process. That being said, with limited budgets, there are only so many wants that we can afford, and perhaps these have to be prioritized by need.

The final outcome of that prioritization will always leave someone wanting more or different services. The agency that has the responsibility to set that prioritization will never be popular.

In the discussion of "wants" and "needs," it's also important to recognize the importance of choice in a client-focused system. As a community, we place high value on the concept of choice. An example of this in health can be found in the choosing of long-term-care facilities. Consumers and their families may choose to limit their choice to one facility. There is a cost associated with offering consumers choice in health. With the long-term care example, that cost may be higher ALC rates. As a community, we need to determine whether these costs are acceptable or not and how choice should be weighted in the debate of wants, needs and prioritizations.

With those thoughts before you for consideration, I understand that this committee is looking for recommendations, so I also offer the following for your consideration. As health service providers and the LHIN work on an engagement practice with the consumer community, we believe it is necessary to bring primary care to the discussion and planning process on a more consistent basis. As others have commented, primary care is pivotal to providing care, particularly to the frail seniors who are the service focus for VON's community support services in this LHIN and others. Although some primary care providers do voluntarily work with others, we need this to happen consistently and we need to share goals and measurable outcomes. The voice of primary care is important to the discussion of want, need, choice and prioritization.

To achieve this, the LHINs need authority to require primary care's participation with some form of accountability agreement. Some may feel that primary care already has a responsibility to participate in the process of change. However, responsibility is different than accountability. Responsibility can be given; it can even be assumed. But that doesn't automatically guarantee that accountability will be taken. Accountability agreements are the best way to solidify a commitment to shared goals and measureable outcomes.

Additionally, we would recommend in favour of allowing LHINs to carry funding over the end of the

fiscal year. As a service provider community, the cycle of "spend it or lose it" in-year impacts our ability to plan and execute effectively, as projects are tied to the funding cycle when they should be tied to an implementation schedule that makes sense from a client service or a project perspective.

In closing, I would again thank you for your attention today. I would also like to leave you with a final thought. Some believe this journey started eight years ago; some say four. But one thing is certain: When we started on this path, we knew the destination, but no one provided a map. We're in a better place than we were. The work is encouraging to us, as health service providers, and it's important that the collaboration continue. Thank you.

1030

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have six minutes, so we have two for each party. We'll start with Ms. Jaczek.

Ms. Helena Jaczek: Thank you so much for coming in and expressing your thoughts and giving us a good overview of, I guess, all of our desires to see more integration. You mentioned involving primary care, and you're talking about that through an accountability agreement. You're an experienced person. You know that physicians are very often, still, in this day and age, solo practitioners and are not used to, perhaps, the type of collaboration that, I guess, we would all envisage. How would you suggest engaging the primary care community with a view to having them understand the value and so on? Could you give us kind of a bit of a road map as to how we might roll this out?

Ms. Linda Lopinski: I guess my comments, in relation to an accountability agreement, actually relate to, again, based on experience, having been on both sides of the fence—both having been on the engagement side of the LHIN fence and also currently working within the health service provider community.

I agree with you: Physicians, as a community, have always been one of the toughest groups to engage. But the reason for that is that they do not see themselves within the accountability chain. They see their work as being related, for sure, and very impactful, of course, to the client care that's provided, and I think they recognize the impact that it has on funded services, but they don't feel an obligation to participate in that conversation on an ongoing basis.

An accountability agreement—I guess the way it's labelled, it sounds very heavy-handed, but it really doesn't have to be. Maybe it's a memorandum of understanding, like whatever that relationship has to be. But I think we do need to find some way to actually craft out those shared goals. Like many other situations, sometimes having a commitment to something on paper actually makes it easier for people to stay focused on the same goals and ensure that we're having the same conversation.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation today, the good solid recommendations. I'm interested in the second one, actually, about allowing the LHINs to carry forward funding from year to year. It certainly makes sense from a planning perspective. If you want to do beyond one- or two-year planning, you need to be able to have the funds to be able to carry it out. I'm wondering if you could give us a little bit more of an understanding of how you would see that happening.

Ms. Linda Lopinski: Well, I'll give you a direct example of what happened this year. We were successful in our application to the LHIN to receive funding for a new project that is focused on seniors with developmental disabilities. This is a community that has not gotten a lot of attention. As a matter of fact, this is not a community that anyone even planned to exist. People with developmental disabilities often did not live past their forties. We are now seeing seniors in the community who are in their sixties living with their 80-year-old parents.

We did propose to the LHIN, with a community investment round this summer, that such a project be implemented. We are moving forward on that basis. It puts a different kind of pressure on us as a health service provider to ensure that that has to happen within the funding year, because now—even though it's new; it's a new community; it's a new program—we have to also plan to have this implemented before the year's end to ensure that the money is spent within that funding cycle.

If the LHIN had the opportunity to actually carry that money over, we could perhaps plan more effectively and take the pressure off, because some of—I wouldn't say they're barriers—the things that are creating some pressures for us are, we're working with Developmental Services Ontario, which is an MCSS-funded agency. They do all the intake and the assessments for seniors who have developmental disabilities in relation to their support needs. They do a fulsome—their assessments are four to six hours in length. There's only so many of those that they can actually fit in within their system, and they aren't funded by us, so they answer to another ministry entirely. So we're putting pressure on them; they're not necessarily able to—

The Chair (Mr. Ernie Hardeman): I'm sorry to cut you off; we're very stuck on the time.

Ms. Linda Lopinski: My apologies.

The Chair (Mr. Ernie Hardeman): Miss Taylor. Oh, Ms. Armstrong.

Ms. Teresa J. Armstrong: Thank you for presenting. I found your suggestions quite interesting and very forward-thinking with regard to engagement and how it best accomplishes the goals of an agency to continue, change, plan and so forth.

One comment I was interested in was your senior exercise program. You had mentioned how that could have been done better. Can you elaborate on that, how that would have benefited your agency if there was—the perspective from what you can see—more consultation and more engagement?

Ms. Linda Lopinski: In this LHIN, VON is a service provider for the falls/exercise initiative in 80 locations.

What we found is that when the funding was announced and when things began on August 1, we didn't necessarily have a fulsome understanding of the community in which we were working. Although the province planned—again, the numbers all work and it's great, but we're going to have exercise classes that have 35 people in them and they're going to be open to the public. There wasn't necessarily an appreciation for what was happening at the residents' end, where a retirement home may only have a room that holds 15 people, and there are hoops to be jumped through in terms of allowing people from the outside in, right?

We have now jumped a lot of those hurdles, so I think things are going very well now. I think it got off to a bit of a rocky start, and I actually had to spend a fair bit of time myself travelling around to those locations in the LHIN, helping seniors to understand what we were trying to accomplish and how they were going to benefit from it. If we had been able to perhaps execute on some of that education first, and then introduced the initiative and took into consideration the limits on room sizes and all of those kinds of things, it would have rolled out more smoothly than it actually did.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate your insights.

Ms. Linda Lopinski: My pleasure. Thank you.

MR. JOE McREYNOLDS

The Chair (Mr. Ernie Hardeman): Our next presenter is Joe McReynolds. Thank you very much for joining us today and putting your time in to come here. We will have 15 minutes for your presentation. You can use all or any of that as you see fit. Any time left, if it's less than four minutes, will go to the third party, is it? Anyway, it will go to somebody. If it's more than four minutes, it will be split equally among the parties. With that, the floor is yours, and we thank you very much for being here.

Mr. Joe McReynolds: Thank you, Mr. Chairman and members of the committee. Good morning and thank you for the opportunity to present. You're getting a copy of my presentation and, as you will see on it, I'm somebody who has spent almost 50 years in the human service sector, so I come to you with some expertise from learning what I've done through those years. I was a founding chair of one of the LHINs, so I have the experience of doing that. I've been in a district health council system. I've been throughout the provincial government for a number of years etc.

What I come to you today about is to support the concept of the LHINs because health care is a very extremely complex system. Our own health system is a very amazing system in itself; it's so complex. The structure: We have thousands of independent providers in this province and the nature and the size of those providers vary greatly. Across the world, there's a change going on from a medical model to a population health model. These changes all make the delivery and planning of health care very complex. So we need, in Ontario, a system that will establish a process for planning and delivering services at a local-based level. The LHINs are a tool to do that. I believe, personally, that they are the powerful answer to the requirement we have to deal with the complex system that we have, but they must be given more freedom and more authority if they are to build a sustainable health service system.

Other provinces, as you probably know well, control and staff their own services. Ontario has chosen to harness the resources of communities through local boards and service units and, with this approach, it makes tasks for the system coordination and system integration much more challenging. But I believe the value of the local control and the involvement of local volunteers and resources help the Ontario approach to be more aware of and more responsive to the needs of our local communities and local residents. For that reason, I think we need that process, and I think the LHINs are a good start in that direction.

Now, I'm not going to speak to why I value the LHINs because I think you can read it. They're good system planners, they're excellent system managers in the service accountability agreements, as an example, that happen now across the province. What we experienced when we started the LHINs were many deficits occurring. Today, you do not find those deficits in the health care system. That's a result of the impact of the LHINs in our system. They're obviously engaging local communities and, I think, doing an excellent job of that, and they are a neutral body of change. They really do, in their Integrated Health Service Plan, provide one of the best planning models that we see probably in the world. The depth and the comprehensiveness of those planning processes really gives anybody who has the time—and I must say, it does take a lot of time to read them, because they are up to 1,000 pages in many cases. So if you have the time to read them, you get an incredible view of what's happening in your local communities.

1040

Okay, let's move on to what I think should be changed, what I would recommend to you.

First of all, I would implement all the authority that is in the current legislation. LHINs were supposed to be able to allocate and reallocate resources to provide the goals of an integrated health services system plan. What I see happening after eight years is a continuing failing to change policy and practice that would allow the LHINs to allocate and reallocate funds to implement their plans.

Amongst you, as the political leaders, I see little support for or discussion of this aspect of the legislation. One example is the use of surpluses, and the previous speaker addressed that. The legislation does allow that, but currently, it has never been implemented.

Further, there were some examples in the early years of some discretionary funds being made available to the LHINs to be able to do the kind of change that has to occur. That's what the legislation expects. There has

been a reluctance in the system to do that, and a lack of support across the political parties. We are still dealing with what I believe is a quasi-regional office approach these days. It deserves much better from all of us at the moment.

Second, I'd expand the mandate of the LHINs to include primary care and public health, and previous speakers have spoken to this. Certainly, from a primary care point of view, unless we have the physicians and other care providers in the room, in the planning processes and in the management planning processes, it will not happen. Health links is an excellent example of moving in the right direction, but the leadership of primary care must be part of the planning process and they must be managed, along with the other health care services. The LHINs should have primary responsibility for that.

Everyone speaks about health promotion and well-being as part of the health care system, but our primary vehicle for public health remains outside the discussion. The ministry is currently recognizing the necessity for a stronger community health system, but the remaining foundation piece, the public health, which helps people understand what good health means and how to stay healthy, is not included.

As a member of the board of Health Nexus, which is a national organization that advances healthy communities through community development, early childhood development and aboriginal maternal health, I experience how much outside the system health promotion really is. Bringing the leadership and expertise of public health into the responsibility of the LHINs will move the health care system in the right direction.

Third, I would encourage the governors and senior directors of the LHINs to continue to plan a local health system within a provincial health care system, so that there is a common approach to system planning, system management and system change. It's all about systems.

In the past eight years, we have been challenged to ensure that there's a common approach to the roles and responsibilities of LHINs. Initially, there was a great emphasis placed on the local nature of LHINs. LHIN governors and executives are increasingly working to plan and manage in a more coherent manner. LHIN leaders need a legislative mandate to strengthen their collective partnership, so that residents can expect the same standard of service wherever they live in Ontario. This would allow LHINs to continue to explore how to manage the health care system collectively, while preserving the requirement to address local conditions.

Finally, one of my own pet peeves: Add the responsibility for ensuring not only that residents know about services, but that in every community, there's a way to help persons acquire the help to get services they need through what I would call system navigation for clients. At every community event I've ever attended, the common voice of the residents is that there's a need to find out what services are available and a need to help them manage navigating the system. Depending on the complexity of the need, this assistance can be delivered by a care professional or it can be delivered by a trained volunteer.

We are beginning to see the evolution of navigation across the province, but as the needs become more complex and there are more providers involved, we need somebody to help guide and sometimes advocate for us. LHINs should be mandated to ensure that the community has the necessary services of client system navigation.

I thank you for letting me share my thoughts with you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about six and a half or seven minutes left. We will start with the official opposition, and we'll have two minutes each.

Mrs. Christine Elliott: All right, that's great. Thank you very much, Mr. McReynolds, for your comments. You've raised some really interesting propositions. This concept of system navigators: Certainly we've heard a lot about that in the mental health and addictions select committee and currently in the developmental services select committee. I think there's certain client populations that will always need to have system navigators, but I think the system navigators in general health issues probably should be looked at as more or less a temporary thing until we get it sorted out. We should be able to have a system that people can navigate themselves. We've made it unduly complicated, I think, in some respects.

Mr. Joe McReynolds: Certainly, 75% of us should be able to find our way through the system if the system is clear enough to us; I don't disagree at all. But, as you say, it's the individuals who are suffering from various disabilities as well as the seniors who require some support and help through the system.

I have a daughter who is working in a TeleCheck system. They deal with 125 seniors a day who they check with—they check both physically and mentally where those seniors are each day, but they also help guide them through it. This is the kind of thing we have to see across the province if we are really going to deal with our most vulnerable people in our society.

Mrs. Christine Elliott: I agree with you entirely.

Do I have time for one more question, Chair?

The Chair (Mr. Ernie Hardeman): Very short.

Mrs. Christine Elliott: Okay. The other concept is that you talk about encouraging the governors and the senior executives of LHINs to work together to make sure that we have a common system across the province with variations for local conditions. Surely there's also a role for the Ministry of Health in that regard to set the tone, to establish the priorities, which the local organizations can then deliver upon. Could you comment on that and how you see the ministry fits into that?

Mr. Joe McReynolds: There's certainly no question that the government is responsible for setting direction and design in where we're going. But what I'm talking about is finding a way to help the LHINs have a more coherent process across the province. It may be as simple as putting something in that says they will produce an annual provincial report, as a group, about where they're going. I'm not sure, but we need to support that. A lot of

work is being done by the LHINs to do that, but it needs to be more.

The Chair (Mr. Ernie Hardeman): The third party: Ms. Armstrong.

Ms. Teresa J. Armstrong: I'm getting a little worried because I'm having some like-minded questions with the Conservatives here.

Interjection.

Ms. Teresa J. Armstrong: Yes, I think so.

One of the questions I had, and I'd like to maybe probe this just a little bit more—you talked about the need for navigation within the system. I actually did a health consultation, I can't recall when—in the last two years—where that was a very important piece. Where do you see that navigation happening for assistance with people wanting to enter—well, they're forced to enter the health care system. Where do you see that happening? At what point does that help the patient or person?

Mr. Joe McReynolds: At what point?

Ms. Teresa J. Armstrong: At which point should that service be offered to them? Where should they access that service?

Mr. Joe McReynolds: For me, it happens in the local community, when they are at the point where they are looking for something. We may be able to educate a good neighbour in the community to do that. We may need a professional, depending on the complexity of it. But the LHINs should make sure that, in every community, that kind of a system exists, is what I'm saying.

Ms. Teresa J. Armstrong: Okay. The feedback that I had gotten was, when people are in the hospital, that's when they're most in need of that information. They're not feeling well, and that's when all the information comes to them; it's bombarded to them. Most people aren't going to look for that navigation assistance until they want it, until they need it, right?

Mr. Joe McReynolds: There are those who are in the hospital who require supports—

Ms. Teresa J. Armstrong: Yes. It's at a crisis point there.

1050

Mr. Joe McReynolds: And the hospitals have and continue to try to make that linkage with the communities etc., but for people who are in the community who have mental health problems or are aging etc., it's more of a gradual process.

Ms. Teresa J. Armstrong: Okay. So you see that out in the community, not necessarily in hospitals when people are in crisis.

Mr. Joe McReynolds: I see it more in the community.

Ms. Teresa J. Armstrong: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek?

Ms. Helena Jaczek: Thank you very much. Mr. McReynolds, I've just been waiting for someone just like you to come before us, because this is a question directly related to the legislation.

I'll share my bias: The chair of my LHIN has found that the need to have a health professionals' advisory committee, which is specified in the legislation, hasn't really panned out to be what was anticipated. In other words, there does not seem to be a real utility to having that committee in place. Could you comment, from your experience, on how that worked and how you feel about that being in the legislation?

Mr. Joe McReynolds: Well, I'm probably going to insult some of my friends on this one. I mean, it was put in place at a time when there was a lot of small-p activity going on in the LHINs etc., so it was put in place to really be expert advice to the executive levels of the LHINs. I think we lost a little bit by not finding a way to link it to the governance levels of the LHINs as well.

Perhaps that is what's going to make the difference, because I think that's where there's a feeling—nobody's really nailed it down, but there's a feeling that they are not as effective as they could be. I think it's because it tends to be more of a technical advisory committee at the moment.

Ms. Helena Jaczek: So would you see actually having the chair of that advisory committee sit on the board of the LHIN, or how would you—

Mr. Joe McReynolds: Now that's an interesting idea. It could happen that way, but they certainly should be invited in on a regular basis to have dialogue with the boards of the LHINs if they don't have direct representation.

Ms. Helena Jaczek: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Thank you very much for your presentation. We very much appreciate you being here.

Mr. Joe McReynolds: Thanks.

HAMILTON HEALTH SCIENCES

The Chair (Mr. Ernie Hardeman): Next is Hamilton Health Sciences: Murray T. Martin, president and chief executive officer. Thank you very much, Mr. Martin. We very much appreciate your time coming in this morning. As with other delegations, you'll have 15 minutes to make your presentation. You can use any or all of that time. If there is time left over, less than four minutes will go to an individual party; more than four minutes, we'll split equally to all caucuses for questions. With that, thank you very much for being here. The floor is yours.

Mr. Murray Martin: Thank you, Mr. Chair, and thank you for the opportunity to present today. Hamilton Health Sciences is the organization that consists of McMaster Medical Centre, McMaster Children's Hospital, Hamilton General, the Juravinski Hospital and Cancer Centre, St. Peter's Hospital and Chedoke Hospital, and we were just advised a couple of days ago that our amalgamation with West Lincoln Memorial Hospital has now gone through.

That makes us one of the largest health care organizations in Ontario, and we actually provide the broadest range of services of any health care organization in

Ontario. This is particularly an honour as it, in actual fact, will be my last official duty, as I actually retire this Friday after 43 years in health care.

I was actually raised in Regina, Saskatchewan, and I recall when Premier Douglas introduced medicare in Saskatchewan. My family moved to a new neighbourhood, and our next-door neighbours were a family doctor who was in private practice, and our other neighbour was the doctor the government brought in from the UK to set up community clinics in the province. I had the honour of shovelling both of their driveways; they both paid very well—one, of course, for the season and the other on a shovel-by-shovel basis. That was my first health care experience.

In my 43 years, I did work 13 years of it in Saskatchewan, 10 years in British Columbia through multiple versions of regionalization, and then the longest stretch, 20 years, in Ontario. During that time frame, I've certainly seen a great deal of change: In my 10 years in British Columbia, there were three versions of regionalization. That was between 1991 and 2000, so certainly the LHIN structure in Ontario has been relatively stable to change in health care structures elsewhere in the country.

What I've experienced being, in my mind, the key driver of success—yes, it does have to do with structure, but it more than anything has to do with relationships. I believe that, within our province, with the LHIN structure, where relationships have been strong, you've seen strong deliverables from the LHIN. I have a particular bias, in that I do believe our Hamilton Niagara Haldimand Brant LHIN has been, if not the most successful LHIN, one of the most successful LHINs in this province. That is because of the fact that 25,000 health care providers in our LHIN see themselves as all being part of one team, with common goals and a very, very strong sense of partnership.

The relationships have been built around trust and a common purpose, but there truly is an understanding that we all collectively want to achieve the same things for our population that we serve. It is recognized that around the world, it's a challenge for health care systems everywhere to cope with the rate of change and the growing demands on health care services and the financial limitations that exist everywhere around the world.

One of the reasons that I do believe LHINs have been successful is that they've actually given us some defined geography within which it's understood that we are collectively accountable. When I first came back to Ontario in 2001, prior to LHINs, individual hospitals saw themselves as individual entities with accountability only to the province, and they didn't see a greater sense of accountability within a community.

Within our LHIN, we actually have the highest capture rate in the province. What that means is that we service within our LHIN 92% of our population, meaning far fewer than many others need to go outside of our LHIN. We have a LHIN that has critical mass. In actual fact, to do things, to drive efficiencies, you do need scale and to have that scale, again, you need critical mass. That does allow you to create centres of excellence and drive efficiency. We do recognize that—or maybe it's not often recognized—that the size of our LHIN, with a million and a half people, is actually larger than six of the provinces. We do have that scale, and, again, I do believe that is essential.

For the future, what I'd like to see is the system move to a more decentralized model with autonomy at the LHIN level, and I'll use my example dealing with local issues, such as alternate-level-of-care patients. Our own experience in our LHIN is that the ALC issue was not an issue elsewhere in the province until it became an issue in Toronto, because there is this, in our belief, over-focus on the needs of Toronto, and then solutions are created in response to what may be going on there.

Two recommendations that I would make, and this does come from my experience, particularly in British Columbia, are that I actually do believe that public health needs to become part of our LHINs, and also, I'll add in the ambulance system. I actually believe the ambulance system should be part of LHINs. My early years in British Columbia, they were part of the municipal level, and it was simply done on the basis of trading of greater responsibility for—one service that the province held was transferred to the municipal level in trade for the province taking over public health and LHINs; I think it was in the communications sector. So it certainly is doable and it would, I think, recognize the key roles that those services play in our system.

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The ministry's role needs to continue to focus on providing health system goals and on the development and accountabilities around standards. There are perhaps some changes to the act that created LHINs that do need to be made, but overall I actually think that the act is fine. The act outlines a robust way to decentralize, but I do not actually believe that it is executed in the spirit that it was originally written and certainly not in a spirit of decentralization. We still see a lot of one-size-fits-all; there is a perspective of the need for centralization. In my time in health care, I've seen health care become far more bureaucratic than it was in the past or than I believe it needs to be.

We have seen that the outcome of the focus on issues like eHealth and Ornge is to implement centralized contracts to try and ensure no recurrence, but I do believe there's little thought that, at times, the cure can become worse than the disease itself. It does have an impact of stymying innovation, and we really have to do a better job of thinking through what we're trying to achieve.

Living and working across Canada, I do know that the people of Ontario are blessed with an outstanding health care system, made possible through highly skilled and dedicated health care providers. I am a strong, strong supporter of the role and value of LHINs. I do believe that they can be strengthened, but in that strengthening, it has to be part of a willingness on the part of government to live with a more decentralized system to allow LHINs to achieve what they were originally set up for.

Thank you very much for the honour of presenting.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have two minutes for each caucus. Remember, as you get to the last question, the answer has to be part of that two minutes. We start with the third party.

Miss Monique Taylor: Thank you so much for your presentation. Congratulations on your retirement. I know you've worked long and hard for that, and I hope that you'll keep in the health care realm as you move forward.

It was interesting that you brought up the ambulance service and how that should be brought into the LHINs. I know that here in Hamilton, with the changing of McMaster hospital into a child emergency centre, the paramedics were a big factor when it came to the city and the extra costs that were put on the city with the change in the paramedics and the increase of their budgets. Can you expand a little further on that?

Mr. Murray Martin: It is a matter of incrementally—some parts of the system's costs may go up, but if it actually achieves the overall benefits. I am obviously a strong advocate that what we achieved around our service realignment—people are far, far better off as a result of that. There were certainly offsetting costs in other parts of the system that more than accommodated the increased costs of the ambulance system.

But through that process, it would be, to me, a best example had we been part of the same accountability—that that would have been far easier to accomplish and we could have come up with perhaps even some more effective ways of dealing with it.

Miss Monique Taylor: Because as it sits right now, those costs went onto the municipality. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Mr. Flynn.

Mr. Kevin Daniel Flynn: Thank you, Mr. Chair, and thank you for your presentation. It's only Tuesday; you're retiring on Friday. What are you doing for the rest of the week?

Mr. Murray Martin: Believe it or not, I actually have a board meeting on Thursday night.

Mr. Kevin Daniel Flynn: Best wishes for a really happy retirement.

There seems to be—I'm just sitting in on the committee for the day—a sort of common thread emerging just from the presentations I've heard in Hamilton this morning, in that it's a good framework; it's a sensible process; there's room for improvement. You want to bring in primary care; you may want to bring in public health. I live in and I represent a riding in the Mississauga Halton LHIN, and I've had a tremendous relationship with my LHIN. Anytime I've had to work with the Hamilton Niagara Haldimand Brant LHIN, the response has been tremendous as well.

So I'm wondering—we're talking about the accountability to LHINs of community care or agencies—where do you think the accountability of the LHINs should lie and where should it go?

Mr. Murray Martin: I didn't touch upon primary care, but it's very, very clear to me that there needs to be a stronger alignment of the primary care system with LHINs. It's obviously going to be a challenge to actually get there, for reasons that were referred to earlier, but that is a disconnect. I think when the Canadian health care system is compared to particularly European systems, it's because of that misalignment that we don't do as well and fare as well as other health care systems. I think it is absolutely the elephant in the room and that we have to come up with an effective way.

At the end of the day, the government pays the $11 billion that pays physicians, and so it has to be able to define what it expects, from an accountability point of view, for that money spent.

The Chair (Mr. Ernie Hardeman): Thank you very much. The official opposition: Ms. McKenna?

Mrs. Jane McKenna: Yes, and I'd like to also echo out what other people have said. When we hear your name mentioned out in the community, you've been a staple for us and you will be missed. You have worked extremely hard for Hamilton Health Sciences, and we are very grateful for all your hard work and dedication. So for that, I'm very grateful and thankful.

You said that the act is fine but the spirit of centralization is not. Can you just elaborate a bit on that?

Mr. Murray Martin: There's the inability to problem-solve at a local, regional level. So if we look at our alternate-level-of-care issue, unless it fits into what the provincial strategies are, it almost feels like hit-and-miss as to whether we make progress.

There would be the ability, in terms of moving resources out of acute care hospitals into the community, if we could actually use that money, to actually create the resources that we need. But that's really not possible within the stovepipes that our system still operates. That would be the biggest and the best example that I could think of.

Mrs. Jane McKenna: If there was one thing—for 43 years, you've been doing this. You would be a wealth of information, with all the things you have seen. What is the one thing that you can think of for us today, to take back, to make the system better? I guess that's kind of a hard question to ask, but what would be one thing, just off the top of your head, that would—

Mr. Murray Martin: The one thing, to me, would be the stronger alignment of the primary care system with the goals of the overall health care system. That's where you'll make your greatest level of progress.

Mrs. Jane McKenna: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation today, and good luck in your next career.

Mr. Murray Martin: Thank you very much, Mr. Chair.

The Chair (Mr. Ernie Hardeman): I'm sure there's one out there waiting. Thank you very much.

HAMILTON NIAGARA HALDIMAND BRANT LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Next is our Hamilton Niagara Haldimand Brant Local Health Integration Network: Donna Cripps, chief executive officer. Good morning, and thank you very much for joining us this morning. As with the previous delegations, you will have 15 minutes. Use any or all of it for your presentation. Anything that's left over will be used in questioning from the caucuses.

Ms. Donna Cripps: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you. The floor is yours.

Ms. Donna Cripps: Good morning. It is indeed an honour to be here. I'd like to thank the members of the standing committee for this opportunity to address you today.

My name is Donna Cripps. I'm a wife, a mother, a daughter and a sister, and in all those roles, I've either been a patient or a family member who has experienced our health system.

I've also had the opportunity to be a provider within our health system. I was a registered physiotherapist who had the privilege of providing hands-on care to patients for more than 25 years. I continue to be a proud health care leader, formerly as the president and CEO of St. Peter's Hospital in Hamilton here, and currently as the CEO of the Hamilton Niagara Haldimand Brant Local Health Integration Network.

Our LHIN holds accountability agreements with nearly 200 health service providers that, together, deliver over 230 health programs and services, with funding of more than $2.8 billion. These programs are offered to the more than 1.4 million residents who live in the approximately 7,000 square kilometres that constitute our LHIN.

Today, I want to take time to tell you a story, a real story, of one of our residents, Bernice. While the story is accurate, I have changed Bernice's name and some identifiable information, to protect her identity. If there's one thing I hope that you can remember from today, it's the story of Bernice.

Bernice lives alone in her own home in a smaller, more rural community in our LHIN. The CCAC visits her every week and her children visit her frequently.

One day, Bernice falls at home and suffers a serious cut on her arm. Paramedics are called and Bernice is taken to the local hospital. The team in the emergency department treated her arm. She was discharged home the same day. Unfortunately, Bernice was unable to use her arm when she got home. She had trouble getting her meals, getting dressed and managing her daily activities. There was no follow-up planned and no information was shared with the CCAC or with her family doctor about her visit to the hospital. As it turns out, this fall was a foreshadowing of things to come.

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In fact, over the next 12 months Bernice had a number of falls at home, one of which resulted in a fractured hip. Again, Bernice was taken to the local hospital. It's a small community hospital, and it did not have the expertise to treat her badly broken hip. Bernice waited three days with a broken hip in her local emergency department; it took that long to find a larger hospital that could accept her for the surgery she needed. During that time, she lay flat on her back on an emergency room stretcher. Can you imagine how she must have felt? She was finally transferred to a larger community hospital for hip surgery. Bernice spent six months in hospital recovering and, sadly, her physical condition deteriorated significantly to the point that she could no longer return home and she was eventually discharged from hospital to a long-term-care home.

I'm afraid stories like Bernice's have been all too common throughout Ontario. While every part of the system provided quality of care for Bernice in their individual silos, when you look at Bernice's experience over time, you can see that the system did not treat her very well. In fact, if we cost out the care for Bernice from the time of her first fall and for five subsequent years, we see that the health care system costs were roughly half a million dollars, and the experience for Bernice was not acceptable.

At our LHIN, we're committed to dramatically improving the patient experience for every single person. This means that we need to change every part of our system, change the way we think and change the way we act. That is exactly what we're doing.

Over the past four years, and with the support and involvement of health service providers from across our region, changes have been implemented that would make Bernice's experience very different today. Let me quickly explain how Bernice's experience would play out in today's system.

As you know, Bernice lives alone in her own home in a smaller more rural community in our LHIN. The CCAC visits her every week and her children visit her frequently. One day, Bernice falls at home and suffers a serious cut on her arm. Here's where things start to become different. This time, the paramedics arrive at her home and they are able to treat her appropriately at home. They don't need to take her to the hospital. The paramedics contact her family doctor to inform him of her fall. Her doctor makes a notation of Bernice's fall on her electronic health record—we call it ClinicalConnect. The notation by the physician automatically flags the CCAC of a change in status of one of their clients. The paramedics suggest that Bernice might benefit from a geriatric assessment. The Geriatric Outreach Team comes to Bernice's home where they meet with her and her family. They make a number of recommendations to her physician for medication changes that will better meet her needs, as well as suggest that Bernice enroll in the local physiotherapy falls prevention class that has recently started at the local seniors' centre. At these classes,

Bernice meets other ladies her own age and gets involved with other activities at the centre. Bernice continues to live at home on her own for the next three years and continues to attend various programs at the centre.

Unfortunately, one day as she's leaving the Wii bowling tournament at the centre, she slips and breaks her hip. Again, an ambulance is called and she is taken to the local hospital. She is assessed by staff, and it is quickly determined that they do not have the expertise to treat her badly broken hip, so they call their buddy hospital, a larger community hospital, and within eight minutes, Bernice is on her way to a hospital that can care for her. She is received at the emergency department, without wait, and she is immediately admitted and has her surgery prior to the end of the day. Within 36 hours, Bernice is transferred back to her community hospital for her recovery. Bernice receives care within an Assess Restore Program. This program has been designed to care for older adults. They focus on improving Bernice's functional ability so she can return home. Bernice stays in this program for one month. This time has allowed her to recover to the point that she can return to her home with ongoing support from the CCAC, and it is expected that Bernice will be able to remain safely and happily in her home for many years. This is not a fairy tale; this is not a dream. This is, in fact, how care is being provided in our LHIN today.

So you're probably wondering, if it cost half a million dollars before, what would Bernice's care cost now? Well, we did that math, and this model of care would cost just over $130,000. Compare that to a half a million dollars: that's a difference of $370,000. While understanding that the new model of care provides reduced costs, I hope that you agree that Bernice's experience today is much better than it was before, and, really, that's what's most important.

Bernice's story helps me to illustrate to you what our LHIN does every single day. We bring providers together, from all sectors in our health system, and we work together—we coordinate; we integrate—issue by issue, to determine how, together, we can make the experience better for the people we serve and still provide better value to our citizens.

Before the LHIN, the providers—and I was one of them—quite correctly provided excellent care within their own silo. Now with the LHIN in place, it's no longer acceptable to look at the patient as a fractured hip or a heart attack. We must look at the person we serve. We must look at them as a person with unique circumstances. We must focus on the journey throughout the system.

While our LHIN is well known to have one of the seven wonders of the world in Niagara Falls, I believe we also have the eighth wonder of the world in the outstanding academic hospitals in Hamilton as well as nearly 200 health wonders in our world in our health service providers. In fact, earlier this month, a patient at one of our hospitals in our LHIN was quoted in the local paper as saying, "Everybody raves about the patient care here. And they were right. It's amazing. The staff here are phenomenal." And I agree.

But we also know that there are people in our communities who don't think the LHIN is doing enough to change the way health care is provided or who think we've changed health care too much and who, quite frankly, hate the LHINs. I use that word carefully, but I understand that it has been used at the committee hearings.

We would be completely out of touch with our communities not to recognize that in our LHIN we have made some unpopular decisions. To be frank, we'll probably have to make unpopular decisions in the future. We know that change of any kind is hard to accept, but we know that if we don't change course, health care spending will eat up 70% of the provincial budget within 12 years, so we must do things differently.

Doing things differently often means evaluating our past practices. It means putting new processes, systems and programs in place to support the needs of our communities. We are an organization who challenges ourselves to continuously improve and evolve. We need to learn from our past so that we are better for our future.

For example, the Ombudsman provided a report to our LHIN in 2010. This report was pointed. It made clear recommendations to the ministry and to LHINs. We took seriously his recommendations and quickly addressed them and adopted all of the recommendations.

More recently, we had a request from a local media outlet to release our board materials in advance of a board meeting. To ensure consistency across all 14 LHINs, we spoke to our colleagues and decided we would post our board package the Friday before a board meeting. This has been implemented for our January board meeting.

I apologize to our communities if they felt that we were not as transparent as possible. I can assure you that we will continue to learn more about our communities' expectation of us, and we will continue to implement changes and continue to do better.

I want to take some time now to tell you a few of our local initiatives. With our health care partners, our LHIN has been able to implement a one-LHIN-wide cardiac program. This program is offered on multiple sites. The cardiac care you receive at the new hospital in St. Catharines is the same care you receive at Hamilton General Hospital—one program, great quality, offered on multiple sites.

We've implemented CriticalLink, which partners smaller and larger hospital emergency departments for improved access to care. Smaller hospitals have been buddied with larger hospitals so that the transfer between hospitals is seamless for the patient. That's what Bernice would experience, and I believe Dr. Remington spoke to you about that yesterday.

We've developed 11 health links across the LHIN geography. Health links are about providing consistent and, some would say, the same care in every geographic area of the LHIN. With health links, we are working with

all of our providers, including primary care and some other providers as well, to better, and more quickly, coordinate care for our communities.

We've implemented an electronic health record called ClinicalConnect. ClinicalConnect connects all of our hospitals, our CCAC, our community health centres and our family physicians. It connects them all together. This means that a patient who has received care in Hamilton can go to their family doctor in St. Catharines and, in real time, that family physician can read the notes of what happened in Hamilton. It's truly amazing.

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These and many, many other programs and services that we, along with our health care partners across our LHIN, have put in place are making a difference. While we are not where we want to be, we are seeing results.

When LHINs started out, nine out of 10 people requiring an MRI scan in our LHIN waited up to 124 days. That time has been reduced by 67 days. That means that people are getting their MRI scans more than two months sooner than before the LHINs. Having timely access to these scans decreases the time that our residents anxiously await their results. But they're still waiting 57 days. That's not good enough, and we need to do better.

Our wait times for hip and knee replacement surgeries have been reduced from over 14 months to eight months. While that's six months sooner than before the LHINs were in place, we still need to do better. I have our performance information here with me. If you'd like to see more, I'm happy to leave that for your information.

Have we met all of our performance targets? No, I'm afraid we haven't. Have we made some mistakes along the way? We have. But are we making a dramatic difference for our residents? Yes, we are. Our work is not done. There are many, many more examples, like Bernice—I know your offices hear about those examples—where we now need to focus. But we're on the right track, we're making progress, and we are creating a health system that works the way a system should. My family and I live in this LHIN. We need to continue to bring better care to families like mine.

I've appreciated this opportunity. Thanks for your time. I'm happy to answer any of your questions.

The Chair (Mr. Ernie Hardeman): There's really not enough time left over for a question and answer. We will review your information as we go through this process. Thank you very much for your presentation.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Ernie Hardeman): Our next presenter is the Registered Nurses' Association of Ontario: Doris Grinspun, chief executive officer; and Tim Lenartowych, special projects manager, office of the chief executive officer. Welcome. You will have 15 minutes to make your presentation, and you can use any or all of it. If there's any time left over, we will have questions from our panel.

Ms. Doris Grinspun: Thank you so much. I actually hope to use as little time as possible and to have a dialogue as much as possible. It is a delight to be here with you today to discuss the Local Health System Integration Act.

Let me be clear: We support the LHINs, but the LHINs need some empowerment, and we will speak exactly about that.

The LHINs act led to the creation of 14 not-for-profit corporations called local health integration networks, which work with local health providers and community members to determine regional health services. They have a very broad mandate. However, in our view, the legislation, the act, actually doesn't enable them to do their work.

The LHINs currently cover hospitals, community care access centres, community support services, long-term care, mental health and addictions, and community health centres. That's about it. The LHINs do not cover, because of the act, the following services: home health care and support services, primary care organizations—except the community health centres—and public health units.

Much to our distress, on seeing the unfolding hampering of the LHINs' ability to actually enact what they are supposed to do, which is whole-system planning and whole-system integration, a year ago we decided to undertake significant work. In 2012, we released a report, which is in your files, entitled Enhancing Community Care for Ontarians, or ECCO, which we hope will have reverberations like an echo. ECCO proposes to position the LHINs as the overall health system planner at the regional level. However, for that to take place, we need to include in the act, directly, home health care and support services, primary care organizations—all of them—and public health.

Let me address a bit of what we can do and what the act should look like in the future if we are certain about having health system integration—and unnecessary duplication, which is costly to people, as expressed by our previous colleague in their description of the experience of Bernice, and also to taxpayers.

We are proposing that the CCACs evolve into moving the case managers that they currently have—3,500 of them—directly to work in primary care to actually support patients in the community, ensuring that people like Bernice don't suffer those experiences where an outside entity is supposed to come in a crisis situation to serve them, but it is actually the primary care system that is anchored in case management. Then, evolve the rest of the CCAC administration into the LHIN structure, thus enabling the LHINs to actually provide health system planning for all the services, including primary care, and including home health care.

We also propose that public health units need to be brought way, way more in line with the act and with the LHIN structure, again for two very important reasons. First of all—and here in Hamilton, it is so very apropos to say so—when you have communities that have not and communities that have much, that actually suffer 25 years

of longevity as a consequence—people here in Hamilton live 25 years less based simply on their income. Public health units' key mandate is to actually do health promotion, disease prevention, social determinants of health etc. The problem is that because public health units are not part of the LHINs now, we are again missing the boat.

We have LHINs, as a result of the act, that are primarily focused, I would suggest, on illness care and crisis care, and we are missing all the movement that the entire world—especially progressive countries and OECD countries that are doing things well—is doing with primary care, home care and public health. If we were to bring all of that under the act, the LHINs would finally be empowered to do what they were supposed to be doing in the first place, which is health system transformation, health system planning and health system funding that is fair across the province but localized in our regional communities.

I would strongly recommend, from the nurses' perspective, that we further empower the LHINs by bringing into the act home care services, support services, primary care organizations—not only the community health centres, but all of them—and also the public health units, and that together, then, we move into a model that is much more in tune with health promotion, disease prevention, chronic disease prevention and management, and, of course, also the area of mental health.

I would stop here, because I believe we can do, and must do, much better than the description we heard from our LHIN CEO on Bernice. Whether it was before or whether it is now, we still hear of too many Bernices across this province. In fact, when we released ECCO, we had people from the public contacting us, and we did a focus group with them to actually ask the public, "What will work best for you?" Many of these ideas in ECCO actually come from the experiences that the public shared with us.

Let me open for questions. My colleague Tim and myself will be happy to answer.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about nine minutes, so if we start with the government side—

Ms. Helena Jaczek: Thank you, Chair.

The Chair (Mr. Ernie Hardeman): Okay. Ms. Jaczek?

Ms. Helena Jaczek: Thank you so much, Doris, for, as usual, very specific recommendations. I guess I'll pick up on one that I have some knowledge of as a former medical officer of health, and that's your recommendation in terms of public health units. I guess there are a lot of barriers, and I'm sure you will acknowledge—I see in your presentation that you're suggesting maintaining the local governance model of a board of health, as well as responsibility to the LHIN, and I just see that as extremely problematic, having reported to the regional municipality of York for so many years. The fact that obviously municipal funding is part of—25% of public health funding comes from the municipality.

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Boundaries are a huge issue. Obviously, health units are based on existing municipal boundaries.

I understand where you're coming from in terms of health promotion and disease prevention, but I'm just wondering, in a practical sense, how you see this moving forward and if this dual reporting would be how you foresee that playing out.

Ms. Doris Grinspun: First of all, let me clarify, and my colleague may want to add. We are actually meaning that public health units need to maintain their own governance, no different than hospitals, no different than home care agencies and others, okay? We are not necessarily proposing that the dual reporting to municipalities etc.—we absolutely are saying that the system is missing out hugely. Let me be clear: At the time of the creation of the act and of the LHINs, and the conversations I had back then with my very close friend Sheila Basrur—I was totally on her same page. Let's keep the LHINs. Let's keep public health units out of it because—bugaboo: that was our fear, quite frankly, that hospitals will lead the budgets of everybody that gets in the picture.

I think if Sheila were here today, she would say, as we are saying, that that fear is gone. We are moving to more community transformation. We need to keep people healthy and well-served in their communities, in their homes, aging in place as much as possible. Therefore, we need to bring public health units to the next stage. We are also saying that public health units are supposed to be—many are; not all—the best entity, the best machinery, for community consultation, way better than hospitals, way better than home care etc. by the nature of them. The system, the LHINs and the act that doesn't allow the LHINs—it's missing out on not having that capacity of public health units to champion community consultation for everybody across the system. It's missing out on not forwarding social determinants of health and environmental determinants of health.

So we are saying they need to keep their budget—no different than the hospitals. They need to keep the ability to do also local programs—no different than the hospitals—but there needs to be a layer that is for the entire system as part of the LHINs.

The Chair (Mr. Ernie Hardeman): Thank you very much. We'll now go to the opposition. Mrs. Elliott.

Mrs. Christine Elliott: Thank you. Hello, Doris and Tim. It's great to see you both again. Thank you for presenting to the committee and for your leadership in the production of ECCO. We have had the chance to discuss it several times, and I think there are some great themes in there. We have some disagreements on some parts of it, but I think it's a very solid document with some really good ideas.

I'm particularly interested in the idea of blending the function of the CCACs into the LHINs. We hear about it constantly in our community office, that the transitions are very, very difficult. It seems to me that if they're brought in to the existing LHIN system or there's some way of having them work together that provides seamless

service for patients and truly makes our system patient-focused—I'm wondering if you could just expand on that a little bit.

Ms. Doris Grinspun: We are absolutely, Christine, on the same page on this. First of all, just from the issue of whole system planning funding, it's impossible. If I were the colleague that spoke before—I don't know how you can plan if you actually do not have every player directly there.

Second, the LHINs are extremely lean in terms of their administration. The CCACs, on the other hand, we all know, are overblown in terms of administration. Our suggestion is that the case managers move to primary care where they will service the patients. The rest move to the LHINs or to home care services in terms of actually upping the ability of the LHINs to perform all-system planning. We do not believe that if you have these two overlaying structures—even though one reports to the other—the LHINs will be able to come to their full maturity. We absolutely do not believe that will be the case. They will continue to be hampered by another structure that is muddling in the middle.

The Chair (Mr. Ernie Hardeman): Thank you very much, and—

Ms. Doris Grinspun: We need one overall structure to do system planning, not two or three.

The Chair (Mr. Ernie Hardeman): Third party: Ms. Armstrong?

Ms. Teresa J. Armstrong: Yes, it's a pleasure to see you again, Doris, and it's nice to have you here today, Tim.

You touched upon unnecessary duplication within the LHINs, and I just thought if you could expand on some of those issues that you feel are unnecessary duplication that could help financially and also perhaps deliver services better to the health care system.

Ms. Doris Grinspun: Thank you. It builds on the previous question from Ms. Christine Elliott on the issue that there is duplication, first of all, between some of the functions of the LHINs and CCACs—that's the biggest one—and that that duplication is hampering the ability of the LHINs. And it's structural, because it's based on that. It's not that the LHINs decided; hence why the review of that is so timely and necessary. And it hampers both the ability to integrate and make services smooth, and also it hampers the ability because the dollars are used inappropriately. So that's absolutely the first layer of duplication; that is essential.

Ms. Teresa J. Armstrong: Any other duplication that you can identify that would help that overall delivery of health care?

Ms. Doris Grinspun: I would suggest that the fact that not all the primary care sectors are part of the LHIN create, just by structure, again, duplication sometimes. I mean, you have the CCAC supposedly to coordinate the care of Bernice, but actually, that's a role that belongs to primary care. Now the LHIN cannot mandate it because only community health centres—in fact, in community health centres, Bernice probably would not have experienced that. So that's proof in the pudding.

The third is in the area of public health. Hence why we're proposing that the three come to the act. In fact, you could also see during any of the epidemics—and if we have another one, we will see it again—when in some LHINs, you have several public health units actually giving different directions, at times, than the LHIN. So that's, again, a structural duplication in the way that they structure—that there cannot be a consistent and mandatory lining up of everything.

Ms. Teresa J. Armstrong: Okay. Perfect. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's very helpful, and I'm sure that we'll take it into consideration. Thank you for taking the time to come here.

Ms. Doris Grinspun: Thank you for having us again. Take care.

Mr. Tim Lenartowych: Thank you.

MR. HARRY CHUNG

The Chair (Mr. Ernie Hardeman): Our next delegation is Harry Chung. Thank you very much for coming and sharing your thoughts with us this morning. You will have 15 minutes to make your presentation. You can use any or all of it for your presentation. If time is left, we'll have questions from the committee to address your presentation. With that, thank you very much for being here, and the floor is yours.

Mr. Harry Chung: Thank you for having me. First of all, I'm a front-line health care innovator. I call myself that because I've been looking after my mum for the last six years. My previous careers: I'm an engineer; I'm a licensed security officer as well. I give you a little bit of my background, okay? I have a law degree as well.

I roughed this up last night because I was called to change my time, to come in at 11:45 instead of 1:15, so excuse the grammar or the spelling. I did the best I could.

For the last six years, ever since my mum got out of hospital, I was in a situation where a social worker came to my family without us having an idea of what was going on with our mother. She had a heart attack back then. I just gave up my career and went straight to the hospital and spent 18 hours a day, 40 days there in the hospital, just to make sure everything was running good for her.

Being a lady from a different culture, a Chinese Canadian—I've been here for four generations, my family, in the city of Hamilton. We never had a voice or anything. I think it's time we speak up. The culture for health care given to the public back then was good for people of European cultures, but for the Chinese Canadians—I mean, my mother doesn't eat hamburgers and French fries and mashed potatoes and stuff like that. She likes her culture's food, which is basically Chinese Canadian food. What I'm trying to do is suggest a way to improve our system.

The thing is, our system in a hospital is—it's the way they approach the families. You know, you get the family all split up. There's no cohesiveness and there's no

family unity there after you go through the round table meeting with the social worker in the hospital. Everybody has got different ideas of what's good for our mother, or any elderly people like my mother.

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There's no sense of security in nursing homes, as you can see on these handouts I have passed around. These are all newspaper clippings from the last six years. Before that, there wasn't that much security in nursing homes either, but these are just clippings from within the last six years. I've been collecting these.

Also, there's no sense of security with the PSWs, the in-home-care service. Mind you, the PSWs are great health care workers, but there are some who are kind of shady; I'll just use those words. As you can see on the first page of this, we've got PSWs coming into the house and stealing $57,000 from an elderly gentleman. There's no sense of security, safety, or trust, I guess I'd call it, in the system. But having what we have on hand—you have the home care system and you have the nursing care system—we have to find ways to improve the sense of security in these homes.

I've written some ideas on how to improve what we've got. The system can work if we have a sense of security in the system. My suggestion is that if you're going to have a nursing home, before you should even have a nursing home—a building labelled as a nursing home—to provide health care services, I believe you should have a security system in place. Maybe have specially trained security guards who work in the health care facilities. Without that, it's just a building with a bunch of nurses there. I'm pretty sure the nurses are doing their jobs, but still, there's no security there.

The security staff that they hire: There should be at least three, I would suggest—at least three security guards—with special health care training, just enough so that in case somebody falls or hurts themselves, they are there for the moment until a nurse or PSW comes to take care of the major issue.

These security guards are not just ordinary security guards. I believe they should be trained a little bit, rather than just CPR and St. John Ambulance first aid training. Also, the security system in the nursing homes should be more arm's-length. They should work in tandem with the nurses, the doctors, the caregivers, but at the same time they've got to be at arm's length. Their bosses should be somebody else rather than the nursing home owner.

That's how I would suggest improving the nursing homes in our system.

On the other hand, we have health care providers coming to our house, looking after our elderly. You see, it took me six years to become very friendly with these PSWs coming to my mom's house. I couldn't trust them at the beginning, to be honest with you. I don't know who they are. It took six years for me to be able to say, "Okay, I'm going to go out and have a coffee at Tim Hortons, so that these ladies can take care of my mom." But, seriously, it took six years to build that security and trust. That's six years of my life I gave up, as an aerospace engineer, to do this.

Now, the thing is—I always suggested this: In their house, you should find out how many siblings or how many kids the elderly parent has. If you have none, that's a different story, but it's also suggested in here how we can go ahead and fix that too.

You should have at least one show of a family member in the house. That family member—they're there, right? They can be watching TV or sleeping in the next room or on the computer or gardening, or just going for two minutes to Tim Hortons and back. I don't think they should leave the elderly at home by themselves.

When you have a PSW come to your house or a health caregiver come to your house, even if they're so friendly and nice, you still need that interpretation. All the health caregivers I have come to my house speak Spanish, Ethiopian, East Indian, but my mom's Chinese Canadian. She doesn't speak a word of good English. By the way, for that one reason, they should also have a family member in the house. I know we can say, "I'm too busy doing this, I'm too busy doing that," but the thing is, it should be mandatory. They should find out how many siblings or kids the elderly parent has. As an example, if they have four kids, maybe three daughters and a son, take the 24-hour clock and divide it by four—four members. Or if they have grandkids who are over 18 years old, count them in as well.

But just say, for example, you've got an immediate family member and maybe four kids. Take the 24-hour clock; divide it by four. That's six hours each. Six hours each a day is not much. If you're at home cooking a meal, you could be cooking a meal at your mother's house and make her a meal, too. The PSW comes. There's a sense of security there for my daughter, my son. But we're not asking them to do all the caregiving, because they can get tired doing that every day. But just be there. Have a show that they're at home. This is called family unity.

At the same time, the caregiver and the person at home can work in tandem. If they need a little bit of help, call 911, or if something happens to the PSW. At the same time, that extra person at home can provide a little bit of help. This is where I'm coming from, in terms of sense of security and safety in the house.

The reason why I mention this is, because also in the newspaper here, there are people going into people's houses; for example, the first one. The first example here, you've got a PSW coming in here. I'm pretty sure she has good intentions of taking care of the old man right there, but the thing is, though, you've got a blank cheque that's laying around, and you can write any price you want. So you've got two PSWs at court this month. We don't know what the outcome is.

There's various other cases. It's all here. You've got the elderly at home by themselves. They fall and hurt themselves, and nobody knows about it. Then you've got examples in the hospitals, where some of the health care providers in the hospitals and the nursing homes—they are basically neglected. You've got examples where you've got an elderly lady letting—mice, rats eating the

corner of their eyes. They're alive. There are instances like that in these newspaper clippings here.

You've got an instance where you got a nurse who burnt down a nursing home with about 87 patients who have dementia, and five didn't make it. There's various situations like this. It's all here, for the last six years—all here.

This is my suggestion. This is what I suggest to help improve our system. We have a system, but it's just a matter of improving it. You have a choice: nursing home or a caregiver coming to the house. But they should be looked upon as equal.

Also, the kids who are asked to be at home show us a sense of security for the elderly, this should be a mandatory thing. If you have four kids or five kids and maybe three grandkids who are over 18, and you're still in the Hamilton area, you should get these people to work out a schedule and make it mandatory. They have to do their hours. It's their parents we're talking about. They may have differences, but still, it should be a mandatory thing.

We're not asking these people, like myself, to actually do a lot of health care work but just to be around. You don't want to leave an elderly 87-year-old in a house by themself with strangers walking in. These health caregivers—they may have good intentions. But, then again, who knows? They're strangers. They're strangers to the 87-year-old elderly. You don't want to make them feel like they're in a house with a strange person.

I know one can say, "Well, we don't have enough people to come to the house. Why don't you throw them in a nursing home?" You should look at the situation. Can this person survive in a nursing home? I don't think my mother could survive in a nursing home; she'd probably die in two weeks. But here she's living still: dementia, 87 years old. We cope with it, find a way around it. That's the idea of taking the siblings, divide it by a 24-hour clock so that we're not always there for 24 hours listening to your mother when she's in dementia mode. So that takes a load off of a lot of people. Then you've got the PSWs coming in to give that extra measure of help.

So this is how I think we can improve our system. We got a system there. It's just a matter of improving it.

Any questions from anybody?

The Chair (Mr. Ernie Hardeman): Okay. Well, we have a few minutes left. I have about a minute and half for each caucus. We'll start with the official opposition.

Mrs. Christine Elliott: I'd just like to thank you very much, Mr. Chung, for coming and appearing before the committee today and raising some of the significant issues around frail, elderly patients and their caregivers, and the need to make sure that there are choices whether they go into a long-term-care facility or whether they choose to remain in their own home. I think, for the most part, that's where people want to be. It's also more efficient for our health care system, so we need to make sure that we have a robust system that allows people to have those choices. So thank you very much for bringing this forward today for us.

Mr. Harry Chung: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. The third party? Ms. Armstrong?

Ms. Teresa J. Armstrong: Yes. I want to thank you, Mr. Chung, for sharing your experiences that you are going through right now. I got a sense that you obviously feel very committed to your mother, and how important family is to you, looking after your mother when she is in this situation.

You also raised a theme about security and trust when people enter your home. A lot of people do have those issues, but perhaps I'd encourage you to call your local CCAC and find out what their processes are, in order to maybe substantiate some of those security and trust issues you may have. I'm sure there are systems in place that help that situation.

Congratulations on trying to find that balance there, and having them come into your home, and having your family also participate. Thank you.

Mr. Harry Chung: I do talk to my local CCAC—for the last six years—but it's just coming to your house, sitting at a laptop and asking what kind of medicine your mom takes. I'm very well aware of that.

Ms. Teresa J. Armstrong: That's good.

Mr. Harry Chung: Nothing is happening. I'm taking advantage of this meeting to make it happen. I'm a practical person, a technical person. I'm not a politician. I have a law degree. I'm an engineer, but I consider myself a health care innovator. I believe in making it happen, making it work.

Ms. Teresa J. Armstrong: No, your contributions were—

Mr. Harry Chung: This is my experience sharing it with somebody who has never had it for six years. I'm still doing it, so I'm learning a lot. I'm bringing my front-line experiences onto the table. That's what I'm talking about.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much. We'll go to the government. Mr. Colle?

Mr. Mike Colle: Yes. Thank you, Mr. Chung. Obviously, you care a great deal about your 87-year-old mother, that you're coming here on her behalf—and other mothers like her—so I want to commend you for that.

I think you make a very good point: We can't just keep serving people hamburgers and chips in the hospitals. I know that one of the complaints I get the most is the food. It's just the same old hamburgers and chips. Meanwhile, we've got such a diverse province with people from all different backgrounds. We need to take more attention to look at the cultural background, the family background, especially of our elderly, to make them feel comfortable when they're in a nursing home or a hospital. I think you've made an excellent point that we've got to pay attention to and all the providers have got to pay attention to. We just can't do the hamburgers and chips forever.

Mr. Harry Chung: That's right.

Mr. Mike Colle: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That does conclude the 15

minutes, so we thank you very much for coming in. We do wish you well.

Mr. Harry Chung: Thank you for having me, everybody.

The Chair (Mr. Ernie Hardeman): Thank you.

We now have a recess for lunch. That's the end of it for this morning. Lunch is in the Charlton Room. We shall see you there.

The committee recessed from 1154 to 1300.

COMMUNIST PARTY OF CANADA (ONTARIO)

The Chair (Mr. Ernie Hardeman): We'll reconvene the committee. Our first presenter is Elizabeth Rowley from the Communist Party of Ontario. Bob Mann is also here with her. Please come forward and take a seat at the table. You have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If you do not use it all and there is less than four minutes left over, we will give that to one caucus to ask questions; and if there's more than four minutes left over, we'll divide it equally among the three parties. With that, the floor is yours. Thank you very much for being here.

Ms. Elizabeth Rowley: Thank you very much. Good afternoon, ladies and gentlemen, brothers and sisters. My name is Elizabeth Rowley. I am a former public school trustee and member of the board of health and currently the leader of the Communist Party of Canada (Ontario). With me is Bob Mann, who is a member of the Communist Party's Ontario committee and also a retiree from Stelco, down the road.

Perhaps we'll just go straight to the brief that we want to submit and begin by thanking you for this opportunity to address you on the review of Ontario's local health integration networks and the legislation.

When the LHINs were first created in 2006 by legislation, we noted that their main purpose would be to serve as a buffer between the government and the public. Eight years later, it's clear that the real purpose of this legislation was to redirect public anger away from the government, which had continued implementing most of the privatization policies introduced by the Harris government, including those the Liberals had campaigned against in 2003 and, in particular, P3 hospitals, cuts to hospital and health care spending, new and higher user fees and privatization of health care services. This government also extended balanced budget legislation to hospitals, in the process extending the Harris' government's create-a-crisis policy in education to health care.

According to the Canadian Institute for Health Information, public health care spending in Ontario dropped to $3,963 per capita in 2012, compared to Alberta at $4,896 per capita and Newfoundland at $5,399 per capita. From a leader in health care in Canada, Ontario now ranks eighth out of 10 provinces. Compared to the average per capita spending on health care across the provinces, Ontario spends $8.6 billion less on health care.

Ontario ranks dead last in the country on hospital spending, with per capita spending in 2012 at $1,372. Alberta, which was ranked second, spent $2,194 per capita in the same year. Compared to the average per capita hospital spending across the provinces, Ontario spent $6.7 billion less on its hospitals. Further, in the past 30 years, spending on hospitals has been cut by almost 50% as a percentage of all public health care spending.

As a percentage of the provincial GDP, Ontario's health care spending has dropped to 8.07%, again ranking Ontario eighth out of 10 provinces. As a share of provincial spending on all social programs, spending on health care in Ontario has dropped from 47% in 2012 to 42% today. Ontario has the dubious distinction of ranking last in all social program spending across the provinces.

Further, in last year's budget, the government introduced means testing for seniors' drug benefits. User fees are expanding and increasing as the government continues to de-list services and procedures.

What will the picture be two years from now if this austerity plan continues? Indeed, as these figures show, a health care crisis has been created as a result of deliberate cuts to the funding of health care and hospitals in Ontario. It's this made-in-Queen's-Park crisis that the LHINs are expected to mitigate and to answer to an increasingly angry public.

As expected of an agency created by, appointed by and accountable to the government of Ontario, the LHINs have become an important instrument of privatization.

Again, according to the Canadian Institute for Health Information, Ontario has the highest percentage of private health care spending in Canada. Fully 32.3% of all public health care spending in the province is spent on private health care. Even Alberta, the ideological home of privatization and deregulation, spends less at 27.1%.

Private health spending is 5.3% higher in Ontario than in Canada as a whole. Private health care administration costs an astronomical 6.4% of public health care spending, while public administration costs just 1.8%. Part of this is due to the absence of regulations over private and private for-profit health care facilities in Ontario.

According to the 2008 Auditor General's report, P3 hospitals have cost hundreds of millions of dollars more than publicly procured hospitals. In the case of the Brampton P3 hospital, Ontario's Auditor General calculated a $194-million difference in building costs and a $64-million additional cost in renovations for the P3 over public procurement. This included a whopping 13% cost overrun, almost three times the amount permitted in public procurement contracts. This P3 hospital generated a very tidy profit for the for-profit partners in this P3, while the public organized bake sales to pay for it. Furthermore, the hospital was smaller, with fewer beds and staff, than the public hospitals it replaced.

While the government continues to chip away at universal health care and the Canada Health Act, it is today moving to speed up privatization by enabling and directing the LHINs to eliminate many hospital services and contract them out to private and for-profit clinics, known as independent health facilities, IHFs. There were

825 of these in 2012, 97% of them for-profit clinics, according to the Auditor General in his 2012 report.

Contracting out hospital services is not intended and will not free up hospital beds or alleviate long wait times for emergency care or surgeries. In fact, many of the IHFs are expected to provide surgery as part of their mandate. Already existing private clinics have been the subject of sharp criticism and demands that the government act to stop them from demanding fees for service and other illegal charges from patients while also charging OHIP. Furthermore, medical oversight and regulation is de facto absent over most private clinics today. The death of Krista Stryland is an example. It will be completely absent if the Conservatives form a government and carry through with their promise to eliminate red tape—regulation, in other words.

As hospital services shrink and decline with the introduction of IHFs, so too will hospital funding, along with hospital beds and wards. Small hospitals could be pulled apart as services are pieced out. As already noted, the Brampton P3 provides fewer beds to a larger and growing population than its two public predecessors, so much so that at least one person has died in the waiting room of Osler's emergency department.

Rural hospitals, which are generally smaller, and services to rural residents, who live in a larger geographic area than their urban counterparts, are most immediately in danger because of their size—or at least they are first in line—with the introduction of IHFs, privatization by any other name.

If the government wants to decentralize public hospital services, it can do it under the Public Hospitals Act by creating publicly owned and operated clinics, either stand-alone or connected to particular hospitals. The government's apparent decision not to do this and to contract out these services to private and for-profit clinics is very telling.

By making the LHINs the agency that actually cuts and privatizes these important health services, the government expects public anger to focus on the local LHINs and not on the minister or cabinet. It is a cynical policy, indeed, and one that contributes greatly to widespread public cynicism about parliamentary democracy, transparency and accountability.

Ontarians want hospitals and health care that measures up to the standards in the Canada Health Act and exceeds them when it comes to pharmacare, long-term care, vision and dental care, and mental health care. Instead of colluding to destroy medicare, the provincial and federal governments must invest in public health care and hospitals, as well as in public education and universal social programs that benefit all Canadians. User fees should be outlawed.

Recovering the estimated $15 billion in corporate tax cuts and significantly raising corporate tax rates, now the lowest in the industrialized world, according to budget papers, would generate the funds needed to pay for universal health care services while creating jobs in health care and improving the health and well-being of all Canadians. Canada is a wealthy country, and Ontario is a wealthy province. Progressive taxation based on ability to pay would ensure that the public purse was up to the task. What is missing is a government up to the task.

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The Ontario and federal governments, current and future, should be guided by the principle that health care is a right, not a privilege. In this scenario, there is no room for IHFs or LHINs, which should be abolished along with private, for-profit medicine and the private clinics and health care corporations that are the barbarians at the gates today.

The LHINs should be replaced by boards of health that are publicly elected and accountable, and that in fact place "significant decision-making power at the community level and focuses the local health system on the community's needs," as stated on the Ministry of Health website.

In conclusion, the first plan for socialized medicine in Canada, laid out in the 1930s by Dr. Norman Bethune, laid the basis for the successful fight for universal medicare that involved millions of Canadians from coast to coast in the post-war period, and the courage of Tommy Douglas and the CCF government in Saskatchewan to bring it to life. Medicare was no gift to Canadians. It was the fruit of a historic struggle by working people—labour, farmers, women, youth, seniors, professionals, aboriginal peoples and migrants—to win universal, quality, public health care as a fundamental right for all. Governments of all stripes were finally forced to put people's needs ahead of corporate profits—a victory that corporations and governments have been working hard to undo ever since.

Canadians will not stand by while medicare is privatized, by stealth or otherwise, as polls consistently show. The Legislature would do well to take note.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We'll start the questions with the—

Interjection.

The Chair (Mr. Ernie Hardeman): Okay, it's just one party. There are just 2.46 minutes left. We'll have questions from the third party. Ms. Taylor?

Miss Monique Taylor: Thank you for being here today. Thank you for your presentation and for putting the effort in to come to speak to this very important issue regarding the LHINs.

I don't really have any questions of you. You definitely put together a very pointed presentation with a lot of—actually, I do. Where did you get a lot of your facts and figures from—the numbers?

Ms. Elizabeth Rowley: As you will see, it says in the brief that most of the figures come from the Canadian Institute for Health Information.

Miss Monique Taylor: They were good numbers, and they were a little different from what we've been seeing, so I was happy to see those numbers come forward.

Thanks for bringing to light the fact that Tommy Douglas was the first person to bring forward health care and make sure that we had that legislation in place. Health care is definitely not a privilege; it's a right.

Ms. Elizabeth Rowley: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

The last presentation was cancelled, so that concludes our meeting for today.

Is there anything else that anyone wishes to bring up? If not, I just wanted to remind the committee that tomorrow morning, the meetings start at 8 o'clock as opposed to 9. So if we could all be in Kitchener-Waterloo at 8 o'clock, that would be much appreciated.

With that, the meeting is adjourned till tomorrow morning at 8 o'clock in Kitchener-Waterloo.

The committee adjourned at 1316.

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