ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40e législature

Official Report of Debates (Hansard)

Wednesday 5 February 2014

Journal des débats (Hansard)

Mercredi 5 février 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

Président : Ernie Hardeman
Greffière : Valerie Quioc Lim

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

http://www.ontla.on.ca/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-3708.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7410 ou le 325-3708.

Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

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

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Wednesday 5 February 2014

Mercredi 5 février 2014

The committee met at 0905 in the Valhalla Inn, Thunder Bay.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): Good morning. We'll start the meeting. We thank everybody for coming to the Standing Committee on Social Policy meeting of February 5. We're here for the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of the act. We're doing the public consultation, and we're happy to be in Thunder Bay this morning to hear presentations.

NORTH WEST COMMUNITY CARE ACCESS CENTRE (THUNDER BAY)

The Chair (Mr. Ernie Hardeman): Our first presentation is the North West Community Care Access Centre of Thunder Bay: Rob Stinchcombe, chair; Brad Coslett, vice-chair; and Tuija Puiras, chief executive officer. Thank you all very much. I just want to point out, first of all, that I have trouble pronouncing my own name, so I have real problems with others, but the Hansard will copy them all perfectly. The record will show the right way.

Thank you very much for being here. As we've been doing around the province, we do have 15-minute presentations. You'll have 15 minutes for your presentation. You can use it any way you like, any or all of the time. If there's extra time, we'll have questions from the committee to your presentation. If not, you can use it all yourself. Your 15 minutes starts right now.

Mr. Rob Stinchcombe: Right now? You can hear me? You can hear me, I'm hoping.

We picked our presenters because of the difficulty of their names for pronunciation purposes.

Good morning, Mr. Chair and members of the Standing Committee on Social Policy. The North West Community Care Access Centre appreciates the opportunity to present to you today as you continue your review of the Local Health System Integration Act.

My name is Rob Stinchcombe. I'm the chair of the board of the North West Community Care Access Centre. I'm here today with my colleagues Brad Coslett, our vice-chair, and Tuija Puiras, our chief executive officer. I'll be doing most of the presentation today, and then Brad will be joining in. Tuija is here to make sure that we don't say anything out of line.

Ms. Tuija Puiras: I can answer questions.

Mr. Rob Stinchcombe: The North West Community Care Access Centre is a health care service provider as defined by the LHIN legislation, and we're accountable to the North West LHIN through our service accountability agreement.

Each year, we provide over 13,000 people with the care they need at home, at school and in the community. In total, the North West Community Care Access Centre covers a geography of 460,000 square kilometres, approximately 47% of the land mass of Ontario. The northwest region has approximately 230,000 people, including significant aboriginal and francophone populations. This large land mass, with a population density of one half of a person per square kilometre, makes the delivery of high-quality, cost-effective home care and community care pretty challenging. To provide this service, we have 14 locations throughout the region, and our care coordinators can be found in any of the 13 hospitals, and doctors' offices, schools and other community agencies.

Fortunately, the North West LHIN understands the regional challenges we face and promotes robust, collaborative partnerships and assists in facilitating finding better ways to serve the people throughout the northwest.

Community and home-based care continue to grow in importance as we look to meet the changing needs of the people in our communities. We're continually faced with significant and growing challenges to ensure that we can provide high-quality health care and prepare for future demands.

The North West CCAC believes that the LHIN legislation review is a great opportunity to further strengthen the current system and promote optimal health and well-being for everyone.

Our provincial association will be providing a broader perspective in its submission to the standing committee. However, in our time today, we would like to focus on how we work with the North West LHIN in relation to the current framework for local health system planning, funding and accountability, and provide some recommendations for improving the current framework.

The North West CCAC works directly with people so they can live and age safely in their own homes and

return home after a stay in hospital. Basically, what we do is help people.

Here are a few of the ways we helped people last year: Our employees helped about 4,700 people to return home after a hospital stay. Our employees completed approximately 10,800 visits with people to talk about what services they need so they can be as independent as possible. On any given day last year, there were 4,680 people receiving services from the North West CCAC. Our employees helped 637 people access a long-term-care home. Our employees helped 1,819 children by setting up services such as speech therapy so they can go to school every day. Our employees connected 949 people to a primary care provider through the Care Connector program.

In addition, our care coordinators are health professionals who work hand in hand with people and their families to develop a care plan that is right for them whether it is nursing care, meal delivery, a day program or help finding a family doctor.

Care is delivered at the right time through efficient care coordination practices that allow for timely identification and timely provision of needed services. The people we serve and our health sector partners continue to tell us that we are doing an excellent job.

The LHIN legislation requires LHINs and health service providers to engage their partners and the public. In our experience, the North West LHIN undertakes extensive community engagement to inform, educate and empower stakeholders in planning, decision-making and improving the experience and outcome of the patient experience.

The North West LHIN carries out local system level planning and funding as it relates to the needs of the community. It guides integration initiatives with health service providers while respecting the experience of the stakeholders. The recent Telehomecare initiative is one example of many where the North West LHIN focused on the expected outcomes and left the implementation of the program to the partners. The Telehomecare program assists people with heart failure, COPD and other chronic conditions, and augments the care people receive from their primary health care providers. It also allows people to stay in their homes longer and eases the pressure on the local health system.

The North West LHIN recognizes that every model of health care cannot apply to every community, and instead carries out local system level planning, resulting in the region's Health Services Blueprint containing 44 recommendations for ways of reducing demand for hospital services, lowering the number of emergency department visits, and improving access to care and delivery of services in our various communities.

The North West LHIN Health Services Blueprint is based on the integrated health services model, and will ensure services will be organized at three levels within the LHIN: the local, district and regional.

The health system model will bring decision-making and accountability closer to the community level to improve the patient experience and make the system more sustainable. An example of how this is working is the myCare program. This unique pilot was the first of its kind in Ontario, and studied the possibility of meeting the needs of residents with local nursing resources that would be funded by the North West CCAC, hosted by the Manitouwadge hospital and managed by the family health team. The program is successful and plays a significant role in helping more patients live safely at home, especially in small and rural communities.

MyCare is also a great example of how the current system works by building on the solid foundation provided by the LHINs and the LHIN legislation, and by constantly keeping the patient at the centre of the care plan.

We would like to suggest one area for improvement in the legislation. A well-designed system is one that promotes strong partnerships, a shared vision and effectively supports patient care. Funding stability and predictability have significant impacts on the consistency and quality of care for patients in the home and the community system. As a paradigm for progress for the delivery of care in the community, we believe there is a need for the ministry, the LHINs and health service providers to consider opportunities to improve the funding allocation process. Inequity in funding levels and in funding enhancements across regions can create challenges in providing equitable access to consistent levels of care. The confirmation of funding allocations varies with health service providers and uncertain allocations create fluctuations in the delivery of care, thereby creating confusion and compromising the confidence of our patients, families and our health care partners in our services and in the system overall. Some form of multi-year funding would create more stability in our service-level planning and provide more predictable service-level patterns.

0910

Overall, the Local Health System Integration Act provides a well-structured foundation and the ability for the North West LHIN to promote community engagement, allocate funding and require accountability, as well as carry out local, regional and district-wide planning. The current legislation supports the North West LHIN in its work with its partner organizations at the board level, the leadership level and at the front-line level to find new ways to better serve the regional population's health care needs.

Brad?

Mr. Brad Coslett: Building a stronger, higher-quality health care system requires effective integration throughout the health system. Getting there involves community engagement. The current legislation allows the LHINs the ability to lead through community engagement funding and planning, where all stakeholders understand the vision and priorities for change and build the system through mutual accountability across the care continuum. The current system does work, but we know we can do better.

Community and integrated primary health care focus will provide opportunity for chronic disease management and build a system that is geared to support healthy aging. Health links is a critical piece in the transformation of health care throughout the province and, more importantly, throughout the defined geographical areas where all health care providers can work together to improve access to care and provide better value and higher-quality care for those who need it most. Development of the long-term capacity plan is needed for each LHIN and the correct balance will detach any schisms to ensure the right services exist across the continuum of care to meet current and future needs.

Mechanisms to improve the predictability of funding over multiple years will assist in meeting those needs by enabling better service-level planning. The milestones reached with the current structure are significant within our communities for moving forward in meeting our future needs. Ultimately, regardless of structure, a common vision focused on the people we serve and strong, collaborative relationships are the key ingredients to making the health care system work. With our LHIN and our health care partners, we know we can continue to create an improved system and provide better care to the people of northwestern Ontario.

Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about two and a half minutes left, so we'll have questions from the government. Ms. Jaczek.

Ms. Helena Jaczek: Thank you very much for coming in. You've probably heard—this is day six of hearings—that there have been some suggestions that perhaps the CCAC could be folded into the LHIN and that the LHIN could, in fact, contract service providers directly for the purposes of home care and all the other activities that the CCAC currently engages in. What comments do you have about that suggestion?

Mr. Rob Stinchcombe: Maybe Tuija would like to add to what I have to say. Right now, there are two distinct functions. The LHIN obviously has a planning function, allocates funding to various organizations and requires accountability for the use of those funds. What we do as a CCAC is direct delivery of service, care coordination, and it's quite a distinct function to what the LHIN provides. I'm not sure that the LHIN would be in a position to provide the kind of service that we do. Based on my experience in my working career, I think the differentiation between the funder and the service provider makes a lot of sense.

Tuija?

Ms. Tuija Puiras: Just to add, I think there is quite a bit of work happening with the evaluation of the services, and there are opportunities to look at integration more on a horizontal level, like community support service organizations, mental health organizations and so on, where efficiencies can be better accomplished.

Ms. Helena Jaczek: In other words, rather than reduce administration within the CCAC, you're talking about efficiencies amongst other health care—

Ms. Tuija Puiras: Virtual integration, as we have started with many of the service providers, where we are concentrating more on the actual service provision and making sure that there is better integration and seamless flow from setting to setting.

I will remind you also that we did merge already from 43 community care access centres in 2007 to 14.

Ms. Helena Jaczek: Okay, thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate you taking the time to come and talk to us this morning.

Mr. Rob Stinchcombe: Thank you.

NORTH WEST LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next delegation is the North West Local Health Integration Network: Laura Kokocinski, chief executive officer, and Reg Jones, board member. Thank you very much for taking the time to come and talk to us this morning. As with the previous delegation, you will have 15 minutes to use as you see fit. You can use any or all of that time. If there's time left over, we'll have some questions and comments from our committee.

The floor is all yours for the next 15 minutes. Thank you.

Ms. Laura Kokocinski: Good morning, Chair and honourable members of the standing committee. My name is Laura Kokocinski, and I'm the chief executive officer of the North West Local Health Integration Network. With me here today is Reg Jones, the secretary-treasurer of the North West LHIN's board of directors.

I would like to thank you for the opportunity to speak with you today as we review the Local Health System Integration Act. I have read through the Hansard transcripts, and the comments and questions being asked show your strong commitment to the health care needs of the people of Ontario and the sustainability of our health care system.

I am also aware that you have already received the LHIN's four recommendations about the legislation. As a result, my plan today is to focus on our local story: the North West LHIN's performance as it relates to the mandate given through the Local Health System Integration Act of 2006, and why local planning, funding, performance management and accountability are essential to these successes.

The North West LHIN has the largest geography of all the LHINs, with approximately 47% of Ontario's land mass and 2% of Ontario's total population, with nearly two thirds of our region having no road access. We, along with our 93 diverse LHIN-funded health service providers, face unique challenges in planning, funding and integrating health care services to ensure a healthier population and a strong, sustainable health care system

and service to all residents of northwestern Ontario. In fact, over 93% of hospital-based health care services for the people of northwestern Ontario are provided right here within our LHIN.

Health care system planning is complex. Over the years, we have heard from our health service provider partners the need for a common vision, something that brings the health system transformation into focus for northwestern Ontario. As a result, in 2010, the North West LHIN began a process of extensive consultation, community engagement, collaboration, and research to build a framework to guide the work of the LHIN and its stakeholders, culminating in the North West LHIN's Health Services Blueprint. I've provided a summary document in your package today for your information.

This blueprint is a customized, multi-year integration strategy made in northwestern Ontario, for the people of northwestern Ontario, that will improve population health, access to care, quality of care, and sustainability.

There continues to be significant engagement as we advance the blueprint, and I'm very proud to report that champions for change are taking on the leadership roles necessary for system transformation in our region, and you will hear from some of them today.

The LHINs have the legislated ability to bring health service providers together to implement innovative and effective local solutions that meet the unique needs of each community. Convening providers around the same table through a collaborative governance approach has been a critical step as we create a common vision to achieve a system that is population-based and person-centred. For example, we have reduced unscheduled repeat emergency department visits for substance abuse and mental health conditions through a program called GAPPS—Getting Appropriate Personal and Professional Supports.

0920

The GAPPS program began six years ago when the North West LHIN issued a call for proposals to reduce emergency department visits. Three separate providers submitted similar proposals. The North West LHIN met with the providers and asked, "What could you do if you worked together?" The result was the GAPPS program, built to respond to the unmet needs of a marginalized population of vulnerable persons with serious, unstable and complex mental health and addiction issues. For example, an individual we will call John visited the emergency department more than 88 times in a year, with 11 hospital admissions totalling 107 days.

Working with GAPPS, John was connected with permanent housing and the right care to stabilize his conditions. Because GAPPS helped John navigate the system to find the right care in the right place, he no longer visits the emergency department, nor has he been admitted to hospital in over a year.

Access to care can take on many forms. The North West LHIN eHealth strategy is one way we are improving access to care. Stemming from local planning and collaboration, as already noted, all 13 hospitals in our region share a common health information system. Almost 72% of primary care practitioners have implemented electronic medical records, and the vast majority of those have adopted a physician office integration approach, which allows them to securely receive patient data electronically, directly from any hospital in the North West LHIN.

I could talk about the financial and the health human resource benefits that are realized through this shared platform, but instead, I will speak to the impact on patients and their families. For example, imagine that Mr. Smith has been brought to the emergency department at the Lake of the Woods District Hospital in Kenora near the Manitoba border and needs to be transferred to Thunder Bay Regional Health Sciences Centre for acute care. Lab tests were started in Kenora, but the results were not available at the time of his transfer. By the time Mr. Smith reaches Thunder Bay, his medical information, including those lab results, will already be with the attending physician.

Seamless, person-centred care, care in the right place in the right time by the right provider, almost 500 kilometres from home: This is system integration at its best.

The LHIN continues to explore options to improve access to care. Through extensive community engagement, the people of northwestern Ontario, particularly seniors, tell us that it is important that they receive care closer to home. That is why over the past four years the North West LHIN has invested more than $18.8 million in the community sector, increasing access to home care, community support services, assisted living, supportive housing, community respite and primary care services.

In addition, telemedicine is widely used in our region, giving residents and health care providers the ability to consult with specialists thousands of kilometres away. Through LHIN funding, telemedicine clinical visits nearly doubled between 2010 and 2013, and the North West LHIN continues to be the second-highest user of the Ontario Telemedicine Network. Recent investments in a new Telehomecare program will support and monitor 300 people per year newly diagnosed with congestive heart failure and chronic obstructive pulmonary disease. They will learn to manage their condition, and emergency room visits will be reduced in the first year by over 20%.

With a sparse population dispersed over a vast geography, we know that mobile solutions also work very well for our region. For example, a made-in-the-north solution is the diabetes mobile unit, funded by the North West LHIN, which visits nine communities on a regular basis to provide primary care services such as eye care, foot care and diabetes monitoring, diverting people from emergency departments and improving the quality of care through better chronic disease management closer to home.

Even with these investments, access to care continues to be challenging for patients and their families in northwestern Ontario, and we know there is still more work to

be done. The LHIN legislation lays out an accountability framework, and the North West LHIN board of directors has developed a policy whereby the North West LHIN investments achieve desired outcomes and demonstrate value. Through our service accountability agreements, we are measuring health care performance, setting targets and holding health service providers accountable for achieving specific results and outcomes.

I'd like to illustrate how the North West LHIN demonstrates value for money. We recognized early on that chronic disease self-management was emerging as a leading practice in improving patient outcomes. In 2008, the North West LHIN implemented the chronic disease self-management train-the-trainer program. By 2009, more than 75 master trainers were positioned across the region, including as far north as Fort Hope, our northernmost community, on the shores of Hudson Bay. In 2010, the self-management program was transitioned to a health service provider that continues to operate the program today, with more than 300 people receiving self-management training and support each year through the region to manage their own chronic conditions.

The chronic disease self-management program gained provincial recognition and, last year, became a provincially funded program. We know this model works, and it works very well in our region. We are now embarking on a new self-management program that will focus on foot care, to reduce the number of amputations, decrease the number of hospitalizations and improve health outcomes for people living with diabetes across our region.

Over the past eight years, the LHIN has seen several voluntary integration initiatives that have resulted in reduced duplication, overall cost savings, and enhanced access to services: better value for health care dollars spent.

Last month, four providers shared two integration stories with their peers at the North West LHIN's biannual governance-to-governance session. The first integration saw a reduction in duplication when an Alzheimer's day program merged with a local supportive housing organization. In the second, a consumer-driven mental health agency amalgamated with a larger mental health organization. Successes were nearly identical. Duplication was reduced, and realized savings were reinvested into expanded patient care services.

The North West LHIN continues to work with its providers and stakeholders to look for innovative approaches that are cost-effective and evidence-based, in service to the people of northwestern Ontario. As regional planners, the North West LHIN recognizes that effective population health planning involves understanding the needs of patients, communities and the subpopulations that reside in our region, and the LHIN is well positioned to address these needs through the legislation, with decision-making at the local level.

I've told you about our geography. Now I'd like to talk about the people.

We know that residents of northwestern Ontario are among the most active in the province and have a strong sense of community belonging. However, we also have a high burden of illness and high rates of hospitalization and emergency department visits, particularly for diabetes, mental health and substance abuse, chronic obstructive pulmonary disease and heart disease.

The North West LHIN also has the largest population of aboriginal persons in Ontario, at almost 20% of our total population, and we fund 44 organizations to provide appropriate care in communities. Additionally, 3% of the population of northwestern Ontario is francophone. The North West LHIN understands that health care needs differ from community to community, and that it is important to provide culturally safe health care services for diverse populations.

The North West LHIN has a number of processes in place to ensure that these populations are actively engaged in health care planning, and they help to inform the LHIN's work. Many of these processes are outlined in the annual report, which we have included in your package today. Additionally, to address equity, in 2013 the North West LHIN added a diversity indicator to the health service provider service accountability agreements, and the subsequent reports will assist future planning in this area.

As you have heard, the North West LHIN has embraced the legislation and is working with communities, as well as funded and non-funded health care partners, to address the health care needs of the people of this region.

0930

Thank you very much for the opportunity to present to you today. Reg and I would be very pleased to answer any questions you may have.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about a minute and a half left. It will be the official opposition: Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation this morning. We really appreciate you coming to address us. I'm particularly interested in the way that you engage different populations. I know you've told us that they're in the report. We've heard from some First Nations groups that they don't feel that they are adequately involved in planning and consultation, not necessarily in this LHIN, but I'm wondering if you could tell us how you engage particularly First Nations and francophone communities.

Ms. Laura Kokocinski: I'll start with talking about the initial strategies that we put in place to engage our aboriginal communities and the populations. Back in 2008, we held our very first Aboriginal Health Forum right here in the city of Thunder Bay. We had well over 300 aboriginal communities, health directors, chiefs and councils that attended that, from Inuit, Métis, on-reserve and off-reserve individuals, to talk about health care.

What we were told at the time—this was the first time that that group of people had ever been together to begin to have a dialogue and a discussion about health care. Certainly, part of that forum was to talk about the process

in Ontario and what is happening with health care in Ontario.

Since that time, we've held two other Aboriginal Health Forums. Following that third forum, it was agreed that we would continue to work with the health directors. So we have 69 health directors that we meet with twice a year. We actually fund some of their travel. Due to some of the funding issues on-reserve, it's very difficult for people to get together. We also use telecommunication and videoconferencing to link people together to talk about what the needs of health care are.

In addition, as we're doing our integrated health services plan every three years, we have surveys that we also use and engage that population in discussion and dialogue.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your participation this morning. We very much appreciate it.

Ms. Laura Kokocinski: Thank you so much.

OPSEU, MENTAL HEALTH DIVISION AND HEALTH CARE DIVISIONAL COUNCIL

The Chair (Mr. Ernie Hardeman): Our next presenter is OPSEU, mental health division and Health Care Divisional Council: Ed Arvelin, registered practical nurse.

Thank you very much for coming in this morning. We very much appreciate your participation. You will have 15 minutes in which to make your presentation. You can use any or all of that time in that presentation. If there's any time left over, we'll have questions and comments from our committee members. With that, the next 15 minutes are yours.

Mr. Ed Arvelin: Thank you and good morning. With me today is Carl Thibodeau. He's an executive board member through OPSEU and part of our region 7 here.

My name is Ed Arvelin. I'm the Chair of OPSEU Health Care Divisional Council, which represents approximately 47,000 professionals and support staff in Ontario's public health system.

In 2010, the Ombudsman expressed concern about the level of public engagement by the local health integration networks. In The LHIN Spin, André Marin summarized what many of us were led to believe the LHINs would be about:

"Citizens, health service providers and other stakeholders were repeatedly told by government representatives that under the LHIN system, they would have a voice in the health services decisions that affected them. The public was assured that with the advent of the LHINs, an aloof, centralized bureaucracy would no longer be making significant decisions about the future of community health services. Instead, decisions would be informed by local needs and priorities, and made in and by the community for the community."

This contrasts greatly with what the LHINs themselves have had to say. Matt Anderson, a former CEO of the Toronto Central LHIN, speaking at a Longwoods forum in Toronto in February 2010, six months prior to the Ombudsman's report, was blunt about where the LHIN priorities came from. He told the forum: "If they"—the elected officials—"say these are the priorities that the people of Ontario wish for, these are the priorities."

Globe and Mail columnist Adam Radwanski questioned how Anderson, a rising star in the health system, could leave the most powerful LHIN in the province to eventually assume the helm of three suburban hospitals—Anderson is now the CEO of the William Osler Health System. The answer is simple: There is no real or substantial power at the LHINs. They are, by legislation, an extension of the Ministry of Health. We closed seven regional offices to open 14 in their place.

During the same speech, Anderson indicated that despite a budget of $4.2 billion, the real discretionary fund of the Toronto Central LHIN was approximately $10 million to $12 million. The reality of the LHINs has always been at odds with the vision that was initially sold to us and outlined by the Ombudsman.

Despite being weakened by the closure of regional offices and significant reductions in staff, the Ministry of Health and Long-Term Care still maintains all the real power, leaving the LHINs to essentially tinker around the edges and to take the blame when unpopular decisions are made.

Back in 2006, we warned that the LHINs would be used to deflect criticism around rationalization of our health care system. The examples of this are many. When the Globe and Mail reported on the closure of ERs in Fort Erie and Port Colborne, journalist Karen Howlett wrote in 2010: "Ontario Premier Dalton McGuinty is distancing his government from the controversial closing of emergency departments in two hospitals, saying it was a provincially appointed health agency that made the decision."

Cobourg's Dr. Alex Hukowich was an original member of the Central East LHIN board to 2010. In his departing speech to his fellow board members, Hukowich lectured his colleagues, concerned that quality indicators got less attention than financial accountability. He also emphasized the difference between accessibility and availability, particularly as it applied to such delisted OHIP services as physiotherapy.

At the end of his farewell, he presented the LHIN chair with a game he had invented that he said would help with decision-making. The game consisted of coloured playing pieces and a black box. Green pieces represented funded parts of the health system that were valuable, red pieces represented funded parts of the system of little or no value, white pieces represented new initiatives that would be good for the system, whereas yellow pieces represented new projects from special interests that were of little use.

The objective was to pick out the red pieces from the box while leaving the green pieces in. You had to do this while your opponent tried to toss in white and yellow

pieces. There was one other criterion: The player had to pick out the red pieces and deflect the yellow pieces blindfolded.

After four years on the Central East LHIN board, it was a frank admission that the good doctor had no idea whether they were contributing to the benefit of the health system.

At times, the board seemed to openly question whether the changes they made to solve one problem didn't inadvertently create new problems. Our health system is clearly interdependent and yet the big picture seems to be continually absent from specific integration decisions. After seven years of local health integration networks, we still really don't know the answer to Hukowich's question.

It's not like there haven't been good initiatives. Having an organization bring together varied community health providers has merit, especially if we want to move away from silo thinking. Health links, for example, appear to have promise even if it is too early to assess the results. One Toronto community mental health provider told us that at one time the dozens of agencies in the city had no idea who was providing similar or complementary services. That has changed under the LHINs.

The emphasis on financial accountability appears to have made a difference in reducing the number of hospitals running operational deficits. Like Dr. Hukowich, we would have liked to see a more balanced approach to the quality indicators, given these deficits were often fought at the cost of access to clinical services.

Having the LHINs in place has also given us an opportunity to intervene on planned closures and ask pertinent questions around service transfers, including whether adequate human resources have been put in place. We have also seen LHINs reallocate services and find new providers when an agency simply decides to close their doors. When Toronto hospice Perram House gave little notice of closure, it was the LHIN that was able to find last-minute alternate arrangements for the remaining palliative clients at the hospice.

One of the biggest difficulties for us was the realization that despite the broad definition of "integration" in the Local Health Service Integration Act, this did not mean that all of these integrations would be subject to detailed public disclosure or, often, an opportunity for public input in the decision-making.

0940

For example, the Ottawa Hospital decided last year to divest 4,000 endoscopies to the community. The LHIN decided that it did not constitute an integration because the hospital was merely following an accountability agreement. Clearly, the LHIN was willing to let the hospital shed any services it chose in order to balance its budget. This, we believe, is completely irresponsible.

Similarly, in 2008, when the Rouge Valley Health System decided to transfer acute mental health beds from Ajax-Pickering hospital and consolidate them with the Scarborough Centenary hospital, it was never treated as an integration decision. In fact, discussions between the LHINs and the hospital on the decision were not only withheld from the public but also from the LHINs' own working group on mental health.

When we unsuccessfully challenged the absence of public input at a judicial review, the LHIN made it clear that, given the transfer was taking place between the two sites of the same hospital corporation, it technically didn't constitute an integration. There was no shame in the fact that the public was completely shut out of this decision that impacted many families in the west Durham community.

At the time, the Ajax-Pickering hospital was undergoing a significant capital expansion that included a state-of-the-art mental health facility. The mental health unit was completed; it was never used. Evidently, to save money for the hospital's operating budget, the LHIN was more than willing to squander significant capital expenditures on the new facility.

While it would be simple to add up the failures of the LHINs and return to a central ministry-driven system from Toronto, we believe that this would be costly, disruptive and unlikely to make much of a difference. Instead, we would advocate that the LHINs themselves become integrated back into the Ministry of Health with a robust mandate to engage the public in health system planning.

When the LHINs were first established, we made a point that there was no evidence to suggest the regionalized health systems were any better than a central command-and-control system. Alberta now has both, yet continues to have among the highest health costs in the country, despite having one of the youngest populations.

The reality is that Ontario has both systems. It is clear from LHSIA—the act—that the LHINs take direction from the Ministry of Health and are only accountable to the minister. There appears to be very little independence, nor would we advocate it under the present circumstance, given the absence of any direct accountability to the communities they serve.

That raises the question as to why we have regional LHIN boards when all the real decisions are made by the ministry. It is odd that we have a health system with no central board, but 14 boards at the point of delivery in the regions.

That doesn't mean we believe the public should be shut out of the decision-making process. On the contrary, we believe the integration process should be expanded and enhanced so that the public has an opportunity to not only express their view but also to get full disclosure on proposals that come before the LHINs. We agree with Dr. Hukowich that there is too little information on which to base important decisions.

All integrations, as defined by LHSIA, should be subject to public engagement and full disclosure, including comparable operational costs, costs of transfers, volumes, impact on access and quality to patients, as well as how the change impacts other health providers in the region.

We should also know why the integration is taking place and when it is proposed to happen. We should know what public engagement has taken place to date, including the response to that engagement. We should know how to fit within regional health planning. Integration should also include transfers within the same corporation, especially given amalgamations can bring together very geographically disparate locations. No integration should ever take place where the destination of service is unknown.

We have become very cynical about promises that deleted hospital services will be replicated in the community without any detail as to where or when such services will appear. Our experience is that these services either fail to materialize or are done so in a way where access is significantly reduced.

We also believe that the public should be afforded a longer window to respond to an integration proposal and have the opportunity to depute before decision-makers, whether that is a LHIN board or, in the absence of a board, an appointed panel of experts. At present, only eight of 14 LHINs offer the opportunity to directly depute before their boards.

Ultimately, the LHIN should be responsible for ensuring compliance with the process, but it is the elected officials who must remain accountable for the decisions that are made.

It is our view that the province has repeatedly damaged its own brand by blaming unpopular decisions on the LHINs when the minister continues to retain the right to overturn such decisions. OPSEU president Warren Smokey Thomas will be appearing before the committee next week in Kingston with further recommendations for reforming the LHINs and will elaborate on some of the points I have made today.

Thank you for the opportunity to speak to you today, and I welcome any questions for the remainder of our time.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about a minute and a half. The third party: Ms. Gélinas?

M^me^ France Gélinas: Thank you so much for coming. It's a pleasure to meet you. I'm most interested by the comments that you've made: that "the LHINs themselves become integrated back into the Ministry of Health with a robust mandate to engage the public on health system planning." Take me down the—how would that work?

Mr. Ed Arvelin: We are developing strategies currently within the health care division council, as well as our president Smokey Thomas and Rick Janson, who is our health critic. Our planning is to put back and have the LHIN have maybe more power or more accountability to decision-making so that way it's not an arm's-length process where the minister has the ability to say, "Well, it was the LHIN that made that decision; it wasn't us."

M^me^ France Gélinas: So all of the powers of the Ministry of Health would then be transferred into those new units? Because the LHINs right now have a mandate for hospital long-term care but they don't have the mandate for primary care, for health units, for many other things, so I'm just curious.

Mr. Ed Arvelin: The strategy will be revealed more. Unfortunately, I don't have the plan right now. Rick Janson and Smokey will be reviewing that in Kingston. I could elaborate further; if you give me your email address, I can have our people forward that strategy to the LHINs presentation as part of the record.

M^me^ France Gélinas: I will be there next week to hear Smokey, so that's fine. Specifically—

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

FORT FRANCES TRIBAL AREA HEALTH SERVICES INC.

The Chair (Mr. Ernie Hardeman): Our next presenter is Fort Frances Tribal Area Health Services Inc.: Calvin Morrisseau, executive director. Thank you very much for coming in this morning. As with the previous delegations, you will have 15 minutes time allotted. You can use any or all of that time in your presentation. If you do not use it all and there's some time left, we'll have some questions or comments from the committee. With that, your 15 minutes starts now.

Mr. Calvin Morrisseau: Bonjour. Aanii. It's nice to be here. Good morning, Chair, and all members of the Standing Committee on Social Policy. I have with me my director of behavioural health, Lori Flinders. She also has an Anishinaabe name, but I can't pronounce it. My English name is Calvin Morrisseau and I'm an Ojibway, or Anishinaabe, from Couchiching First Nation. I work as the executive director of the Fort Frances Tribal Area Health Services in the Rainy River area. We offer home care, mental health counselling and outpatient addiction services to those 10 First Nations.

I'd like to acknowledge all of our people who suffer from illness in this great province of ours. I'd also like to acknowledge all our aboriginal peoples across the province who have sadly passed into the spirit world and those who are still suffering from the pangs of illness and disease.

0950

It is well documented that the indigenous population of this great province is the fastest-growing population as well as being the youngest. It is not surprising that the mainstream and indigenous populations have different priorities. It is these differences which I would like to address.

Aside from reviewing all of our differences in terms of world view, I'd like to address some of our similarities as well as some of our solutions to what we in the Rainy Lake area have put forth but which, unfortunately, have been met with silence on behalf of the provincial government and its bureaucratic arm.

I'd like to draw your attention to the three areas in regard to the LHIN; namely, their decision-making process, accountability, and how their obligations were fulfilled under the act. Our intention is not to create discord but, through open dialogue, to create a cohesive health delivery system for Ontario, and the Rainy Lake area in particular, in the most cost-effective manner possible. In doing so, we feel that total honesty must come forth in the most respectful way possible.

Our forefathers teach our people that communication is one of the most important aspects in creating balance in all our relations. It is balance which we seek in terms of services and financial resources. At this point in time, we feel that we have had difficulty in providing services in terms of home care; palliative care; treatment of addictions related to problems and associated illnesses; mental health, including psychiatric services; as well as other community-based programming supported by the LHIN.

In our area, for the most part, we have not had the same level of services in most areas as the rest of Ontario has. We have met with LHIN 14, and our concerns have been well documented at that level. However, nothing appears to be changing. We believe there needs to be an evaluation of the process and how the LHIN provides operational dollars to providers.

For instance, when Fort Frances Tribal Area Health Services goes to any of our 10 communities, it is not unusual for us to see up to 15 clients during one visit. One of our communities is two and a half hours away, and over one hour by dirt road. The community care access centre would see, if they went to that community, only one client, making it a very expensive client service. The new addition known as the rapid response nurse, whose commitment is to see a client within 24 hours of emergency room visits, would take one whole day to see one of our clients in these communities.

My questions at the integrated district meeting were as follows: Why did they not ask us what the best way to service our people was, before implementing something which would not work for us? If they did consult, who did they consult? It certainly was not the community or any of the agencies which provide the service. Why not make that part of an existing service delivery system which already visits those communities?

One of the hallmark features of the LHIN process is integration. We feel that the Drummond report spells out some important points which could spell disaster for the health and social service delivery system in Ontario.

We wish to be greater partners in ensuring two things are accomplished for our communities and Ontario: (1) that services are improved to each of our communities; and (2) that it saves money.

We suggest that there needs to be a greater look at integration at the service delivery level. We feel strongly that instead of using the CCAC model of services for all things, there are some key components which could be integrated within our program, thereby enhancing and reducing cost; for example, access to long-term care and case-management end-of-life care, chronic disease management, and acute care.

Fort Frances Tribal Area Health Services allows for greater access to home and community support services for our First Nations people we service in those communities. We all know the cost is far less to provide care for people at home, compared to being hospitalized. At Fort Frances Tribal Area Health Services, we have eliminated the middle manager by having our registered staff trained as case managers in our home and community care program.

In the preceding years, we significantly reduced the number of amputations in our catchment area. This allows the health care system to operate more efficiently and give us greater value for our money.

The Drummond report warns us with the following statement: Before health service costs take over all social programs, for a humanitarian Ontario, change needs to happen. We concur, as service providers and leaders in our community, that change must occur.

The Local Health System Integration Act, 2006, was the vehicle which heralded the transformation agenda for all Ontarians. Unfortunately, First Nations people, particularly those in our area, have not benefited from this transformation. We still see high levels of addictions and mental health issues, diabetes and other illnesses which create early deaths for our people. We need the government to listen to us as we strive to prolong our lives with the greatest quality possible, while ensuring our priorities are seen as important and worthy of consideration.

I was raised on my reserve and I was educated in two worlds, first by my father and grandfather, who taught me the way of the land—its herbs, roots and bark. They taught me how to live off the land, and to survive in minus-40-degree weather, skills I have not used often since being taught by my other teachers, the schools.

I am a graduate of Lakehead University, McMaster University and Confederation College, specializing in social work and addictions. I pride myself in being able to walk comfortably in two worlds, that of the Anishinaabe and that of regular mainstream society. In our health and social services world, as Anishinaabe, we must learn healing methods of our people, the Anishinaabe, and those prescribed in the clinical field. We are expected to be skilled in both, because that is the makeup of our people. Some are still very traditional, and some are not. To help our people heal we must be knowledgeable about both worlds.

We do not feel that we can discount the ancient practices of our people. In the area of addiction services, we use the sweat lodge and traditional teachings as key elements to healing. We firmly believe that the restoration of our identity through cultural revival is vital to the welfare of our people.

The LHIN needs to become even more aware of those practices in order to respond in a culturally appropriate way. I applaud their efforts to date; however, to enrich the cultural programming, a wide variety of cultural knowledge must be attained through the utilization of our

medicine people and elders. Immersion must be an increasing part of the LHIN development, especially in our area where such a high percentage of the population are indigenous, each having its own practices and beliefs.

When this is accomplished, you will understand the barriers and challenges faced by our people. For this to occur, consultation is critical. For instance, if we had been consulted, we may have expressed some challenges to the rapid-response nurses in our area. We may have raised concerns that detoxification or in-patient addiction services are non-existent; all people in our Rainy Lake area must travel outside their community to access these services, raising the costs and lowering accessibility to much-needed services.

Lastly, I would like to spell out our position on how the LHIN did in relation to fulfilling the act. We believe that the LHIN has made an effort of inclusion; however, their inexperience and lack of understanding as to the validity of First Nations delivery systems within each community has been overlooked. We believe that, in accordance with self-government principles, a direct-funding relationship which works toward bypassing the current agency, which is mandated to provide services, is critical to our health needs. This direct relationship has already been established, according to my research, in other parts of the province. Not only does it make sense to us; we believe it to be necessary for all concerned.

I would like to say gitchi-miigwich—a big thank you—for taking the time to listen to us. It is this dialogue which gives us hope that one day we will end the needless suffering of our people and gain affordable and easy access to the services we desperately need.

1000

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have exactly four minutes left, so we will just have one caucus do it. It will come from the government caucus: Mr. Fraser.

Mr. John Fraser: Thank you very much for your presentation and for your work in your community. I would just like to go back on a couple of questions, but first, in terms of how you were talking about engagement with the LHIN and their engaging you in terms of your participation in helping to serve your population: What would you say works right now and what doesn't, and what would you say would be the most important thing for you in that regard right now?

Mr. Calvin Morrisseau: That's a really big question.

Mr. John Fraser: It is, yes.

Mr. Calvin Morrisseau: It is a really big question. I'll try to answer it.

I think right now, the way the process works—my understanding of the process is that they have the governance govern meetings, and then there are different forums. I think what would be really useful for us is if we could set the agenda, if we could talk about the issues that affect our communities and the challenges we have in delivering the services in the communities.

I mentioned earlier that most service delivery agents will go out and see one client and then back. When we go out, we see up to 15 clients in one day. In terms of wound care—we've sat with people for palliative care. I think those are the stories that we need to address.

I was just at a governance session of the LHIN. It really had nothing to do with the challenges that we face. It had more to do with the challenges that broader society faces in terms of the hospitals and some of those service providers. We're talking about almost two different worlds. So I'm sitting there and I'm thinking, "I don't even know why I'm here, because it's really got nothing to do with how we do business."

I think that's the message that we have to get to the LHIN. We have to bring that message to them so that they can begin to hear us, because there are ways in which we could help them cut costs. There are ways in which we can deliver more enhanced services that will affect—like I said, we reduced amputation rates by over 90% in our area through good wound care, through diabetes education, through chiropody, which we bring to the communities. So it's not like going to a doctor's where you have to make an appointment. We'll see whoever we can for as much time as we can be there.

Mr. John Fraser: So if you had a recommendation in terms of a vehicle for you to express that, what you're saying is you'd like to set a separate agenda from say, for instance, that. Have a specific committee branch of the LHIN or—

Mr. Calvin Morrisseau: Yes. The other thing is that their board member—I tried to have a meeting with their board member because we wanted to talk about the specific First Nation issues. I was told, "That's not our First Nation representative; that's a LHIN board member." To me, they don't speak for us. Who speaks for us is our grand chief through the treaty agreements with Canada.

Mr. Mike Colle: Just to follow up on that very briefly: Why don't you ask right now what you would like to meet on and when you'd like to meet with the LHIN—right now?

Mr. Calvin Morrisseau: I would like to talk about how we can integrate with the CCAC to provide better services and enhance services in our communities, at a cheaper rate.

We've begun having those discussions, but the meetings have been six months apart.

Mr. Mike Colle: Okay. So you want to make that request of the LHIN—

The Chair (Mr. Ernie Hardeman): Let the man answer.

Mr. Mike Colle: —the CCACs?

Mr. Calvin Morrisseau: Yes, yes.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes your presentation. We thank you very much for coming forward and being so helpful with your information.

BRAIN INJURY SERVICES OF NORTHERN ONTARIO

The Chair (Mr. Ernie Hardeman): Our next presenter is Brain Injury Services of Northern Ontario: Alice Bellavance, executive director. Thank you very much for joining us this afternoon—this morning.

Ms. Alice Bellavance: Yes, it's still morning.

The Chair (Mr. Ernie Hardeman): As with other delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If you leave time at the end, we will have questions from caucus to use up the 15 minutes.

With that, thank you very much again for being here. The floor is yours for 15 minutes.

Ms. Alice Bellavance: Thank you. Good morning, members of the Standing Committee on Social Policy regarding the review of the Local Health System Integration Act and the regulations made under it, as provided under section 39 of the act. I'd like to thank you for the opportunity to submit this presentation. As indicated, I'm Alice Bellavance, the executive director of Brain Injury Services of Northern Ontario.

I'm actually not going to get into geography and all that other stuff that other speakers have done earlier, because that's usually my favourite rant. I'd rather get into what I wanted to speak about with regard to the LHINs.

We remain supportive of the principles that were laid out by the government when establishing the LHINs through legislation: local planning, accountability, community integration and co-operation.

Making the system work more like a system, leading with quality and safety through continuous improvement: The North West LHIN has developed a 10-year Health Services Blueprint, which is the culmination of extensive collaboration, research and leading methodologies, and community engagement with health service providers and related community partners. Other provincial initiatives, such as the launch of health links, are directed by the Minister of Health and Long-Term Care.

The challenge is of ensuring that "all players play nice in the sandbox together," especially some who are outside the purview of the LHIN or even outside of the Ministry of Health and Long-Term Care. Attempts at standardized software, to be utilized across the province for health links—the care co-ordination tool—hold promise.

There is a need for better communication between the Ministry of Health and Long-Term Care and the LHINs. A number of years ago, the North West LHIN approached the Northwest Regional Mental Health and Addictions Network about our recommendations with regard to the addictions supportive housing initiative, which we happily provided. However, the Minister of Health and Long-Term Care disregarded our recommendations and only funded certain health service providers. A similar process occurred, predating the implementation of LHINs, with regard to health accord funding. If agencies or networks are consulted for their recommendations, they should be valued.

The LHINs, along with health service providers and the Ministry of Health, need to work collaboratively to review the historical perspective of how some programs and services were funded under specialized initiatives, such as ABI funding—acquired brain injury funding—that was part of the repatriation of Ontario residents from American programs, which began in 1996 and was completed in 2002.

Millions of dollars were flowed through the then home care programs, which predated CCACs, to support community support service agencies—which is what we are—to develop supportive housing, which is now known as assisted living. It also provided intensive in-home support to families to care for high-need individuals at home, to prevent institutionalization of young adults. In the northwest, some of these plans were as much as $90,000 per annum, which is certainly still cheaper than keeping a person in the hospital.

When individuals died or moved into assisted living, these budgets were rolled into the base of established CCACs. Rather, these funds should be reallocated to dedicated acquired brain injury community support service agencies.

Ensuring value for money; holding the gains; a system-wide culture of accountability: Moving to a three-year cycle of community annual planning submission, or CAPS, which results in the development of our service accountability agreement—in our case, it would be the M-SAA—has been a timesaver and allows health service providers to be more strategic in their planning. BISNO, as a member of a number of provincial associations, such as the Ontario Community Support Association, Addictions and Mental Health Ontario, and Community Health Ontario, has stayed abreast of the negotiations to fine-tune these agreements.

There's also an increased emphasis on performance measure and quality indicators. Though the provincial ones seem to be focused on hospitals, the development of meaningful ones for the community sector will need to emerge.

Improving access; enhancing access to primary care; access to care that people need as close to home as possible: BISNO has been very fortunate, through the provincial ABI strategy and the North West LHIN funding, to implement services to smaller communities in the northwest to support this principle.

Individuals with complex multi-jurisdictional needs unfortunately need to stay in Thunder Bay. The unit cost is high, and we require some economy of scale as well as access to other specialized services which are only available in a larger urban centre. Again, with health links, it is anticipated that this will be further improved.

1010

Taking a population health perspective and promoting equity, enhancing coordination and transitions of care for targeted populations, and improved health care outcomes resulting in healthier people: The North West LHIN,

through its local administrative process, has given organizations like ours an opportunity to be included at tables to which we were not invited in the past. This is important for sharing visions for health care and best practices. There is a downside for regional providers such as ourselves, as we don't have the resources—human or financial—to be at every possible meeting. Recent moves to use technology will assist with this expectation.

There is an opportunity for the LHIN, Nishnawbe Aski Nation and health service providers in the northern integrated district network, or IDN, to further develop services for First Nations people we serve. As you heard earlier, we have a large aboriginal population in the North West LHIN, and it's about one third of our business in terms of our agency. Many of the First Nations people we serve get stranded in Thunder Bay due to lack of services closer to home, so we've established a business plan: Assisted Living in Sioux Lookout—Acquired Brain Injury, Rehabilitation Services and Assisted Living Project: A Business Case to Drive a Model of Care for the Town of Sioux Lookout and the 31 Remote First Nations Communities It Serves, phase 1. It's a stakeholder consultation and engagement document. It is ready to be circulated; we just need to get some confirmation from a few of the players.

The LHINs are not perfect. However, for BISNO, this has been a huge improvement, and we are prepared to continue to work within the current structure. Political rhetoric about the dissolution of the LHINs would immediately place the health system in crisis and further distract from more immediate issues impacting the delivery of home and community care, since we are the poor cousins to the acute care and long-term-care sectors. For hospitals and long-term-care facilities to remain healthy, we require strong and vibrant community and home care services for our citizens.

Keeping people living with supports in the community and out of hospital is the most effective means of health care delivery. Increasing investments in home and community care will address the alternate-level-of-care crisis and emergency department pressures. Both are provincial targets to be addressed by the Ministry of Health and all LHINs. In the past three years, the LHIN has funded us to support alternate-level-of-care clients in community settings.

We have run out of physical space. We have submitted to the Standing Committee on Finance and Economic Affairs the need for more assisted living, not just operating costs but also infrastructure, and I've attached a copy for your information.

Even with designated increases in the last two Ontario budgets, agencies are still behind on maintaining the necessary infrastructure, as budgets have not kept up with inflation. Many Ontario Community Support Association and AMHO members are now struggling to keep even more clients while solidifying the services they already provide. Acknowledging and addressing this reality is a key determinant in ensuring the effective delivery of quality results that the government and the public rightly seek. Funding allocations for ALC and/or other expansion is necessary; however, using current funding does erode existing base requirements, thus reducing capacity. Meeting collective agreements, increased utility costs and increased cost of supplies etc. can only result in a reduction of services when base increases are not provided.

The second connected issue is the shortage of home and community health workers. Recruiting and retaining workers is made difficult by the disparity in compensation and working conditions between the community health sector and the institutional health care sector. We must ensure, to meet current and future demand for community and home support services, that there is sufficient funding flexibility afforded the sector to attract and retain qualified workers.

Thank you, and I'll leave the rest of the time open for any questions that you may have.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have just a little over five minutes, so we will start with the third party in the round.

M^me^ France Gélinas: I just want to be absolutely sure that I understood clearly. Since the LHIN has come, your agency, as well as many others like yours in the community sector, feel that they are more valued, that they are being heard more and that they have more of an opportunity to be part of improving the system. Is this the message that you've tried to give us today?

Ms. Alice Bellavance: Absolutely.

M^me^ France Gélinas: Okay. So for you, and agencies like you, it has been positive. How do those positive steps translate into better outcomes for the clients you serve?

Ms. Alice Bellavance: Let me give you one very clear example around the whole alternate-level-of-care situation. People in the back of the room have heard me do this many times. We had a gentleman who had very high needs, very complex needs, who was constantly being hospitalized. I often referred to him as the Six Million Dollar Man because the cost to the system was huge. We finally received funding to get him out of hospital after he had been there for over a year, and we've now had him out of hospital for almost two months. In that period of time, he has not made one 911 call. Previous discharges from hospital, without any planning or consultation with organizations like ourselves or the CCAC to ensure that his discharge to home was going to be good—he would be back in the hospital within three hours after being discharged from hospital.

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

Ms. Helena Jaczek: Thank you so much for coming. We've heard the message around assisted living through—this is day 6 for us. Thank you for going to the Standing Committee on Finance and Economic Affairs. It's really important for community agencies to get out to that group as well.

I'm interested in your comment regarding performance measurement and quality indicators, because it's

very striking that, to date, the indicators are very related to acute care procedures and so on. Have you been consulted by the LHIN on moving forward with some community measures?

Ms. Alice Bellavance: I think that right now, organizations are just looking at measures that are in our own M-SAAs. I know the community support services sector has had some discussion with the LHIN around doing some broader system kinds of indicators. We haven't come up with any yet. I think our focus has been on the blueprint. It has now been focused on the health links and all of the IDN meetings.

Again, as small community support service agencies, where do you divide your time in terms of what your focus is going to be? So there's a bit of a balance struggle there.

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

Mrs. Jane McKenna: Thank you so much, again, for coming out here today. I just wanted to know if you could elaborate on this. You say that there is a need for better communication between the MOHLTC and the LHINs. What exactly do you mean by that?

Ms. Alice Bellavance: Well, you see, I've been at this for a very, very long time. I've worked in this organization for 23 years, and I was part of a provincial body that worked with the Ministry of Health at that time with the repatriation of people from the United States. We were spending about $30 million a year in the US to buy services for about 130 people on an annual basis. So the push was to get people home, but that meant we had to look at infrastructure and services in the province of Ontario.

There was a huge committee within the Ministry of Health and Long-Term Care, made up of bureaucrats from the home care sector, OHIP—because, of course, it was OHIP that was paying for people to be down in the United States when insurance funding and/or other funding ran out—people from the institutional sector, as well as the community support services sector, and they came up with plans. They designated Hamilton Health Sciences as sort of the case manager, to case-manage getting people back home from the United States. Hamilton Health Sciences and their acquired brain injury program worked with community organizations to get people back.

But there weren't necessarily mechanisms in place to roll out some of the funding the way that they wanted to roll it out. So they would use home care as it existed at that time and say, "Okay, we'll call it homemaking, and we'll allow this amount of money to pay to support an agency or a family to get a person home." Then CCACs were formed.

So, just for example, just in our LHIN alone, the amount of money—that was supposed to be protected ABI money—is just under $400,000, that has been rolled over into base somehow. It should be with a dedicated ABI agency.

That history in terms of moving some of those things forward—because the systems have changed about how we're going to manage that—that hasn't kept up with it. We're going to lose some of that historical perspective, and we're not going to remember why or how some of that stuff was funded.

I'm just using ABI as one example. I think there are many other programs within hospitals or community agencies that were funded for certain reasons, because that was the only mechanism available, but it may not still be the most appropriate.

1020

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation this morning. The time is concluded.

Ms. Alice Bellavance: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you for taking the time out of your busy schedule.

SIOUX LOOKOUT MENO YA WIN HEALTH CENTRE

The Chair (Mr. Ernie Hardeman): Next is Sioux Lookout Meno Ya Win Health Centre: David Murray, president and chief executive officer. Good morning, and thank you very much for coming to share some time with us this morning, and some information. You will have 15 minutes to make your presentation. You can use any or all of that in the presentation. If there's any time left at the end, we'll have some questions from our committee.

With that, the clock starts on your 15 minutes.

Mr. David Murray: Good. Thank you very much. I'd like to thank you for the opportunity to present to you today; it's both an honour and a privilege.

I just want to give you a little background. I've been in health care in Ontario for 25 years, and I've lived in over 10 different communities, from the north, in Sioux Lookout, down to places like Hamilton and Kitchener-Waterloo. I've lived in Sault Ste. Marie and North Bay, and I've worked for organizations in the primary care and ambulatory care settings, like the Group Health Centre in Sault Ste. Marie, which has been nationally recognized as a very innovative organization.

I've worked in a small CCAC, I've also run a large CCAC after the amalgamations in southern Ontario, and now I get to be the CEO of Sioux Lookout Meno Ya Win Health Centre, which is a very unique hospital, a beautiful $140-million hospital that has been built under what was called a four-party agreement. It was the joint effort of the municipality representing the provincial hospital, the federal government, the provincial government and Nishnawbe Aski Nation, acting on behalf of the 28 remote First Nations we serve that are fly-in.

Our hospital serves a third of Ontario's land mass, and we have 20,000 patients arriving each year by air, so it's quite unique. About 84% of the services we provide are to First Nations people from the north.

I should also mention that I was also a CEO of a LHIN, so I'm going to have some good things to say

about the LHIN. I know, reading through, that there have been a fair number of negative things, but let me start by telling you about the North West LHIN. Our LHIN has done a great job, I think, of developing a very sound blueprint for moving forward.

They have developed a very workable plan around some key integration concepts. I think you've heard about some of them. We have the 14 local health hubs that will see integration of services at the local level. This then feeds into the integrated district networks. There are going to be five of them, and each of the five networks has a district health campus to provide specialty services within that area. Then, the overlay on all of this is regional specialized services.

This is a plan that has been well thought out and well documented. It certainly supports local delivery and local decision-making, and it will also improve access to specialized services. We're very early in the implementation of this, but the leadership of the LHIN and the staff at the LHIN have been really excellent. Even if Laura wasn't sitting behind me, I'd be saying the same thing, I just want you to know.

When we look at it, this ability to direct where we're going at the local level is very important. Sometimes we tend to look backwards at the past, as though everything was so much better way back when. I remember a health care system before the LHINs, back in the 1990s, when I was involved in the home care sector and the creation of the CCACs. We had an 800% variation in home care funding by communities. If you were lucky enough to live in the Kingston area, you actually had eight times as much funding per capita as you had in Huntsville to deliver home care. There wasn't an equitable playing field. There were lots of mistakes made when there was central planning.

I know the LHIN legislation is very enabling. What has to happen, though, is that the decision-making has to be passed down to the LHINs—I should say "some decision-making," not all. There are still a lot of things that have to be decided provincially.

I want to focus on some bigger system issues in my short time here. One of them is unintended consequences, decisions that adversely skew delivery patterns. That's one area I want to talk briefly about. Telemedicine and virtual care opportunities are a second, and the last one I'd like to talk about is primary care.

Centralized decision-making often leads to unintended consequences. While the policy decision may look good on paper, oftentimes we get unintended consequences. I'll give you a couple of examples. Wait times: The Wait Time Strategy has been really good at reducing the waits for hip and knee surgeries, and there's been a lot of pressure and focus to drive hip and knee surgeries through rewarding hospitals to do this and setting targets for wait times and the number of surgeries done. When I was with the LHIN in the northeast, this had a particular problem especially in Sudbury, which didn't have the orthopedic capacity to do all of the wait time, and we ended up unwittingly moving resources away from doing oncology surgery and covering the ER with orthopedic surgery to doing wait time stuff. So it was an unintended consequence of the Wait Time Strategy.

Another one is ambulance services. We devolved ambulance services, took them away from hospitals, and set them up under either municipalities or district boards. In the north this has been pretty much a disaster in small communities. We now have stand-alone ambulance services with highly trained, well-paid staff, who sit in garages waiting for infrequent calls. These people used to work in the hospital, were far more valuable, and we could be using them more extensively in the hospitals today, but we have a model that, once again, works in large parts of Ontario, but certainly in rural and northern communities it doesn't work that well.

One of the other things is that sometimes decisions are made for very good reasons. Underservicing: During the 1990s we had a lot of problems trying to access specialty services. In our three districts here—Kenora, Rainy River and Thunder Bay—we had a need for 10 psychiatrists, and there was only one here in the 1990s. So the solution, on an interim basis, was to have psychiatric outreach from southern Ontario. We're 20 years later and that interim solution has become pretty permanent. Just last week, I got a beautiful annual report from the Ontario Psychiatric Outreach Program, from Toronto, and now what we've done is we've taken what was an interim solution and it's become a permanent solution, and it has skewed the way we deliver health care in our region. There are several examples of that.

One that I'd really like to talk about is the northern travel grant. This year, it's expected to cost close to $70 million. It's about $300 per person. There'll be over 200,000 people accessing the northern travel grant. That's roughly 1,000 people every working day, Monday to Friday, on the road going to access services from a specialist. That was started at a time when we didn't have enough specialists, so people had to travel to get services, and the northern travel grant was the way of lessening the load, financially, on the patient who had to access services. The problem is that we're now spending as much getting people to the service as it is to provide the service. The $70 million actually supports about $30 million of consultations, so we're really spending a lot of money moving people around. Those dollars could be better used to provide services in the communities where the people are coming from.

There's also a different cost, other than the poorer access and the inconvenience etc. In Fort Frances and Atikokan, just before Christmas, we had two different car accidents that killed three people: a husband and wife, and a fellow in the other one. In all three instances, they were travelling for appointments, so there's a tremendous personal cost in some of this as well. I did mention the fact that we're addicted to the northern travel grants and moving people around to support specialty services in urban centres.

One of the things we could be doing is a much better job of telemedicine and virtual care. Just as a disclaimer

here, I'm on the board of OTN, so I'm going to speak, obviously, positively about the work that OTN has done. OTN is the world leader in telemedicine, but one of the biggest challenges they continue to have is, is it an option? They will do about 400,000 consults—and remember I said that there are 200,000 northern travel grant consults—there are 400,000 virtually done by OTN, which is a good number. OTN's budget is only $22 million, so you're getting good value from OTN for those 400,000 consults, but remember, there are about 170 million consults in Ontario each year. So even at 400,000, we're not even scratching the surface with OTN, and this is something which is going to need a lot more muscle put behind it by decision-makers to make sure we drive a system where we use virtual care.

Just as a comparator, Alaska—a very similar geography, obviously, to remote parts of Ontario—for each dollar they spend on telemedicine, they save $11 in travel costs. But more importantly, for specialty consults, if you are in a remote community in Alaska and you need to see a specialist or have a consult with a specialist, 40% of the time you'll have that consult within 60 minutes; 60% of the time, within four hours; and 70% of the time, within 24 hours. In Ontario, we measure this in weeks and months, not in days and hours. So that's something to consider.

1030

The last area I just want to touch on—and this is a soapbox for me—is primary care. Having worked a lot in primary care—this is the engine that drives the health care system. I really think we have to find ways to bring primary care under the LHINs. The LHIN is the transmission that will connect it to the rest of the system. Right now, it's like an engine that's just running in neutral; we're not going anywhere. The ministry has tried dozens of different APPs and different arrangements. I'm here to pitch an idea that I think should be considered.

We have a model in Ontario that is very successful—Cancer Care Ontario—that has strong provincial guidelines and goals and objectives, and a very strong local delivery system. CCO has worked on and has done a tremendous job of improving cancer care services in this province. Maybe we should think about PCO, "primary care Ontario," and put together all the APPs, the CHCs and the CCACs as well—one of the misunderstood organizations in Ontario—as well as OTN and eHealth into a primary care juggernaut that could really change the way in which we deliver primary care and make it far more useful and accessible to the people of Ontario.

That's my pitch for the things that I think the LHIN should be doing. Our local LHIN is doing a good job. Thank you for the opportunity to present today.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about a minute and a half for each party, so we will start with the government side. Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Mr. Murray, for some really innovative ideas. I think a few of us jumped when you talked about "primary care Ontario," sort of modelled on CCO, because several of us have also advocated for a "mental health Ontario" as a potential way of bringing services together with strong provincial guidelines.

Could you perhaps expand a little bit on that idea—what you see as the benefits and how would you see them interacting with LHINs?

Mr. David Murray: Much the same way as CCO. What you need is a provincial organization which can set down the big ground rules of how it's going to work. Obviously, there's going to be resistance from the OMA and others. There's a lot of inertia in the existing system. We have so many different players in primary care now; I call it the alphabet soup of alternative payment programs. It's time to bring them together so that they have common goals and objectives.

Oftentimes, there are a lot of unintended consequences, as I was mentioning before, with APPs. You introduce APPs, and suddenly physicians walk away from their hospital work and they're no longer integrated with hospitals, or they stop providing other types of services that they used to do: supporting long-term-care facilities etc.

There's a fair number of things where we've got to standardize what happens in primary care, but you have to leave enough flexibility to make it work at the local level. In my particular hospital—I'm in a town of 5,000 people—we have 78 physicians on our staff. They're not all there all the time, obviously, but we do have around 18 regular physicians and we have almost 40 locum physicians who are fairly regular ones, and then others who just come on occasion.

The Chair (Mr. Ernie Hardeman): We'll have to stop there for the question from Ms. Elliott.

Mrs. Christine Elliott: Thank you very much, Mr. Murray. We're really intrigued by the concept of PCO. Like Ms. Jaczek, I'd like to learn more about it. Do you have any written material or anything else that expands a little bit more on the concept?

Mr. David Murray: As a matter of fact, I do. I think I might have even emailed it to you once upon a time.

Mrs. Christine Elliott: All right, I'll have to go back. As part of the submissions to this or—

Mr. David Murray: No, no. This was a couple of years ago, probably. I sent it to a whole bunch of—all three parties and people who were the health critics etc., and the minister.

Just to expand on it, the reason that I would make sure that eHealth and OTN were rolled into that: Virtual care probably provides us with the greatest opportunity to have a sustainable health care system. If we don't get it right at our level, we're going to soon see it happening around us. People aren't going to wait for the health system to respond. They'll just pick up their iPads and start doing it themselves.

Mrs. Christine Elliott: Would you mind—

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

M^me^ France Gélinas: So I take it that we will all receive a new, shiny copy of your ideas as to how we move towards "primary care Ontario"?

The idea of bringing primary care under the LHINs has been presented many times. You are presenting it in a way that could actually make it feasible, because, as you say, the pushback from some of the players is already there and will be tremendous. If we could move forward towards something better, then there's certainly value in sharing that with us.

Continuing on that thought, you would see not only primary care but you would see OTN and e-Health—all of this—also falling under the LHINs, so there would be 14 OTNs? How would that work?

Mr. David Murray: No, they would be there. Part of the reason to bring OTN is to make sure that the virtual care opportunities in Ontario are right across the province. There's been a lot of discussion, as you know, about CCACs and their role. CCACs are very powerful organizations and they use a common system right across all 14 CCACs. They have 236 offices across the province. They touch every part of Ontario, so it's a ubiquitous system. I think that OTN could bring that to the table, as well.

M^me^ France Gélinas: Okay.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate it. The time has been consumed.

Mr. David Murray: Thank you.

ST. JOSEPH'S CARE GROUP

The Chair (Mr. Ernie Hardeman): I understand the next presentation is not yet here: St. Joseph's Care Group.

Ms. Tracy Buckler: We are here.

The Chair (Mr. Ernie Hardeman): Oh, we are here. It's just that our good and faithful doorman didn't want you to come in.

Interjection.

The Chair (Mr. Ernie Hardeman): It must have been time to take a break.

Thank you very much for coming in. We have Tracy Buckler, president and CEO, and Ray Halverson, past chair of St. Joseph's Health Group. Thank you very much for being here this morning. You'll have 15 minutes in which to make your presentation. You can use all or any of that time for the presentation. If there's any time left, we'll have some questions from the members of the committee.

With that, the floor is yours.

Mr. Ray Halverson: Thank you, Mr. Chairman and committee members. My name is Ray Halverson. I have served, as a volunteer community member, as a director on the board of St. Joseph's Care Group in Thunder Bay for the past six years. With me is Tracy Buckler, the president and CEO with the care group.

Thank you for giving us this opportunity and thank you for travelling this long distance to Thunder Bay and for bringing this warm weather with you.

St. Joseph's Care Group, established by the Sisters of St. Joseph in 1884, is a regional health care provider with program areas including seniors' health, rehabilitative care and chronic disease management, and addictions and mental health. We have eight sites located throughout Thunder Bay and we employ over 1,700 people.

I would like to make a few personal comments from a board member's perspective before turning it over to Tracy. I am here today to express my support for the Local Health System Integration Act and the LHIN. I believe the act is sound. It offers an excellent opportunity to improve our health care system and, at the same time, make it more affordable. I believe also that the local/regional concept, as envisioned by the LHIN structure, is a good one, and that governance by local volunteer boards is of much benefit to our region.

The North West LHIN has done an outstanding job in providing education and capacity-building for both the local board directors and the health care administrators. It has provided extensive local engagement and consultation, the nature of which we have not experienced before.

Challenges that we experience in the northwest are going to be unique to our area and can be dealt with best by local discussion and problem-solving. As we respond to the needs of our population, we are beginning to see successes in program changes, partnerships and mergers that will result in better client care.

In my opinion, we now need to move to a strong focus on implementation of the intent of the act. Health service boards and the leadership of all our organizations will need to take a stronger system perspective and address in particular any duplication and fragmentation that exists. I believe this could best be addressed by a regional representative implementation team that would extend beyond the voluntary integration approach currently being used.

St. Joseph's Care Group supports the local health integration network structure overall and we appreciate the opportunity to provide constructive feedback to improve the effectiveness of our current health care system.

I will now turn it over to Tracy to provide more on the management perspective. Tracy?

1040

Ms. Tracy Buckler: Thanks very much, and good morning, Mr. Chair, and committee members. Thank you for the opportunity to speak with you this morning.

Mr. Murray went before me and stole some of my material, so I'm not going to repeat some of what you've heard already. Just to give you a little bit of context, I'm in my 29th year in health care in the province of Ontario and so have seen a fair amount of changes in structure and systems over time.

Also, to give you a little perspective on St. Joseph's Care Group, as far as our mission to meet the unmet needs of people in northwestern Ontario, we believe that our mission aligns very well with the intent of the LHIN

system from a local and regional focus and perspective. Our strategic plan fits very well with the LHIN priorities—the integrated health system plan.

We do have a regional obligation. You've heard about the challenges of land mass: 47% of the province's land mass and 2% of the population. So certainly trying to reach out in a way that's effective and provides care in the best manner for the people we're here to serve is an ongoing challenge and something that we strive towards every day. The low population, of course, has its own issues and challenges with respect to some new funding formulas and some population-driven challenges that way.

We want to comment on the North West LHIN particularly, as far as the benefit to the people of northwestern Ontario and to the health service providers. There are a few reasons for that. One is that the responsiveness to local and regional issues—geographical and the small and rural challenges—is better understood when you have some local context.

We have the opportunity to develop professional relationships perhaps on a closer-to-home basis than we might otherwise in previous systems. Also, leveraging the existing expertise of voluntary governance structures has been of benefit.

We understand that the Ontario Hospital Association and various other bodies that represent parts of our business have provided some written submissions, so we're not going to repeat that today. But I would like to just provide you with a bit of local perspective through the four themed areas that have been identified in the review, and I should say that these comments and suggestions are really intended as tweaks or opportunities to consider within the LHIN structure and the LHSIA review.

The first theme, then, making the system work more like a system: Ray has mentioned the education that has been provided, so the governance-to-governance sessions have been a real benefit to the various independent boards to understand the concept of integration and what that might look like and also to provide a level of understanding of the LHIN's role and function. We also think that it's important that there's continued work on developing that shared understanding of integration. I think people become a bit fearful and threatened by the big "I"—the capital "I" word. Integration can be a continuum, whether it's a partnership, a memorandum of understanding or a true merger in the sense of an amalgamation, so I think there's a continuum that needs to be recognized there.

The other couple of points, as far as making the system work more like a system: The opportunity is really that system outcomes can be measured more consistently. We need to focus on the accountabilities and the efficiencies in the system to enhance the effectiveness of all health service providers in our region.

We talked about the independent voluntary governance. We would suggest that similar elections or appointments processes for the LHIN board might be something beneficial in terms of good governance practices; that might be something to consider.

The other areas, the opportunities, the LHIN structure, the responsibilities—we would appreciate further clarity and definition of roles. I think that ongoing communication around the connectedness between performance and planning responsibilities is important.

You've also heard about some provincial or centralized initiatives versus the local autonomy. We think there's a role for both as far as the provincial standards and some standardization across the province but also to allow the local LHINs more autonomy to be able to do what makes sense in their region, and you've heard about some of the unique challenges of the northwest.

Secondly, the theme around ensuring value for money, and that's always a significant and important one: We believe there's an opportunity for some further clarification on the role of the ministry versus the LHIN, particularly from an operational perspective, as well as with respect to capital development, because there's still some centralized ministry role, for sure—just to clarify those responsibilities as to where we need to go for what, from a health service provider perspective, and how we might work together to streamline some of those processes would be extremely helpful.

We also wondered about the potential to integrate further roles into the LHIN structure from a capital perspective, from a quality perspective, and what possibilities there might be. Primary care has been talked about a couple of times. We wondered if there was opportunity to consider inclusion of primary care into the LHIN structure. It's certainly a significant part of an overall health care system and a significant amount of money being spent in primary care. It seems to me that if we worked in a truly integrated fashion and had opportunities for further dialogue and conversation with the primary care sector, things would be a lot better for the people whom we're here to serve.

We also believe that there's a role for the LHIN to assume some centralized command and control, if you will, in times of crisis; yet on the other hand, there's the LHIN's role for planning, responsibility and not managing daily operations. Those things need to be clarified.

I can give you an example of a program that, in Thunder Bay, with support from the LHIN, ensured value for money and improved access for people. We run a program for withdrawal management. The withdrawal management program was very over-subscribed. You've heard about some of the population challenges in the northwest. We were able to expand that program to allow for additional care within one of our centres and significantly reduce the visits to emergency departments, significantly reduce the visits to the jail, the police responsiveness. That was a great example and continued success as far as the value for money. As well, Laura mentioned the GAPPS program. We're one of the three organizations that provides that service to allow access for people who might not otherwise receive care. Particu-

larly in addictions and mental health, there's a big challenge.

Improving access to care is pretty significant and very important with this geography. You've heard about OTN; you've heard about telemedicine. The health links opportunity: It's a little early to tell what the successes might be as far as health links, but we believe that that may really improve access to care for those who need it the most and that telemedicine or OTN would certainly help that as well, given the dispersed population and our geography. The Health Services Blueprint that the LHIN developed, as far as the regional role, the local health hubs and the integrated district networks, seemed to fit well with the health links model. Again, we'll work in partnership to make that happen and hopefully reduce some of the fragmentation and try to look at better opportunities to improve access for the people who need our services.

Finally, the fourth theme, the population health perspective and promoting equity: We wanted to highlight that community engagement is a responsibility of not only the LHINs but every health service provider. We think that's a shared responsibility that we take quite seriously. Also, the quality of service that's provided: As local independent boards, our board has a responsibility to ensure the quality of care and service that's being provided.

We expect and acknowledge the expertise within the health care system—that not one person knows everything and that across the system there's a lot of expertise that can be leveraged to make sure that the services are the best possible. We also believe that the LHIN needs to advocate for our regional needs, as our region's planning body, and needs to know the gaps and the needs of the people who we serve.

Just in closing, we believe the intent of LHSIA and the vision for the LHIN structure has been more beneficial than the previous centralized model. There are still significant opportunities for improved care; there's much more work to be done. Potential cost savings will be realized by clarifying some of the sections of the act and with a concerted implementation that will ultimately better serve the people of the province by having a local and regional systems approach.

1050

The LHIN needs to work in close collaboration with all of the health service providers to ensure continued quality and safe care for the people that we're here to serve. I guess we all need to be system thinkers and certainly try to remove those silos to make sure that we're doing the best job possible.

Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have just over a minute left. The official opposition: Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for coming today and bringing us perspectives from the St. Joseph's Care Group. You mentioned that there are many things that still need to be done; we appreciate the things that are working. Can you tell us what your first priority would be for improved care with respect to the operation of the LHINs?

Ms. Tracy Buckler: I think that ongoing work needs to be done. As far as the first priority, we need to talk about more serious implementation of opportunities for integration in that continuum that I mentioned. Whether it's through partnerships or further memorandums of understanding, we need to get to the heart of the matter, which is to get a few things accomplished. There's been a lot of education, a lot of planning and a lot of development—which needs to happen, absolutely. Now we believe that it's time to get to implementation.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate your time, and sorry I didn't recognize you when you were here.

WESWAY

The Chair (Mr. Ernie Hardeman): The next presentation is Wesway: Margaret Boone, president, and Daniel McGoey, executive director. Thank you very much for taking the time to come and talk to us this morning. You will have 15 minutes to make your presentation. You can use all or any of that time as you see fit. If there's time left at the end, we'll have questions from the committee. With that, thank you very much again for being here, and the clock has started ticking.

Ms. Margaret Boone: Thank you very much for the opportunity to be here. I think it's really important that we continue to look at, evaluate and examine the things that are going on in health care within our province. I'm going to just spend a little bit of time describing Wesway, and then I'll turn it over to Daniel.

Wesway is a non-profit organization, and it's been going now for about 40 years. It's a community-based respite service for families, and those are families of individuals who are dependent on a family caregiver. The range of the individuals that we service is from right across the lifespan, from birth to old age, and many of them may be either frail seniors or people with physical activities, or maybe people with Alzheimer's or other kinds of dementia, or anyone, really, who is needing some family care.

We serve the city of Thunder Bay, plus into the rural area. There are 40 communities that we service as well, so that's a pretty wide range of services across northwestern Ontario. I think you can probably imagine the size and the range of the communities across northwestern Ontario. It means that Wesway has to be pretty flexible and pretty innovative in order to meet those individual needs and to meet the larger goal of looking at areas of cost reduction. I think that's one of the areas that LHINs have been able to help with, in terms of looking at some innovative ways and being able to test out some pilot projects in those communities.

Respite care is what we offer. That's our focus; it's all respite care. I'm sure that most people recognize that, if

you are responsible for constant caregiving of a family member, it's extremely stressful. It's time-consuming, but it's very stressful. It often can result in some real social isolation and some depression. People tend not to look after their own health, simply because they can't sometimes get to the places to look after their health. So it really starts to take a toll on the caregivers. When it takes a toll on caregivers, they can then become people who are needing the health care system as much as the individual.

What Wesway is able to do is give some respite to those people, even to attend to their own health needs or just to get a break, to get rest and be able to build themselves up again. So it's a very critical service within our health care system. We provide support for the families, and also, as I say, it allows people—not only care for the caregivers, but it allows the individuals to be able to stay at home, to have some dignity and to not be using up, essentially, very expensive and otherwise costly kinds of health services.

We're very much part of the continuity of care. To be able to provide a nice, smooth continuity of care for individuals, it really depends on integration, co-operation—people working together. To be able to go from a community into an acute care setting and back again and so on really means that we need people who are working together.

I think Wesway has had a long history of doing that, being able to co-operate and look and search for areas of integration, but this has certainly been enhanced with the work going on most recently by the LHINs. Particularly, as a board member, I've really appreciated their governance-to-governance meetings, which brings boards together to look at—if we're looking at policies and setting policies for our agencies, we're able, at a board level, to look at some of those as well.

We think that through that kind of—not only does it provide for a smooth transition and continuity of care, but it also, as I mentioned before, provides for areas of cost-cutting, because we don't have a lot of duplication. We're using and we're maximizing the resources that we have when we're able to work together.

The LHIN has certainly provided us the opportunity as a community group to come to the table, to work with others, to be heard, so that people know what we're able to offer, and as I say, then start working together to provide that kind of integration. They've also assisted with things such as pilot projects. As I mentioned before, we're servicing 40 communities in the region, so we need to look at some innovative ways, and they've been able to assist with pilot projects to look at some of those as well.

I think they recognize the need to decrease the stress and the increased use of emergency, very often by people who could be better cared for at home or have some of their immediate needs attended to in more of a home setting. That's one of the ways that Wesway can work with them.

I'm just going to close off and hand it over to Daniel, but before I do that, I just wanted to quote the importance of what we do from one of our family caregivers. I'd just like to read this quote to you: "I was caring for my husband 24 hours a day, and I wasn't getting any sleep. I was absolutely exhausted. I was at the end of my rope. But with Wesway's help, I was able to get someone to stay with him at night. It was such a blessing. I was able to look after him during the day because I was getting adequate sleep at night. I'm so glad I was able to keep him at home during his final days. It's where he wanted to be." I think that kind of sums up, in a way, what Wesway is able to do within the health care system.

I'll hand it over to Daniel.

Mr. Daniel McGoey: When I listened to your comments and your questions this morning, it's obvious that you've been at this a long time. You say "six days of intensive listening." You've heard a range of things. I think you asked a question that made me sit in my chair and say, "Oh, my God, she just took away my entire thing that I had to say." So I'd actually like to go back to your question. I think it was very, very informed.

1100

The messages we have are relatively straightforward: that we believe a continuum of care is the answer. We believe that primary care has its role, acute care has its role, long-term care has its role, but community care has an enormous role, because we know as individuals and we know as people who have constituents that we want to age in our place, in our homes, in our community, and we want care as close as we can.

We also know that there are four types of people in the room. There are people who have been the recipients of care, people who will be the recipients of care, people who have provided care or will provide it, and we know that the care of caregivers in homes of loved ones is the backbone of the Canadian health care system. If informal caregivers stopped providing care, the system would crash, so those are the people we have to support.

The community support sector, of which we're a part—you've heard this earlier, and it dealt with your question: The LHIN has allowed us to get at the table and to have a voice and to bring our focus to the discussion, which is that we need local planning, we need local solutions, we need support to caregivers. The health care field is a very large field, full of many, many groups, some very, very large and some very, very powerful. In the community support sector, it has in the past been very difficult to get to the table, to get through the rhetoric and to be heard. If nothing else, from our experience, that's what the LHIN has done. It has been that third party who has brought everyone to the table and said, "Let's respect everybody's roles, let's respect what everybody does, but let's make sure that everybody is doing what they do best and not everything else as well."

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about five and a half minutes. We will start with the PCs. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation. I think this is the second presentation you've given in a few weeks. I think you presented as well to the developmental services group?

Mr. Daniel McGoey: No, we provided it to the financial standing committee.

Mrs. Christine Elliott: Oh, financial. Okay, that's where I saw it, then.

Mr. Daniel McGoey: Yes.

Mrs. Christine Elliott: Thank you very much for being here anyway today, and you are performing a vital service in the community. The caregivers do need to be supported. We've certainly heard that from many groups.

What else could the LHIN do to further support the work that you're doing?

Mr. Daniel McGoey: I think they are doing it. I think that health links, if it rolls out properly, will be an enormous benefit because the principle of health links is twofold. Right now, they're focusing on the 1% and the 5%, which is a lot of the issue of primary care and acute care, but once that's rolled out, what they are looking at is community support services to make sure those people are diverted from the acute care hospitals. So I'm very excited at that because I think we will be able to perform a role that will allow acute care to do what they do best.

Mrs. Christine Elliott: Thank you.

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

M^me^ France Gélinas: You are the CEO and you are the president of the board. You can see that having a board adds value to your organization, and I'm sure you volunteer your time because you see the value of it. I would like to have a little bit of your insight as to what you think of the board of the LHINs, the process of having them nominated by order in council with the ministry, rather than the way that you choose your board members. Does that work for you? Is there something we could do better, given what you know from your own agency?

Mr. Daniel McGoey: Again, assuming that order in council is based on competency, we have no issues.

M^me^ France Gélinas: That's a big assumption. It's not always the case, is it?

Mr. Daniel McGoey: It would be one thing we would hope for.

M^me^ France Gélinas: Okay. Anything else?

Ms. Margaret Boone: I like the system because I think it takes it a little bit away from getting people on the board who are just the people you know. I think it gives it a much broader base. People look further within the community and the region when they're developing that board. So I like the system.

M^me^ France Gélinas: You yourself were elected at the AGM by the people who are members of your corporation?

Ms. Margaret Boone: Yes.

M^me^ France Gélinas: Okay. You realize that, at the LHINs, that's not how it's done?

Ms. Margaret Boone: Oh, I know that.

M^me^ France Gélinas: Okay. What are the advantages of the way that you got on the board versus the way people get on the boards of the LHINs?

Ms. Margaret Boone: The advantages for our board? Well, I think that for some of us, if we have an interest in an area, we'll approach that group to go on the board. Other times we're asked because people know we have certain abilities and qualifications. They will ask us to go on the board—

The Chair (Mr. Ernie Hardeman): We'll have to stop it there. To the government side.

Ms. Helena Jaczek: Thank you so much for coming in. Obviously, you're fulfilling a very important need in the community, so thank you for the work you do.

I presume that your employees are mostly PSWs. Would that be correct?

Mr. Daniel McGoey: No. Actually, what we've found is that we don't go for the regulated professions. Because the needs of families are so distinct, and we do serve families from birth to old age, we often find that, depending on the needs of the family, different workers are required. For children, one of the most effective workers we have is outdoor recreation.

Ms. Helena Jaczek: I see. So it's very individualized. Do you do some sort of training in-house in terms of standardization?

Mr. Daniel McGoey: Absolutely. We make sure that we've done quality assistance, we've done sensitivity, we've done back care, we've done medication policy, we've done health and safety, HR—absolutely.

Ms. Helena Jaczek: Are you finding it difficult to recruit people to provide this care?

Mr. Daniel McGoey: Yes, but for perhaps slightly different reasons. Our workers work anywhere from an hour and a half a day to six to seven to nine hours a week. What we find in community supports is that our workers are employed in at least four other agencies.

Ms. Helena Jaczek: I see. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much, and thank you very much for your presentation. It's much appreciated.

ONTARIO NATIVE WOMEN'S ASSOCIATION

The Chair (Mr. Ernie Hardeman): Next is the Ontario Native Women's Association: Kezia Picard, director of policy and research.

Interjection.

The Chair (Mr. Ernie Hardeman): Oh, it'll start by itself.

Dr. Kezia Picard: Oh, okay.

The Chair (Mr. Ernie Hardeman): Thank you very much for being here this morning. As with the previous delegations, you will have 15 minutes to make your presentation. You can use all or any of that time. If there's any time left over at the end of your presentation, we will have some questions and comments from the committee. If there's no time left over, that's totally up to you. Right

now it's your 15 minutes, so thank you very much for being here.

Dr. Kezia Picard: Thank you. Good morning, Chair and honourable members of the Standing Committee on Social Policy. My name is Dr. Kezia Picard, and I'm the director of policy and research at the Ontario Native Women's Association.

As Ontario's voice for aboriginal women and their families, the Ontario Native Women's Association is pleased to present to the Standing Committee on Social Policy as it begins its review of the Local Health System Integration Act. As director of policy and research, I'll probably be talking more about high-level policy issues here.

The Ontario Native Women's Association, ONWA, is a not-for-profit organization that was established in 1972 to empower and support aboriginal women and their families throughout the province of Ontario. ONWA's guiding principle is that all aboriginal ancestry will be treated with dignity, respect and equality, and benefits and services will be extended to all, no matter where one lives and regardless of tribal heritage.

This presentation is informed by our knowledge of the local health integration networks, or LHINs, the act, as well as our experience working with aboriginal women and their families. ONWA's submission is also shaped by our overarching mandate to provide the supports and resources necessary to empower aboriginal women and their families, build capacity within our communities and increase opportunities for collaboration for aboriginal women at the provincial, local and federal levels.

ONWA strives to address and respond to the service gaps and barriers that continue to impact our people, recognizing that aboriginal women continue to be marginalized by our system.

ONWA is the voice of aboriginal women in Ontario, and as such must ensure that the needs of aboriginal women and their families are reflected in all government policies and legislation. This is particularly needed at this level, in terms of the act being addressed today, because aboriginal women experience health disparities. For example, aboriginal women, as a population, have been identified as having the poorest health and shortest life expectancies in Canada. Aboriginal women and girls are three times more likely than non-aboriginal women to be victims of violent crime, and nearly seven times more likely to be victims of homicide.

1110

Aboriginal people in general are likely to get type 2 diabetes, the most common type of diabetes. Up to 40% of adults on First Nations reserves have type 2 diabetes versus 7% of adults in the general population.

Aboriginal women are three times more likely than non-aboriginal women to contract AIDS, and we know that the highest number of HIV/AIDS cases that are being diagnosed are in aboriginal women. Urban-dwelling aboriginal women have lower life expectancy rates, a higher incidence of victimization and violence, lower rates of employment and income security, increased likelihood of living in inadequate housing, and poor access to health services.

From ONWA's perspective, there is ample space for improvement in how LHINs engage with aboriginal women. There needs to be more emphasis upon health equity, the social determinants that contribute to poor health, culture-based services and the creation of aboriginal support systems within communities across the province—for example, facilitating sharing circles or peer support groups in a culturally safe way.

To achieve these changes, ONWA urges the committee to consider the following directions for change:

(1) Mandate the LHINs to incorporate a health equity approach, with considerations to the impact of social determinants of health on aboriginal women, and recognize the impact of intergenerational trauma on the health of aboriginal people.

(2) Enhance the capacity of the LHINs to support indigenous organizations to deliver culture-based, aboriginal-specific care that is responsive to the needs of our local communities.

(3) Widen the LHINs' scope to ensure that health equity outcomes, supportive services for mental health and addictions patients, and culture-based services for aboriginal people are included as part of the LHINs' strategic and operational plans.

(4) Support strong, aboriginal-specific, culture-based services that are informed by community engagement and input. The Aboriginal Health Policy for Ontario set precedent by recommending community control over program delivery and the authority to redefine programs as needed. ONWA envisions the LHINs supporting such community-based initiatives.

ONWA views health from a holistic, aboriginal perspective, recognizing that in order to feel healthy, we must not only be physically healthy but also mentally, spiritually and emotionally balanced. ONWA feels strongly that the LHIN must broaden and expand upon its approaches to health care so that it supports a holistic aboriginal health practice.

In reviewing the act, we are cognizant that the stated purpose of the LHINs is to improve the health and well-being of Ontarians. Beyond the preamble, however, the act shifts from focusing on improvements in health care to service integration. Though integration is fundamental to the operation of the LHINs, ONWA feels strongly that the goal of improving holistic health, supporting indigenous organizations to deliver culture-based services, and addressing the social barriers to health should be a primary goal of the act.

The LHINs' long-term goal should be fostering collaborative partnerships between themselves and aboriginal leadership. Under subsection 14(3) of the act, the ministry is mandated to establish an aboriginal health council to ensure that the needs and priorities of aboriginal peoples, including women, are heard and addressed. A comprehensive evaluation of the LHIN's roles and purpose in regard to its ability to adequately serve the needs of aboriginal people must be conducted.

In order to reform the LHIN to a system that will fully address the unmet needs of aboriginal women, ONWA has identified a number of outcomes:

(1) improving health equity outcomes for aboriginal women and their families;

(2) increased aboriginal involvement in the LHIN's planning processes;

(3) increased capacity of indigenous organizations and aboriginal communities to provide input throughout strategic planning and evaluation;

(4) increased emphasis upon preventive population health; and

(5) establish the aboriginal health council.

In order to implement these overall objectives, the committee must comprehensively examine the current act and engage in consultation sessions such as this, seeking out input from aboriginal communities and organizations on how best to amend the act so that it is cognizant of and informed by the health care needs of our communities and people.

I'll go over some of those recommendations in a bit more detail.

The health equity outcomes: On the issue of health equity outcomes, ONWA has duly noted that these are only referenced in the preamble. ONWA feels strongly that health equity outcomes and the social determinants that are linked to them are often at the root of the ill health and lack of balance experienced by aboriginal women. Poverty, intergenerational trauma and the lack of affordable housing all impact aboriginal women's health, demonstrating that health care is more than treating just physical illness.

All research indicates that aboriginal women have worse health outcomes than the general population. Aboriginal women have a lower life expectancy and higher infant mortality rates. We know that circulatory diseases and injury account for nearly half of all the deaths among First Nations people. We know that the province and the LHINs can do substantially more to advance equitable health outcomes and reduce these health disparities.

The ministry-designed health equity impact tool, which has been designed for the specific purpose of identifying and mitigating unintended health impacts by health initiatives, could be instrumental in ensuring that the programming offered by LHINs or any other provincial initiatives responds appropriately to the health issues faced by aboriginal women.

On our second point, increased aboriginal involvement in the health planning process: Indigenous organizations and communities must be involved in health planning that is responsive to our input and concerns. We ask that LHINs be respectful of the rights of aboriginal people to be involved in making decisions regarding our health.

As aboriginal women, we have historically been subjected to government decisions which were not in our best interests. This can no longer continue. LHINs must acknowledge and honour the constitutionally protected right of aboriginal peoples to actively participate in health planning systems and policies that will impact our health and the health of our future generations.

Additionally, as aboriginal people have cultural beliefs that guide our perspectives around health, we would like to see opportunities where our traditional medicines and healing practices could be integrated into the western model of health care. We envision a health care delivery system that is developed and operated by aboriginal people, informed by our cultural beliefs and traditions, integrating our traditional medicinal healing practices, and supporting our unique needs as a population. This is our end goal.

Speaking about point number 3, on community engagement: Failure to include aboriginal people in the development, implementation and evaluation of health programs and services is the primary reason why these services fail to improve the health of aboriginal people. LHIN board members are, in the main, unaware of the lived experiences of aboriginal people. It is for this reason that we recommend that LHIN board members attend engagement sessions. It is a significant amount of effort for many aboriginal women to come to these engagement sessions, depending on transportation, health care, child care needs etc. The LHINs should, at a minimum, actively listen at these sessions to hear their personal accounts and recommendations of people using their services. This will give them the opportunity to learn about our lived realities as aboriginal women.

Mandating that the LHINs "shall engage the community of diverse persons" does little to reassure aboriginal women that our voices will be heard and that our issues will be addressed in LHIN policies. ONWA also objects to the classification of aboriginal people as a diversity group. As aboriginal peoples, we have constitutionally protected rights which must be recognized by the LHINs and the act.

On point number 4, on a preventive population health approach: ONWA stresses that, while the effective treatment of illness is a necessary and critical component of the LHINs' health strategy, there must also be emphasis on prevention and holistic care. Shifting the focus from treating illnesses to addressing the social determinants that contribute to poor health, the LHINs can strive towards improving the overall well-being of the communities they serve.

The Aboriginal Health Policy for Ontario cautions that moving from a treatment approach to prevention requires promotion, education, and growing self-reliance regarding use of health services. LHINs must invest resources in these areas.

The LHIN should employ a population health approach, focusing on reducing the health disparities between aboriginal and non-aboriginal populations. As a part of its population health approach to care, the LHIN must also shift towards providing services that extend beyond the treatment of illnesses, recognizing that housing, education, food security, affordable child care, and employment are also part of a wellness-based life.

It is apparent that the LHIN does not wish to expand its services beyond providing immediate and long-term health care. Having reviewed the act, there is no mandate for the LHIN to address social health determinants, despite the fact that these factors have a significant impact upon the health and welfare of our most vulnerable populations.

Alongside the need to comprehensively address well-being, the LHIN needs to develop indicators that measure the health and well-being of the people who use its services. These measurements would demonstrate the linkages between preventive care and acute care.

Performance indicators and outcome measurements support the LHINs' obligations for accountability to the communities they serve. In addition, ONWA recommends that a culturally specific evaluation mechanism or tool be developed to measure and evaluate the unique health status and needs of aboriginal people. These unique indicators must be developed in collaboration with indigenous organizations and aboriginal communities.

1120

On point 5, addressing the aboriginal health council: Under the act, the ministry is responsible for establishing an aboriginal health council. Recently, we have made aware of the fact that there has been no progress on the establishment of the health council. Both ONWA and the Ontario Federation of Indian Friendship Centres have submitted letters to the minister requesting that the council be established. ONWA reiterates that the establishment of the aboriginal health council is only an initial step towards responding to the health care crisis that continues to severely impact the lives of many aboriginal women.

As Canada's first peoples, our lives have been shaped by the experiences of our ancestors. As a people, we are still healing from the impacts of colonialism; residential schools; forced enfranchisement; loss of language, culture and lands; the high rates of missing and murdered indigenous women and girls; and aboriginal women's differential treatment under the Indian Act. The establishment of the aboriginal health council speaks to our need to gather our experiences, share our knowledge and advocate for the changes that we need to see in order for aboriginal women to feel safe accessing our health care systems.

In the end, ONWA's recommendations are:

—that the act mandate the LHINs to engage with aboriginal communities and receive advice about local aboriginal health needs and priorities. Currently, there are seven aboriginal advisory committees within the 14 LHINs, of which the North West LHIN is one that has an aboriginal advisory committee;

—each LHIN must establish systems for direct engagement with aboriginal women. ONWA must be assured an allotted seat on all aboriginal advisory councils within any LHIN in which they are established;

—as outlined in section 14(3) of the act, the ministry must establish an aboriginal health council. It is imperative that the council be established immediately to ensure that the needs and unique voices of aboriginal peoples across the province are represented;

—LHINs should be required to work with aboriginal communities and indigenous populations to ensure that culture-based service options are available for aboriginal people across the province, and that these services are evaluated with a culturally specific evaluation mechanism to demonstrate success or signal the need for change—

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

Dr. Kezia Picard: —Introducing an aboriginal-specific health data identifier to track ongoing service utilization by all aboriginal people would facilitate evidence-based planning;

—the focus of the LHINs must shift from an acute-care approach to a population-based approach, based on culturally specific aboriginal models;

—recognizing that 80% of aboriginal people live off-reserve, each LHIN board of directors should have one mandated seat for a community-selected member of the urban aboriginal community; and

—the act should be amended to ensure that the LHINs prioritize supports and services for mental health and addictions issues.

ONWA recommends that the LHINs develop a system that is founded upon the delivery of community-based services that are informed by the determinants of health that are developed through collaboration with aboriginal organizations and communities that are efficient, co-ordinated and culture-based. We again thank the Standing Committee on Social Policy for the opportunity to present and we look forward to further invitations to engage and sit on the health council.

The Chair (Mr. Ernie Hardeman): Thank you very much, and very well done on the timing. Sorry I interrupted you, or you would have been just under. So thank you very much for your presentation. It's very much appreciated.

Dr. Kezia Picard: Thanks.

The Chair (Mr. Ernie Hardeman): And we do look forward to the opportunity to give you this opportunity again. Thank you.

Dr. Kezia Picard: Thank you.

THUNDER BAY HEALTH COALITION

The Chair (Mr. Ernie Hardeman): Our next presentation is the Thunder Bay Health Coalition: Jules Tupker, co-chair. Thank you very much for joining us this morning. As with the other deputants, you get a 15-minute time slot. You can use any or all of that in your presentation. If you have some time left at the end, we will have some questions and comments from the committee.

With that, thank you very much for being here. The next 15 minutes are yours.

Mr. Jules Tupker: Thank you very much. My name is Jules Tupker and I am a co-chair of the Thunder Bay Health Coalition. The Thunder Bay Health Coalition is a

public advocacy, non-partisan organization made up of community groups, individuals and unions who are committed to maintaining and enhancing our publicly funded, publicly administered health care system. We work to honour and strengthen the principles of the Canada Health Act and medicare. The Thunder Bay Health Coalition is affiliated with the Ontario Health Coalition.

I find it quite interesting to be here today eight years—almost to the day—after I presented to this committee with regard to Bill 36 on February 2, 2006, raising some of the same concerns now as I had then.

The first concern I raised in my presentation in 2006 was that of the myth of control over issues facing northwestern Ontario being given to the citizens of northwestern Ontario through our own LHIN. In that presentation, I raised concerns over the language in sections 3, 7, 8 and 18 of Bill 36 that led me to believe that the government in Toronto maintained control over the appointment of the board of directors, the designation of the Chair, the remuneration of the board and the signing by the board to an accountability agreement with the government that would ensure the board would abide by the government's wishes. What I see today is that our local LHIN has put into place numerous initiatives and procedures that originated with the ministry in Toronto, leaving me with the question of why we have a highly paid group of people in Thunder Bay just passing on what was ordered not in northwestern Ontario, but in Toronto. I don't work in the health care field, but I have to wonder if the introduction of the LHINs is any better than the health council system that it replaced in providing efficient health care in northwestern Ontario.

Through our affiliation with the Ontario Health Coalition, the Thunder Bay Health Coalition has been able to keep abreast of issues surrounding possible hospital closures and/or the transfers of hospital services to independent health facilities. We know that these transfers are happening in southern Ontario, but we are unaware at this point of any anticipated closures or service transfers in the northwest. We would expect that, because of the vast distances between communities in the northwest, closures or transfers would not be planned, but if it is happening in southern Ontario, it can happen here under orders from the ministry in Toronto. These closures and transfers have been opposed by many citizens in the respective areas; however, they have taken place nonetheless, leaving us to question if public input into local health care issues really is a part of the LHIN's mandate.

To the general public, "integration" is understood to mean coordination or a combining of services. Under the Local Health System Integration Act, however, "integration" is defined in such a way as to give extraordinary powers to the LHINs and the Minister of Health to order closures, amalgamations and mergers, or even total dissolution of health care provider entities. These are extraordinary powers that did not exist prior to the LHINs legislation. The protections offered in the LHINs legislation for public input and an open public process in decision-making are too unclear and too limited.

In 2012, the Ministry of Health approved the decision to close the Thunder Bay Interim Long Term Care home, a 65-bed facility in Thunder Bay owned by Revera, a private for-profit company. In this closure, the faults in the planning process and the total inability of the public to access information that should have been in the public domain became very clear. The public was never properly informed of who made the decision to close the beds or for what reason. Sound process, including public consultation and the ability for the public to make written submissions, was ignored. The impact on the Integrated Health Service Plan for the North West LHIN was either improperly assessed, or that assessment was ignored.

Thunder Bay could not afford to lose 65 long-term-care beds. The need for these beds was and still is simply too great. In 2012, when the beds were closed, Ministry of Health data showed that there were more than 400 people on waiting lists for long-term-care placements in this region, and residents requiring long-term care faced the longest waits in Ontario. The public relations message from the LHIN about the bed closures focused on the "interim" nature of the licence of these beds. This is a technocratic response that does not address the very real human suffering caused by the upheaval of bed closures and long waits in this community. Since the opening of the new centre of excellence in long-term care, CEISS, is delayed until at least 2015, why would the interim beds have been closed without any replacement beds being made available? The new CEISS building will add a very small number of beds—20, as far as we know—to the overall total of long-term-care beds in Thunder Bay.

With our parent organization, the Ontario Health Coalition, we wrote to the North West LHIN seeking information about the closure. They informed us that they did not consider the decision to close a health service provider and cease its operations an "integration decision" under the Local Health System Integration Act, 2006. However, under section 26(1) of the definitions, such a decision is clearly an "integration decision," which requires a set of processes. We believe that the public had the right to know who proposed to close these beds and why. The LHIN claimed it was the Ministry of Health in Toronto that made the decision; however, they did not answer any other key questions that we had about the decision. They did not answer our question about what facts or information were the basis for this decision. They did not provide us with the documents we requested comprising the approval to close the beds.

Under the LHIN legislation, section 26(3), the public may be provided with notice about the integration decision and be given 30 days to make written submissions. Note: The language of the legislation says that the public "may" be provided with this notice and opportunity to give input. This is inadequate. The Ontario Ombudsman made very strong recommendations that LHINs improve their public consultation practices. In the case of

the TBI closure in Thunder Bay, there was no notice given to the public prior to the finalization of this decision. There was no opportunity for public input. From our discussions with residents, families and community members, no one impacted by the decision to close these beds was consulted, nor was anyone given 30 days to send in their concerns in writing.

We asked the LHIN to provide any documents showing when and how public notice was given prior to the finalization of the decision to close beds, as well as any documents informing the community that they had the right to make written submissions. We also asked them to provide any documents that outlined the consultation process regarding this integration decision. They did not provide us with any of these.

1130

Further, under the LHIN legislation, section 16(6), the health service provider—in this case, Revera—was required to engage the affected community when making plans for the closure. We have not been able to find a single instance in which this was done. We asked the LHIN to provide any documents that showed that the LHIN required Revera to live up to this obligation under the act and any documents that related to Revera's consultation with the affected community. They did not do so.

Additionally, under the LHIN legislation, section 26(7), any integration decision by the LHIN or by the Minister of Health—that's section 27(7)—must comply with the integrated health service plan for the region. According to the North West LHIN's integrated health services plan, access to long-term-care homes is listed as a core priority, as is reducing the alternate-level-of-care problem, which is dependent on improving the supply of long-term-care beds. According to the local health services integration plan, "The North West LHIN has the longest wait time to LTC"—long-term-care—"placement of any LHIN ... and is the third highest for patients on the LTC wait-list per capita."

We asked the LHIN to provide us with any documents showing their evaluation of the proposal to close the 65 TBI long-term-care beds and its impact on the excessive wait-lists for long-term care in our region, as well as how it complies with the stated priorities in the LHIN's integrated health services plan. They did not provide us any of this information.

Finally, we asked to receive a copy of the licence agreements with Revera to operate these beds. They did not provide this.

In addition to the request for information by the Ontario Health Coalition, the Thunder Bay Health Coalition, with the Service Employees International Union, met with the Minister of Northern Development and Mines, Michael Gravelle, and MPP Bill Mauro to raise concerns over the closure of TBI and again asked these two members of the governing Liberal Party to have our questions answered concerning the closure. A letter was sent from Minister Gravelle to the Minister of Health and the CEO of the North West LHIN, Laura Kokocinski. To this date, neither the SEIU nor our coalition has received a response from either person.

The issues we have raised here illuminate the problems that we see with LHIN processes, and we believe these problems need to corrected:

—Key decisions about health services are made in an undemocratic fashion without public access to information.

—Health planning bears little, if any, relation to assessed needs of the community.

—The focus on integration, meaning mergers and restructuring, has overtaken key planning functions so that basic health care planning—that is, measuring and trying to meet population need for services—is not done. We wonder if there has been a proper capacity assessment done on how many hospital beds, long-term-care beds, primary health care services and health care services are needed in each of the LHIN's five health link areas. To the best of our knowledge, the hospital and long-term-care bed capacity plans were done in the early to mid-1990s. Under the LHINs, there appears to be no logical attempt to meet community needs for care.

—The LHINs do not follow their own process for integration decisions; that is, providing public notice and enabling public input.

—Vital documents pertaining to health planning decisions in the LHINs are very difficult, if possible at all, to access by the public.

In general, we feel the North West LHIN needs to become more open to the public in its decision-making and more accessible to questions by the public about decisions made concerning health care in the northwest.

Thank you for your time and interest.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have six minutes left, so we have three minutes for each caucus, starting with the third party. Ms. Gélinas.

M^me^ France Gélinas: Thank you so much for your presentation. You made it clear that you went through quite a bit of time, effort and energy to try to communicate with your LHIN about questions that are within their mandate and came out completely empty-handed and still are waiting for those answers to those questions.

If you had to choose one, what would you like to see change? Do you want change at the local level, or do you want change at the provincial level? If you were to decide, what would you do?

Mr. Jules Tupker: The initial intent, of course, the idea of the LHINs, when it was first introduced back in 2005 or 2006, was a great idea. Somebody within Thunder Bay, within northwestern Ontario, making decisions for northwestern Ontario is really important.

I come from a union background, and decisions with CUPE are made in Toronto. They have a different effect in southern Ontario than they do in northwestern Ontario.

You've heard many presentations today about the distinct issues facing northwestern Ontario. The idea of having a LHIN that makes decisions that bear on the health care of northwestern Ontario is phenomenal.

I don't think that is happening. I think it does happen to a fair extent, but I think there are a lot of decisions made in southern Ontario that the northern Ontario LHIN has to abide by but don't fit.

M^me^ France Gélinas: We've heard about clarity of roles, to really clarify what it is that the LHIN does and what it is that the ministry does so that it would be clear. Would that help?

Mr. Jules Tupker: Yes, absolutely.

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

Ms. Helena Jaczek: Thank you for coming in and providing us with an example of where you felt clearly the communication just was not working at all. Obviously, we're working at the legislation here. Is it more that you see that we need to improve—I guess this is picking up from Ms. Gélinas—sort of the clarity of the roles? Is it the way the legislation is being implemented locally that you feel is at fault? The intention, as I read the act, is to foster communication, to open channels. How do you see us moving forward? How do you see us taking what you're telling us and somehow ensuring that the communication and the explanations and all the public consultation is actually taking place?

Mr. Jules Tupker: I don't know. The language in the legislation is quite clear, that there has to be public consultation.

From what I understand—and again, I'm not in a health care field—there is communication with the institutions that provide health care. That seems to be the LHIN's interpretation of dealing with the public. I'm a member of the public. I'm involved with the health coalition; I'm involved with a number of other organizations—injured workers, the elder abuse committees in Thunder Bay. I don't know anything that goes on. There's nothing in the paper about consultations with the public. I think that's what has to be brought forward to the LHINs, either Toronto or the LHINs—they've probably heard it today—that they have to expand and try to get the public involved in these decisions, not the people that provide the services but the people that are receiving the services. I think that's important.

Ms. Helena Jaczek: Thank you.

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

Mrs. Christine Elliott: Thank you very much for your presentation. My question is very similar to the ones that you've heard already about the clarification of roles. I think you have some general problems in accessing information and some specific ones that you've really tried, through members, to get that information. Where do you think the problem really lies? Is it with the LHINs themselves or is it with the ministry?

Mr. Jules Tupker: Well, good question. We have sent letters to the LHINs themselves. As I said, we sent it to the CEO of the LHINs and we haven't even received a response. That's troubling. Is that from Toronto? I'm assuming it is. That's the local LHIN's issue, and it's very disappointing because I know they work very hard at doing what they do. But they've ignored me. The fact is that maybe I'm just a Joe Public and I don't really have any influence in the health care field, so maybe they don't feel it's important that they get back to me because it doesn't really matter if I know what's going on. That's just the feeling that I get, and the people that I associate with feel that—"You're just Joe Public. Don't worry; we know what's best for the health care system because we are in the health care system, and we'll let you know what decisions we make. We know what we're doing, anyway."

I can't speak for the other LHINs; I can just speak for our LHIN. I'm assuming that—I don't know; it might be a government mandate to not let the public know: "We don't want to know, actually, what people think, just what our own people involved in health care think."

Mrs. Christine Elliott: Okay. Thank you.

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

KENORA CHIEFS ADVISORY

The Chair (Mr. Ernie Hardeman): Our next presenter is the Kenora Chiefs Advisory: Joe Barnes, executive director. Good morning, and thank you very much for joining us this morning.

You have 15 minutes to make your presentation. You can use all or any of that time for your presentation. If there's any time left at the end of it, we will have questions and comments from our committee. If not, they're your 15 minutes, so we want to hear your presentation. Thank you.

Mr. Joe Barnes: I'd like to thank you for the opportunity to come here and present to you today. First, I want to make it clear that I do not speak for First Nations or for any First Nation people. I speak for our organization only, which is the Kenora Chiefs Advisory.

Kenora Chiefs Advisory is a fully accredited organization which has received the highest level of accreditation from Accreditation Canada. Our mandate is to provide programs and services to our First Nations in the fields of health and social services. Our board of directors are the seven First Nations chiefs from our member communities

The funding that we receive from our LHIN is mental health and addiction program dollars. We provide mental health and addiction counselling services to 14 First Nation communities in northwestern Ontario, with the distance between the most easterly and most westerly communities being four and a half hours.

1140

Besides delivering counselling services, we have a crisis response team that goes to our communities and helps them through a crisis situation. From June of this year to December of this year, we responded to 61 crises in 14 communities—everything from suicides to murder.

Our organization needs to work with other groups. We held a Silos to Solutions forum where mental health service providers, hospitals, police forces and advocacy groups came together to create linkages, share best

practices and develop formal inter-organizational procedures and protocols which will guide front-line workers when sharing clients and resources. Over 50 people attended this event in Kenora.

Another program that we're funded for from the LHIN is an aboriginal diabetes education and healthy living program. This program is delivered to seven of our First Nations member communities by a registered dietitian and a certified diabetes educator, who work closely with the community aboriginal diabetes initiative workers, health directors, schools and daycares to address the needs specific to each community. Diabetes is an epidemic in our communities, which we need to bring under control and work on developing more preventive programming for.

Our organization held a diabetes strategic planning session where front-line workers, dietitians, hospital staff, pharmaceutical companies and a prevention specialist came together to develop working relationships and share best practices. This group continues to work together. They have created a Kenora diabetes directory and held a Kenora World Diabetes Day Health Fair and a Kenora Diabetes Expo.

The third program that we get funded from the LHIN is a long-term-care program. We provide support services and training to our member communities for their community home support and home maintenance programming. Our goal is to have individuals receive services and care at home to enable them to live in their communities for as long as possible. We also work with our local hospitals and community care access centres to ensure proper discharge planning and outpatient services are being provided to our community members. This has been an ongoing challenge, and we have had instances where the oversight of the coordination of these services has put our clients at risk.

Our organization continues to advocate for quality health care services for elders in their communities. We are holding elder abuse awareness workshops in our member communities. We have been meeting with our communities, our local hospital and CCAC to improve discharge planning and after-care services. We have developed a strategy for supportive housing and a First Nations long-term-care facility. Unfortunately, we are being challenged with existing government jurisdictional issues, which are preventing us from moving forward with this initiative.

Our organization has identified a fragmented health care service system for our community members. The only way to improve the system is to create partnerships, integrate services and develop a continuum of quality health care services closer to home. This will ultimately improve client care and improve the overall health status of our First Nations community members.

We will not achieve our goal without the support and partnership of our local LHIN. LHIN 14 has been working closely with us since the establishment of the LHINs, and we would not have been able to achieve what we have to date without our partnership with LHINs.

The Local Health System Integration Act, clause 16(4)(a), requires each LHIN to engage the aboriginal or First Nations health planning entity in their geographical region. For the Kenora Chiefs Advisory, the LHIN 14 board of directors, executive director and senior staff have met with the KCA board and our chiefs at our every request.

The executive director and senior staff have participated in our health forums that I just mentioned, and have worked with us on developing strategies for service integration and partnerships. When we are challenged with an issue from other providers or resistance for partnerships, the LHIN has been proactive to bring us all together to work on strategies to resolve the issues in partnership.

LHIN 14 has invited us to be on every working group within their system, and we sit on the integrated leadership council of the LHIN. As the executive director, I feel that LHIN 14's management and staff are dedicated and have made every attempt to work in partnership with our organization on health planning.

The local health integration act's clause 13(3)(b) requires the LHINs to submit an annual report, which must include specific information, including data specific to aboriginal health issues addressed by the local health integration network.

The Kenora Chiefs Advisory board of directors know that having accurate health data is a critical part of developing health services. The Kenora Chiefs Advisory has developed a First Nations client registry, and is working with Health Canada, Canada Health Infoway, the Ministry of Health and Long-Term Care, eHealth Ontario, Cancer Care Ontario, the Ministry of Aboriginal Affairs, the privacy commissioner's office, the Institute for Clinical Evaluative Sciences and LHIN 14 to develop interoperability with provincial registries, and to develop data-sharing agreements specific to First Nations health.

The LHIN 14 senior staff participate on the working groups for this project and contribute their knowledge and expertise in the development of the registry. This registry will assist us to ensure that we have accurate First Nation health statistics, which will enable us to prioritize and plan health services to meet the needs of our community members.

The LHIN working with Kenora Chiefs Advisory on the First Nation client registry will ensure that the LHINs are informed of the policies and procedures developed in this project around sharing and collecting of First-Nation-specific health data and a means to do so.

There is a lot of work still to be done and many barriers that still need to be addressed in order to develop a continuum of quality health care services to the Kenora Chiefs Advisory member communities. One of the barriers that we will have to work on is that the LHIN is only responsible for a fraction of the health services in the delivery system. We need to advocate for LHINs to hold the entire health portfolio of the province.

Another barrier is that someone in the system does not have a full understanding of the challenges that we face

as service providers in northwestern Ontario. If this someone did, we would not be requested to look at saving money in the system. We would be given more to meet the true needs of the population we serve.

There is also a challenge of the numbers game, such as how many clients served. The number of clients seen is often the measure for funding allocations. In our organization, it's about holistic, culturally appropriate, culturally safe health care services being delivered to members in their communities. We take the time required to provide these services to individuals and families. We cannot, and will not, fast-track clients through our care to play the numbers game. We need to figure out a system to allocate funding to meet the needs of clients and not to match the numbers game set out by existing policies.

Last but not least, we need to measure the social determinants of health specific to our communities within northwestern Ontario and work with ministries to improve the quality of life for all. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about six and a half minutes left. We will start with the government side: Ms. Jaczek.

Ms. Helena Jaczek: Thank you so much for coming in. We've heard from a lot of First Nations, aboriginal organizations. I know you speak just for yours. So I'd like to just delve in a little bit more to your issue around the community care access centres. On your second page, you've said, "This has been an ongoing challenge, and we have had instances where the oversight of the co-ordination of these services has put clients at risk." Could you just expand on what you mean there?

Mr. Joe Barnes: We've had situations where clients have been discharged to our First Nation communities without a proper care plan put in place, with the assumption that services exist at the community level to look after these clients. That has happened quite a few times.

Ms. Helena Jaczek: I see. We also heard from the Fort Frances Tribal Area Health Services, and they had a comment related to the CCAC that there was an assessment done for each client rather than coming in and seeing—in their time, it was sort of 15 people that they needed assessed.

Mr. Joe Barnes: Well, as you can well appreciate, client rapport is very important to client care. If you have five or six different nursing organizations delivering client care to one individual, you don't have time to create that trust, that rapport, with the client.

I can't speak for Fort Frances Tribal Health, but I know them very well. The system would be better off if they were the ones that delivered the system continually. Instead of four or five nurses, you have one nursing system—one system to develop care and rapport with clients.

Ms. Helena Jaczek: Okay. That's great. Thank you.

Mr. Joe Barnes: And I think Elinor Chaplin did a review—

Ms. Helena Jaczek: Elinor Caplan, yes.

Mr. Joe Barnes: Caplan, yes—did a review on the contracts with the CCAC and—

Ms. Helena Jaczek: There was a review, absolutely.

Mr. Joe Barnes: —procurement. Yes.

Ms. Helena Jaczek: Okay. So a change, a little bit, in the model of how the service is delivered, specifically when it's very important to have that continuity and the understanding of the culture.

Mr. Joe Barnes: That's right.

Ms. Helena Jaczek: Yes.

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

Mrs. Christine Elliott: Thank you very much, Mr. Barnes. I'm really interested in the concept of the First Nation client registry. Is that something that's relatively new? And do you know if any of the other organizations or any other LHINs are participating in that in Ontario?

Mr. Joe Barnes: Just the LHIN 14 is participating. The concept is developing a model for all First Nations across Canada. Our organization is actually working with AFN and all the partners I've listed. We're developing a model at a small scale, but it's to be shared across the country.

1150

Mrs. Christine Elliott: And you've got a number of partners that are working with it. This was an initiative that your organization started?

Mr. Joe Barnes: No, it was an initiative that AFN started, and they were not able to secure funding for ongoing development. Our chiefs were able to meet with LHINs, the Ministry of Aboriginal Affairs and Health Canada, and they all contributed funding to make it go. Now it's part of the HSIF project, which is the Health Services Integration Fund from Health Canada.

Mrs. Christine Elliott: Well, it's a great initiative, because you do need to have the data to improve the system, so congratulations. I hope things continue to go well.

Mr. Joe Barnes: We have a little hiccup with eHealth Ontario because they don't have their—

Mrs. Christine Elliott: There are many hiccups with eHealth Ontario, unfortunately.

Mr. Joe Barnes: They don't have their registry in Ontario. Develop that—and they're doing an internal review so that it's following the proper PHIPA requirements, the protection of personal information act.

Mrs. Christine Elliott: I wish you well with it.

Mr. Joe Barnes: Thank you.

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

M^me^ France Gélinas: I want to come to the conclusion of your report, that for you, as we're reviewing the LHIN act, you see that the mandates of the LHIN should be brought in to include—and you say the entire health portfolio of the province, so that's primary care in health units and everything else that is presently still with the Ministry of Health: You see this would be better if it would be with your LHIN?

Mr. Joe Barnes: Yes, absolutely.

M^me^ France Gélinas: Okay.

Mr. Joe Barnes: It's a long way from Kenora to Toronto, and if we can deal a little bit locally, it's only a five-and-a-half-hour drive instead of 24 hours, and we can start planning together for all of it.

When you're integrating partnerships and relationships with other providers, if they're funded or resourced from another sector of the system, they tend not to want to sit at those tables.

M^me^ France Gélinas: Yes. You also end by saying, Last, but not least ... the social determinants of health...." Do you feel right now that the planning of your LHIN does not take into account the social determinants of health, but stays specific to the acute care needs?

Mr. Joe Barnes: They're looking at the social determinants of health, but we're not doing enough around sharing what we're learning today to the other ministries and how we work together with those ministries. Especially with our First Nations communities that we service as Kenora Chiefs Advisory, we have a lot of social determinants in health that have to be dealt with. If we were trying to keep people in the community longer, how are we going to do that if our housing is inadequate, or if there are jurisdictional issues where we're trying to develop long-term-care facilities, and federal or provincial governments aren't decisive on whose jurisdiction that is?

M^me^ France Gélinas: Okay.

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

Mr. Joe Barnes: You're welcome. Thank you.

The Chair (Mr. Ernie Hardeman): That brings us to the end of the presentations for today in Thunder Bay. We want to thank all the participants who were part of it.

I just wanted to point out that lunch will be in the Odin Room, before we leave the great city of Thunder Bay.

With that, if there are no further comments or questions—oh, I did have a couple of things here I needed to bring up for the committee's information.

On Tuesday, February 18, we will be continuing the report writing of diluted chemotherapy drugs. I just wanted to make sure that the committee knew about that.

On Monday the 24th—that's for this committee—we're scheduling the GTA LHINs for 50-minute slots. We also have the Ontario Hospital Association, the Ontario Association of Community Care Access Centres, and the Canadian Mental Health Association. The staff is scheduling in, so hopefully when we get back to Toronto and when the House comes back, we will be immediately—what do they say, "Hit the ground running." We will have programming in place so that we can have our meetings. Then there are some other issues that we'll need to deal with for further scheduling more information as we move forward with it.

With that, the committee stands adjourned to reconvene next week in Champlain.

The committee adjourned at 1157.

STANDING COMMITTEE ON SOCIAL POLICY

Chair / Président
Mr. Ernie Hardeman (Oxford PC)

Vice-Chair / Vice-Président
Mr. Ted Chudleigh (Halton PC)

Mr. Bas Balkissoon (Scarborough–Rouge River L)
Mr. Ted Chudleigh (Halton PC)
Mr. Mike Colle (Eglinton–Lawrence L)
Mr. Vic Dhillon (Brampton West / Brampton-Ouest L)
Ms. Cheri DiNovo (Parkdale–High Park ND)
Mr. Ernie Hardeman (Oxford PC)
Mr. Rod Jackson (Barrie PC)
Ms. Helena Jaczek (Oak Ridges–Markham L)
Mr. Paul Miller (Hamilton East–Stoney Creek / Hamilton-Est–Stoney Creek ND)

Substitutions / Membres remplaçants
Mrs. Christine Elliott (Whitby–Oshawa PC)
Mr. John Fraser (Ottawa South L)
M^{me} France Gélinas (Nickel Belt ND)
Mr. Michael Mantha (Algoma–Manitoulin ND)
Mrs. Jane McKenna (Burlington PC)

Clerk / Greffière
Ms. Valerie Quioc Lim

Staff / Personnel
Ms. Carrie Hull, research officer,
Research Services

CONTENTS

Wednesday 5 February 2014