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Lundi 27 janvier 2014

Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

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

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 27 January 2014

Lundi 27 janvier 2014

The committee met at 0900 in the Clarion Hotel and Conference Centre, Fort Erie.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): Good morning, ladies and gentlemen, the members of the committee. We're happy to be here in the great city of Fort Erie. The committee on social policy is looking at a review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act. We're happy to be here in Fort Erie, as I said, this morning, to have our first hearing outside of Toronto to hear what the people of the rest of Ontario think.

We'll start with the first delegation this morning. We will have 15 minutes per delegation in the committee, and the deputant can use any or all of the 15 minutes for the presentation. If they do not use all the time and there's less than four minutes left—and this is an arbitrary time—we will, in rotation of the parties, give it to one party for questions and answers. If there's more than four minutes, we'll try and divide it evenly among all three caucuses.

MR. DOMINIC VENTRESCA

The Chair (Mr. Ernie Hardeman): With that, our first presenter is Dominic Venstra? Is that—

Mr. Dominic Ventresca: Ventresca.

The Chair (Mr. Ernie Hardeman): Very good. Thank you very much. I was going to say that we would hope you would introduce yourself for the benefit of Hansard. Since your microphone was on and you have done that, we thank you very much for doing that. Welcome, and we will start the presentation. The floor is yours.

Mr. Dominic Ventresca: Thank you, Mr. Chair and members of committee. It's a pleasure to be here to share some insights with you on the very important topic of our LHINs and health care in Niagara. I'm Dominic Ventresca, as you mentioned, and I'm going to hopefully provide to you today some personal and professional insights into the effectiveness of centralized/decentralized ministry models of delivering health care and then the current LHIN model. I've had 38 years of experience, and so I'm sharing some insights. I'll provide some practical examples that demonstrate my views on the relative effectiveness of the LHIN model in its functions of planning, funding and coordinating, and in its role of being responsive and innovative in finding better health care solutions. Then I'll provide at the end some suggested next steps and improvements.

As a little personal context, I'm coming here as a private citizen. I have a keen interest in the quality of health care in Niagara. I'm currently a volunteer in a number of local health and community service organizations. I was born and raised in Niagara, and worked for 38 years in this field, 36 of those years in Niagara.

Professionally, I graduated with a BA from the University of Toronto, as well as a graduate diploma in gerontology, from one of the first programs in gerontology in Canada, also from U of T. I'm now retired, from 2012. I was director of senior services for Niagara region, and in that capacity we ran eight long-term-care homes accommodating almost 1,000 residents. We have 10 adult day programs and a number of other community programs—supportive housing and so on—serving thousands of people and families in the Niagara region.

I was also formerly a board member of the Ontario Association of Not-For-Profit Homes and Services for Seniors, which has about 200 members, as you know, across the province and represents long-term-care homes, seniors' housing and other programs. Also, I was a member of numerous networks and collaboratives within the HNHB LHIN.

A little bit of history here, briefly: I've had occasion to work with a centralized ministry where our relations as providers were largely with officials in Toronto, and also with a decentralized ministry where area offices were formed. There are two; we worked with the local bureaucrats, but with a very strong central direction. Most recently, we've worked with LHINs as providers, and there was a shift to dealing with a local office that dealt within a provincial policy framework.

A quick comparison of models: From my experience, the centralized and decentralized—I'll couple them together—were both centrally directed and controlled, with little allowance for local input, innovation and responsiveness. With the current ministry/LHIN model—and I have a number of examples to support some of my statements here—there is a provincial framework for major policy areas. There is significant opportunity for local input, and there is an improved opportunity for innovation and responsiveness to local needs and better care.

Community engagement is one of the examples where I think the current model has advantages. For example, in developing the strategic health systems plan, a steering committee was established by the LHIN. I was a member of that steering committee and had opportunities to provide input from the gerontological and long-term-care perspective. We had a review of best practices and leading practices worldwide given to us, to guide us in our thinking. We identified a common vision for transformational change for health care. This included the need for integration and also the role of the LHIN as a health system commissioner, which was based on some practice from England. Also, there was plenty of opportunity for providers, stakeholders and citizens to provide input.

Another example around the area of provider relations with the LHIN: I cofounded and co-chaired the long-term-care homes network once the LHINs were formed, and also was a member of the community support services network. By being members of these networks, which were basically driven by the desire of providers to get together to share information and so on, we communicated among ourselves. We also communicated as a group, as a sector, to the LHIN leadership. It gave us a sense of functioning in a health care system, and it also helped break down the silos that we had traditionally functioned under. Also, it led to the formation of numerous collaboratives, which led to planning efforts and coordinating of person-centred care and requests for funding.

Another example around local program development under these three models that I mentioned before—centralized, decentralized and LHIN models—is the regional dementia care centre for Niagara. Local needs had been identified under the former Niagara District Health Council for such a centre, and various needs studies pointed to the need, but when we pitched this to the ministry area office, we were basically refused on the basis that it wasn't part of a province-wide policy and therefore was not to be funded locally. However, when the LHINs were formed, we ultimately pitched it there. It was supported, and now it's funded and it's integrated, in fact, into the provincial Behavioural Supports Ontario framework as a best practice, or at least a leading practice replicated in other LHINs.

Another example of local program development is in the area of long-term-care-home residents. The LHIN board made some bold decisions a couple of times to redirect an annual surplus of long-term-care-home nursing funds, which normally would be returned to the province, to keep them locally and to meet resident needs based on good needs addressed by local providers. So we were consulted, as a long-term-care-homes network, and we were funded for installing Ontario Telemedicine Network, or OTN, technology in the long-term-care homes across the LHIN, and also for leadership education for RNs and RPNs, front-line health care leaders, to provide better care to residents.

Another example is around Behavioural Supports Ontario. This is where we formed a collaborative locally. It was formed to enable provider input into the local implementation of this provincial program. We had agreement among providers to pool resources. We recognized a management committee that was struck to oversee, and we also recognized lead agencies that came forth among our group to implement this BSO program across our LHIN. Coordinated dementia care was being provided in long-term-care homes and in the community across the LHIN by this effort of collaboration and co-operation.

Another example is around assisted-living hubs in Niagara. This was a cross-sector collaborative; again, people who would not have normally come together, but we formed this collaborative. We applied jointly for LHIN funding and we got seniors' social housing, so the housing sector came together with those of us in providing community services, and we turned several social housing buildings into assisted-living complexes by introducing 24/7 personal support workers. Accessible bathing suites were adapted in the buildings, and also wellness programs are provided on-site. Then, the success was allowed to extend into the community, where we provided the same services to citizens living on their own in their own homes in local neighbourhoods.

Another example is around the Niagara Health and Wellness Centre, where another cross-sector collaborative formed to jointly apply for LHIN funding, with in-kind support from Niagara College. They offered building space and student placements and supervisions for some of the students who will deal with, largely, seniors in their careers later. It also served an underserviced area of south Niagara. We offered at one site, at Niagara College, an enhanced adult day program, falls prevention, a stroke clinic, rehabilitation and geriatric assessments, which were accessed now in a community setting. They were previously either not accessible or accessed outside of south Niagara.

Briefly, a few suggested next steps: Generally, I think that the committee should consider enabling further evolution of local health care planning, funding and coordination. I think it should allow stabilization of health care improvements and continue tracking system performance indicators to monitor progress. I think you should enable the next set of system improvements and proposed investments, as identified in the five-year LHIN Strategic Health System Plan, in order for it to achieve results.

More specifically, I think consideration should be given to holding the gains already made in health care system transformation, provider collaboration, operational efficiencies, and better care, such as—and there's data to show this—improved patient flow and the whole alternate-level-of care issue, reduced wait times, community and mental health care coordination, and clinical program integration among hospitals and in the community.

Secondly, for more awareness and engagement, there should be a focus on improving the community's and the media's understanding of the relevance of the LHINs in improving local health care and services; strengthening the involvement of local providers/stakeholders/citizens

in improving local health care and in deliberations with the LHIN board; and increasing public transparency and availability of relevant documents and reports.

Thirdly, for improved communication, I believe there should be a focus on strengthening communications and building better relations with local municipal elected officials and leaders; increasing plain-language public reporting of key LHIN initiatives in various accessible media; and ensuring information sharing and replicating best practices among the 14 LHINs.

Mr. Chair, that concludes the statements that I wanted to make. I'd be happy to engage in any conversation with you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do have—I set the arbitrary mark at four minutes and we have exactly four minutes, so we will give it to the official opposition. Ms. Elliott?

0910

Mrs. Christine Elliott: Thank you very much, Mr. Ventresca, for your thoughtful presentation. You raised a number of items. I wish I could ask about more but I'll just concentrate on some of the last issues that you mentioned under "Suggested next steps": Strengthening the involvement of local providers and stakeholders in improving local health care. Could you elaborate a little bit more about what you mean by that?

Mr. Dominic Ventresca: Yes. I think there's always room for improvement. If there is a greater understanding of the relevance of the LHIN and a greater feeling of transparency and accessibility from the public, I believe that more individuals or more groups in the community would feel comfortable about making delegations to the board or submitting information that they really feel will have an impact on health care in their community.

Mrs. Christine Elliott: And has transparency, in your view, been lacking of late in this LHIN?

Mr. Dominic Ventresca: I think it's a matter not so much of lacking; there's always room for improvement. I worked in the municipal sector for 36 years, and all the rules around regional council and so on were built largely around openness, transparency and availability of information. I think there are lessons that can be learned from other public domains that can be transferred to the LHIN, hospital boards and other major, important entities within our society.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated, and we look forward to hearing many more so we can make—I'm sure with your help we'll make educated decisions on improving the system. Thank you very much for your presentation.

Mr. Dominic Ventresca: Thank you for the opportunity.

UNIFOR LOCAL 199

The Chair (Mr. Ernie Hardeman): Our next presenter is Wayne Gates, the president of Unifor Local 199. Wayne, if you would come forward. Welcome this morning, Mr. Gates. We appreciate the time you're taking to come in and talk to the committee. I don't know if you were present before the other one started, but you will have 15 minutes to make your presentation. You can use any or all of your time for that presentation. If you do not use all your time and leave four minutes or less, the questions will go to the third party. If you leave more than four minutes, we will divide it evenly among the parties to ask questions and make comments. With that, the floor is yours. I don't want to use up any more of your time than I need to.

Mr. Wayne Gates: You're suggesting I talk a lot, is kind of where we're at? Okay, I'll try.

First of all, my name is Wayne Gates. I am president of Unifor Local 199 in the Niagara region. I'm a lifelong resident of Niagara. I'm also the NDP candidate for the upcoming by-election in this riding. I thank the Standing Committee on Social Policy for coming to Fort Erie. I thank you for the opportunity to speak of this long-overdue review of the Ontario Local Health Integration Network and to speak about the local LHIN here in our community, the Hamilton Niagara Haldimand Brant LHIN.

When the Liberal government passed a law to create the LHINs, they promised a review like this in four years. That was back in 2006. I have to point out that this is now 2014, eight years later. This review should have happened four years ago. If this review had happened when it was supposed to, four years of problems could have been avoided.

Under this government's watch the people of Niagara have had more than their fair share of problems with the local LHIN. Putting off this review has caused damage. It has denied our community the chance to speak—open and transparent—and to express our concerns. Our hope is that this review will lead to real change, but for so many in Niagara, hope has faded.

People here know me and my record on health care of standing up for all. I have always fought to keep access open to the best-quality health care for people when they need it and where they need it, no matter where they live in our communities.

When the Liberals closed down the ER in Fort Erie, I stood with the yellow shirts. For those who might not know, that was a group that was put together to save their hospital. They had a rally here in Fort Erie with 5,000 residents who attended.

When the Liberals cut services in Niagara Falls, I stood with expectant mothers—and this is one that I've never understood, and I've said this before. Niagara Falls is the honeymoon capital of the world. It's actually where a lot of people from around the world go to make babies. Yet in Niagara Falls, we can't even deliver them. I've never understood the thinking behind that.

When the C. diff outbreak was raging through our hospital, I stood with patients' families where people died. It has been an uphill battle to get the government to listen to the needs of the people of our region. I can tell

you, in Niagara Falls, I organized a rally because we didn't know that C. diff was in our hospitals; we didn't know that people died from C. diff.

I had a rally there, and the rally was called You Have the Right to Know. You have the right to know, when a senior goes into that hospital, that there are issues in that hospital. You have the right to know that if you're having your loved one—and this is what happened right across Niagara: They went in for knee surgery, and they went in for hip surgery, and they caught C. diff and they died. But before they went to that hospital, they never knew.

We didn't feel we were getting the attention, and as more and more people died in Niagara, I organized a victims' rally. Why did I do that? Because we wanted to get the message out that nobody should go into our hospitals in Niagara for knee surgery or hip surgery and come out dead. I listened to the victims, who told their story on how that dreaded, dreaded disease ate away at them. From that rally, it went across Ontario. It was on the local radios, but more importantly, it was on CHCH. More importantly, it was covered by CBC right across the country. I believe because of that, and because of the emotion that was around losing a loved one, that heightened the awareness of the C. diff crisis that we were going through here in Niagara.

It's no surprise that our local LHIN has let us down, because the LHIN is an agency of the government. Many in our community feel that the LHIN has not met our health care needs. Instead, it seems that the main job of the LHIN is to shut out our views. Planning and coordinating health care services is very important work, but for health care to move forward, the public needs to be included and consulted, not overlooked, not ignored. Unfortunately, that's what has been happening in Niagara for too many years.

Unelected LHINs hold great power and responsibility in our health care system. The government made the LHINs responsible for planning, coordinating, funding health services in hospitals, community care centres, community support service organizations, mental health and addiction agencies, community health centres and long-term-care homes. Quite frankly, the Liberal government has shifted responsibility for most of our local health care to the LHINs and, unfortunately, the blame as well.

0920

This LHIN is made up of six members, government-appointed, on an unelected board that has not been accountable to the people of Niagara. Even some local journalists have been blocked when they ask for information about the LHIN. If professional journalists are kept in the dark about the LHINs and what they are doing, then how can people in Niagara know what's happening with their health care? When the LHIN refuses to share information with the public, that means it's not accountable. When the LHIN refuses to inform us—and I give you an example—about their decisions until weeks after they've been made, then that means it's not transparent. When LHINs shut out the public and make decisions behind closed doors, that means we have a serious problem.

The Ombudsman of Ontario agrees. In 2010, after getting complaints about the Hamilton Niagara Haldimand Brant LHIN, André Marin investigated. He found that our local LHIN wasn't involving the community in important decisions about health care in Niagara. It wasn't open; it wasn't transparent. Worse yet—I think this is important—he found that the board members had passed an illegal bylaw that let them meet behind closed doors for so-called educational purposes. He found that these secret meetings were then used to discuss restructuring plans with the key players—again, important—away from public view. No public meetings, no public dialogue. It took a report from the Ombudsman to finally get the Ministry of Health and Long-Term Care to act. It took the Ombudsman to make the local LHIN involve our aboriginal and francophone communities.

But a recent article in the St. Catharines Standard shows that the culture of secrecy hasn't gone away. In November 2013, the newspaper asked for immediate access to the board's monthly meeting reports rather than waiting six weeks after. First, the LHIN said yes; then the LHIN said no. Then they changed their mind again and said yes to public access right before the review—right before this. It's not coincidental; it's damage control and it's political. Health care shouldn't be about politics. Health care should be about Canadians, Ontarians, to make sure that when we go to the hospital, we're going there to get better. We're not going to the hospital for vacations. We're going to the hospital because we're sick, and we should be going there to get better.

LHINs make decisions that directly affect the health and well-being of our seniors, our children, our parents, our grandparents and ourselves in our community. But this LHIN is leaving us in the dark. The Liberal government invented the LHINs, and then they paid their friends top dollars to run it: hundreds of thousands of dollars for executives, almost $1 million on consultants in one year alone from 2010-11.

As you were paying out these dollars, the millions, what was happening here in Niagara? We were having cuts to our services, closing our hospitals; $1 million more on administration costs. All this money, and we hear we can't afford to provide health care in our communities. It could have gone to health care, our front-line workers. They're doing an incredible job every day they go to work, being asked to do more and more.

It's time for the Liberal government to own up to the actions of their LHINs instead of using them as political cover for unpopular decisions, like contracting out cleaning services—which I believe was a major issue here in Niagara—and closing hospitals and ERs in our communities. Even the Ombudsman says that the Ministry of Health and Long-Term Care uses the LHIN as a way of ducking responsibility.

I don't blame the public for feeling disappointed. I don't blame my neighbours for feeling angry. The people of Niagara had to wait too long for this review to come here: eight long years.

This review should have happened four years ago. We should have had our say on how health care decisions are made for all of us. We all deserve to be treated with respect, and our concerns should be considered. Citizens have the right to know.

If this LHIN isn't doing the job it's supposed to, if it makes secret decisions in closed-door meetings, if it continues to shut out the public from important health care decisions, if it refuses to be transparent, if it refuses to be accountable, then the Hamilton Niagara Haldimand Brant LHIN should be abolished.

I'd like to thank the Chair. I'd like to thank the committee for giving me a few minutes of your time today to make my presentation. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. You did do a great job of using your full 15 minutes. Thank you very much for your presentation, and I'm sure it will be quite helpful to the committee.

Mr. Wayne Gates: I really appreciate you giving me the time to be here today.

MR. WILLIAM MILLAR

The Chair (Mr. Ernie Hardeman): Our next delegation is William T. Millar. Is Mr. Millar present? Thank you very much, sir, for coming in this morning. We very much appreciate you taking the time, in particular as I see in some parts of the area the weather is not quite as good as it might be this morning.

As with the other delegations, you will have 15 minutes to make your presentation, and if you have time left over at the end, if it's less than four minutes, it will go to the third party. If it's more than four minutes, then it will be divided equally among the three caucuses for questions or comments. I haven't told the others this: If you use all your time, when we get to two minutes, I'll put my two fingers up so you'll know that you're getting near the end of your time.

With that, thank you very much. The floor is yours.

Mr. William Millar: Thank you, Mr. Chair. I want to thank the LHSIA review committee for this opportunity to participate in the review process. I served as a member of the board of directors of the Hamilton Niagara Haldimand Brant LHIN from March 2007 to March 2012.

My professional background is in public education as a teacher, consultant, principal and a senior administrator. I served as director of education of the Niagara South Board of Education from 1990 to 1998 and as associate director of the amalgamated District School Board of Niagara to retirement in 1999. Following that, I worked with the Education Quality and Accountability Office on a quality indicators program for elementary and secondary schools.

I must say that I'm heartened by the fact that a review of LHSIA is being undertaken. Public education—I regret that we did not often examine the results of the many changes that were made in our system, leading to confusion and disenchantment often among education practitioners, students, parents and the general public, and undoubtedly to uncorrected mistakes. Such reviews require the examination of both hard and soft information and data. I hope that the LHSIA review process will take advantage of the broad range of information that is available from a variety of sources.

0930

The perspective I bring to the review process reflects experiences, learnings and observations during the early period of the LHIN's work, some volunteer involvement with the development of the LHIN's current strategic plan after my board term, and interest as a member of the community since that time.

I believe the LHSIA/LHIN concept of providing for local involvement and authority in planning, integrating and funding health care is a sound one. There may well be differing opinions on what "local" means, and challenges in dealing with the variety of communities with different circumstances, needs and priorities, but there can be little doubt of the difficulty of trying to deal with a highly complex system, such as health care, only from the standpoint of a central authority.

The local LHIN provides, through its board, a group of citizens who bring a variety of perspectives, experiences and skills to the tasks of planning and integration. During my terms, I worked with board members who championed rural health care issues, the needs of the marginalized in urban areas, the health issues of area aboriginals, mental health needs, the challenges of providing for the ever-growing seniors population and so on. They had no illusions about the scarcity of resources and the need to be good stewards of the public purse. While their insights from the communities in which they lived, and the various providers with which they were familiar, were shared, they maintained a system perspective and commitment.

This is a singular strength of the LHIN model. A LHIN board can maintain a system perspective while drawing on the strength, commitment and special knowledge of the volunteer board, provider boards and their members.

It was evident from early on in my board service that the first appointed members of the HNHB LHIN board, particularly the chair and vice-chair, were able to recruit an outstanding first CEO, and that she in turn had assembled an excellent staff. They were and are highly dedicated to their work in establishing both an effective LHIN and a quality integrated local health care system. While I carry some bias towards the HNHB LHIN, I had the opportunity to meet and work with LHIN CEOs and staff from other areas, and I think the province can be satisfied that it is being extremely well served.

From the outset, LHIN CEOs and their staffs recognized the importance and necessity of working with and learning—even perhaps friendly stealing—from their counterparts in other LHINs. As you know, there are formal and regular meetings of all the LHIN CEOs and chairs. In addition, there has been significant collaboration among the LHINs on everything from the development of common forms and procedures to joint development of programs. All of the LHINs regularly contribute staff to province-wide projects.

In addition to the obvious benefits of consistency of practice in common areas and the sharing of scarce resources, cross-LHIN collaboration has created a whole new resource for Ontario's health care system. Collectively, LHIN staff represent a level of expertise in health care planning, funding and integration, that is grounded in the experience and understanding of local systems and providers, that I do not believe existed prior to the development of the LHINs.

Indeed, it is hard to imagine how large-scale programs such as Aging at Home, addressing the alternate-level-of-care issue, and the various wait-time reduction projects initiated by the Ministry of Health and Long-Term Care, with often-challenging timelines, could have ever been successfully implemented without the skill and commitment of LHIN staff. In addition, the relationships which they have developed with the local provider organizations ensured that such programs were effectively designed and implemented at the local level.

It is clear to me that the funding and accountability authority provided to the LHINs under LHSIA has been important in enabling the integration and quality agendas to move forward. I believe that changes being considered in the LHIN mandate will further strengthen their work. But in the HNHB LHIN and, I'm sure, others, more emphasis has been placed on establishing rapport, credibility, trust and a shared commitment to a quality, integrated health care system with the provider organizations and their members than on the exercise of authority.

As a board member, I was impressed with the willingness of busy physicians and other health care professionals to take leadership roles in a variety of projects to address quality and integration in their respective fields. That involvement has led to great work in addressing the challenges of wait times, chronic disease management and many others.

In particular, the HNHB LHIN has developed and partially implemented a clinical services plan that serves to ensure commonality of practice and patient experience across the LHIN. That plan has coordinated such clinical services as complex continuing care, vascular and thoracic medicine, cardiac care and cancer care to date, and implementation in all clinical services is continuing. The clinical services plan ensures that best practices prevail, no matter the location of the treatment. Success in these endeavours requires the ongoing trust and commitment of all of the partners in the health care enterprise.

The collaborative approach taken at the local level has also gone a long way in helping the smaller organizations in the health care system to deal with such new realities as service plans, accountability agreements, and quality measurement plans and processes. While organizations such as hospitals had considerable experience in these areas, they represent challenges to the smaller providers with more limited human resources. I had the pleasure as a board member to observe the patient, helpful manner applied by the LHIN staff not only at submission time but throughout the year, albeit with the clear understanding that the task could not be shirked.

The LHSIA review provides an opportunity for the Legislature, the Ministry of Health and Long-Term Care and the LHINs to examine what has been accomplished to date and where things need to go. The challenge of providing quality, integrated and affordable health care to a populace whose needs seem ever-growing and of managing the complexity of the system that seems to be needed to meet those challenges can be overwhelming. I believe that the emphasis now being placed on the individual patient or client and his or her experience, while a simple concept, is a powerful one. It provides both the rationale and the direction for integration. It focuses measures of quality and identifies improvement directions. It provides the best map for organization of services and hopefully ensures that all levels and components of care are planned and funded in terms of their contribution to the effectiveness of the individual's experience.

Clearly, the inclusion of primary care in the LHIN mandate is a key to the complete and effective integration of health care services and the resulting quality and effectiveness of the patient/client experience. I am aware that consideration is being given to this direction. I would suggest that the success that the HNHB LHIN has had in establishing a positive working relationship with primary care physicians can lead the way in resolving this issue and ensuring that this important and necessary component of patient care and system navigation formally becomes part of the pursuit of a fully integrated health care system.

While I believe I've made it clear that the big stick of funding does not work on its own, LHIN control of funding does create opportunities to incent certain directions being taken that are important to system goals. It is hoped that the LHINs' funding authority and their ability to exercise local flexibility continues to be strengthened as the LHIN concept matures and further gains the confidence of all those involved.

Earlier in remarks I made, I referenced the important role the LHIN boards play in bringing varied perspectives, experiences and skills to planning, policy and decision-making. As well, their system perspective serves as an offset to their provider board counterparts' narrower focus at the governance level. Board members are also a key component of community engagement activities. It is thus important that processes for board member succession be such that a full board complement is maintained as much as possible and that departing members are replaced thoughtfully and in a timely fashion. I would respectfully suggest that the board appointment processes be examined with a view to these goals.

0940

I have not addressed in any specific way actual measured outcomes that I believe need to be examined as part of the review and assessment of the LHSIA/LHIN model. I'm aware of significant improvements in such areas as surgical and diagnostic imaging waiting times, alternate-level-of-care statistics, and admission to long-term care

versus alternatives. I'm equally aware that emergency wait times seem to resist improvement efforts, at least locally, and that mental health and addiction resource difficulties may be contributing to that. It also seems clear that the necessary shift of resources from sectors such as hospitals to the provision of home care, for example, is a difficult one, especially in challenging economic times. But I have neither the currency nor the expertise to properly relate these indicators to the changes in approach that the LHINs have brought. Such an analysis should be done by those with that expertise, and the learnings from that analysis applied to the health care transformation efforts.

As I've indicated in my earlier remarks, I believe that the integration of health care services is bearing fruit in the system's effectiveness and efficiency, and that the LHIN approach to that integration has the best chance of success.

I thank you once again for the opportunity to present to you and to be part of this important review process. I really believe that the province of Ontario got it right in this first move to providing local health authorities. I know you're aware of the models in other jurisdictions, both in Canada and beyond. Most of these jurisdictions continue to examine and often change their structures, and so should we.

I believe, however, that we are well served by a structure which has maintained the strength of skilled, thoughtful volunteers at the provider board level, has left operational management to those who know it best, and has recruited system governance that is committed to an effective and sustainable health care system that is ultimately measured by the quality and effectiveness of the individual's experience of it.

Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about a minute and a half. If the third party would ask the questions.

Ms. Cindy Forster: All right. I'm going to ask a question, actually, that I'm sure Donna would like me to ask. I know that it happens in LHINs across the province and in Niagara as well.

First, I thank you for being here today and for your thoughtful presentation.

Services even within LHINs are not consistently provided to patients. You can have four municipalities bordering on each other, for example, and clients and patients in Hamilton are provided with different services than are available, say, to clients in Niagara. In your experience on the board—and I hear about that in my constituency office on a regular basis. Somebody from Niagara, for example, goes to Hamilton for surgery, but when they come back to Niagara, they actually end up getting different services than the same patient in Hamilton might have been provided with, post-discharge from the hospital, let's say. Can you give us some insight into how the LHIN is trying to address that within LHINs as well as across LHINs?

Mr. William Millar: Well, I can refer to my time. As you know, it's about two years now since I was on the board. I believe that's where the work I mentioned earlier about collaboration among the health service providers—the clinical services plan and the integration of care that that has brought—has created a really broad sharing across the LHIN. Continuing that process will go a long way to address the kinds of variations that you've referred to.

As you may know—I'm not sure how strong the knowledge is—the current strategic plan of the LHIN divides the LHIN up into somewhat larger areas, and its sole purpose is to coordinate the health care services within those and, in so doing, to create a greater commonality of availability in quality and access in each of those areas. So the work is continuing there.

Obviously, the starting points were different in many of these cases, and the resources may not have been available to bring them on at the same pace, but I think that local planning, especially through the strategic planning, through the LHIN concept, is the best chance of addressing it.

The Chair (Mr. Ernie Hardeman): Thank you very much for your time and thank you very much for being here this morning and for your informative presentation.

Mr. William Millar: Thank you.

COUNCIL OF CANADIANS, SOUTH NIAGARA CHAPTER

The Chair (Mr. Ernie Hardeman): Our next presenter is the Council of Canadians, South Niagara Chapter, Fiona McMurran. Thank you very much for coming in and sharing your presentation with us this morning. As with the previous presentations, you will have 15 minutes allotted for your presentation. If there's less than four minutes left at the end of your presentation, it will go to the government caucus. If it's more than that, we will split it evenly between the three caucuses. With that, thank you very much again for coming in. If you get to within two minutes of the time allotted, I will put up my fingers to let you know you have two more minutes. Thank you very much for coming in, and the floor is yours.

Ms. Fiona McMurran: Thank you very much, indeed. I do appreciate being able to present to you all. My name is Fiona McMurran, and I am a 30-year resident of Welland. I'm here representing the South Niagara Chapter of the Council of Canadians. Among its campaigns, the Council of Canadians also works for the preservation of Canada's public health system and the strengthening and enhancement of the Canada Health Act.

With other organizations, we have been drawing public attention to the expiry this year of the Canada health accord. As you know, the Prime Minister has refused even to meet with Canada's first ministers to renegotiate the accord, preferring instead to announce substantial cuts over a period of years to the health transfers to the provinces and territories, all of which are fighting ballooning health costs.

Austerity budgeting arrived in Ontario in the midst of a radical restructuring of the province's complex and

unwieldy health care system through the creation in 2006 of 14 local health integration networks. You have been hearing about the progress of the LHINs with this reorganization. It is our contention that the province's health system is moving rapidly in a direction that will further erode medicare and that the LHINs, while doing much difficult and very demanding work to integrate health services in Ontario, are also serving inadvertently to mask the significance of some of these changes from the public while also preventing the Ministry of Health from having to actually face the consequences of its own policy decisions. We shall never have the public dialogue on the future of health care in Ontario that we so desperately need under the LHIN system.

As creations of the province, reporting to the Ministry of Health, the LHINs carry out policy directives from the ministry, dispensing funding to various health providers, including hospitals. They are a buffer between the public and the providers and the ministry. The act that created the LHINs includes a duty to consult; although the wording is open to interpretation, the intention is clear.

Here in Niagara, unfortunately, we feel that the LHIN system has failed us twice: once in the case of the Niagara Health System's Hospital Improvement Plan, hastily introduced without consultation in mid-2008, and now again, in 2014. As you know, health care restructuring began with hospitals. In fact, consolidation of hospital services has been ongoing since the days of the Rae government, the wisdom of the time declaring that bigger was always better and more efficient.

We have already been subject to dramatic restructuring of our hospital system, with the downgrading of three small hospitals within the Niagara Health System to urgent care centres. Only last week, the province endorsed the closure of the other hospitals in Welland and Niagara Falls, along with the closure of those urgent care centres. Yes, we have been promised a new hospital and two new urgent care centres, but, especially in the current financial climate, why should we trust these promises? We've heard promises before.

The release of the Niagara Health System's Hospital Improvement Plan in the summer of 2008 came like a bolt out of the blue to most of us. Indeed, the mayors of both Port Colborne and Fort Erie had been recently advised by the NHS president and CEO that their small hospitals were not under threat. But the HIP, as we call it, called for both of these to be downgraded to urgent care centres, as well as for the closure of the majority of departments in both the Welland general and the Greater Niagara General Hospital in Niagara Falls. None of this, we were assured, had any connection to the decision to build a new hospital in St. Catharines to replace that city's two aging institutions.

0950

This dramatic consolidation of hospital services, we felt, had been decided behind closed doors, without consultation with doctors in the health system, let alone the community.

Appeals to the NHS, the LHIN and the Ministry of Health fell on deaf ears, so a number of individuals brought their concerns to the Ontario Ombudsman. As you are well aware, André Marin's office investigated the allegation that the HNHB LHIN had failed to adequately consult the population prior to approving the HIP. His findings were published in August 2010 as The LHIN Spin, in which he roundly castigated the LHIN for failure to consult.

What followed was exactly nothing. The HIP continued to roll out, and those of us who were afraid that the next target for closure would be the mid-size hospitals in Welland and Niagara Falls appealed to the Niagara regional council for support, which finally came in early 2011, when a delegation of regional councillors were at last able to persuade the health minister to strike a tripartite committee to review the HIP. That committee had barely begun its work when the health minister put the NHS under supervision.

Kevin Smith was named as supervisor, and the NHS board was dismissed. Smith's first public appearance in Niagara was as a guest at the tripartite committee meeting in early September 2011. He explained his mandate as supervisor and disbanded the tripartite committee, which was now unnecessary since Smith would, of course, be reviewing the HIP as part of his duty to get the NHS back on track.

Smith was a logical choice from the ministry's point of view, having been brought in as supervisor when other Ontario hospitals ran into trouble.

From our point of view, it was somewhat worrying that Smith was CEO of a hospital, St. Joseph's Healthcare, just up the road, as it were, in Hamilton—a hospital also included under the Hamilton Niagara Haldimand Brant LHIN. Was this not a case of conflict of interest?

Since September 2011, when Smith took over as supervisor and the board was dismissed, there has been virtually no hard information forthcoming from the NHS. What was the status of the NHS deficit? How was the new hospital in St. Catharines proceeding? How was staffing coming along?

Smith himself acknowledged, late in 2012, that the new hospital had not succeeded in recruiting the mental health specialists it needed, and that Niagara patients would be dependent to some degree on services at his own St. Joseph's. I also understand that the new hospital is utilizing specialists from Hamilton health services in its cardiac catheterization lab.

As you are well aware, Smith produced his final report on the NHS for the ministry in September 2012. In that report, he recommended the closure of all remaining NHS sites, including the Welland general and the Greater Niagara General Hospital.

Since these have been the property of the hospital system since amalgamation in 2000, Smith intends that they be sold. To replace these services, he advocates a new hospital for what he terms "south Niagara," an area that, for the first time, includes Niagara Falls, the largest urban centre here outside of St. Catharines, and the building of two stand-alone urgent care centres.

The financial case for this is somewhat thin on detail, to say the very least. Smith compares the cost of reno-

vating the two larger hospitals, Welland and Niagara Falls, with the cost of a new hospital in south Niagara, and—surprise—comes up with a smaller figure for the latter alternative.

Not only was there nothing to support those figures, there was no attempt to define the services that the new hospital would provide, or explain where the two new urgent care centres fit into the financial projection, or to indicate that the hospital, at least, would be a P3 project and therefore double the amount at the end of 30 years.

Local mayors, unfortunately, were less interested in close scrutiny of Smith's report than in playing a game he had set up called "decide amongst you on a site for a new hospital," a game that has set municipalities in the south against each other in the same way that the HIP has set north and south Niagara at odds. Predictably, since Smith has indicated from the beginning that a renovation of the Niagara Falls hospital wasn't worth the cost and had shown little to no interest in Welland, the Niagara Falls site has won out.

In October 2013, St. Catharines city council was finally successful in its request to hear from the NHS. Acting president and CEO Dr. Sue Matthews spoke briefly and to the point, telling us that the NHS is in fact in dire financial straits, such that it lacked the resources to open the 100 beds at its new facility in St. Catharines. In order for this new hospital to fulfill its mandate, Matthews declared, the NHS would require a funding increase of 3% to 4% on its annual budget. The present government has declared that there will be a 0% increase in hospital budgets.

This startling news generated no response from Supervisor Smith. The new hospital board, although appointed in May, was yet to call its first meeting. Sue Matthews resigned her acting position in December to take up a position as hospital CEO in Australia, and we were getting what seemed to be conflicting signals from the health minister, who roundly praised Kevin Smith and his proposals, and the Premier, who stated firmly that she could not commit to a major public infrastructure project like a new hospital until she had made progress in eliminating the province's deficit.

With the sudden resignation of Kim Craitor last fall, the Smith plan, with its proposed new hospital for Niagara Falls, became a hot-button issue, especially when endorsed by the Progressive Conservative leader. As the date approached for dropping the writ for two by-elections, Kathleen Wynne could no longer put off a decision on Smith's proposals. Not only were his recommendations approved, but a $26.2-million planning grant was announced to permit further development of the south Niagara hospital proposal.

How can the ministry justify spending $26.2 million on consultants to develop a plan for another new hospital when it can't afford to run the one that has just opened? And where, I ask, is our LHIN in this decision?

For many of us in south Niagara, the significant part of this announcement lies not in the promised new facilities but in the official government approval of the closure of the old ones: the UCCs in Port Colborne, Fort Erie and Niagara-on-the-Lake, and the Welland and Niagara Falls hospitals. The important question there is: When? Can the NHS, unable to make its new hospital fully operational, afford to retain hospital services in Welland and Niagara Falls until a new hospital opens, or will it move swiftly to enact these closures to save on staff and administrative costs, and put these sites on the market? If so, where will the services go?

Some, we fear, will be outsourced by the LHIN. As you heard before the Christmas break, the ministry is poised to make an amendment to the LHIN act, enabling the LHINs to fund independent health facilities, or IHFs. Procedures not requiring hospital stays will be shifted to clinics in the community, funded by OHIP through the agency of the LHINs. Under a community-based specialty clinic initiative of the Ministry of Health, low-risk hospital services will be moved from hospitals to community clinics, which, though private, will, we are assured, be non-profit—for now. For us, this constitutes a significant step away from the public delivery of health services.

Did the LHIN call for public input into this? No, because it was a ministerial decision. One does have to wonder whether, when low-risk hospital services move to such IHFs, they are likely to be reabsorbed later into a new hospital. It seems unlikely. It appears much more likely that our old hospitals will close, the services will be outsourced, and, well, we'll see whether there's actually a case to be made down the line for another expensive hospital in south Niagara.

Or perhaps we're cynics as well as dinosaurs. We're constantly told down here in the south of Niagara that we stand in the way of progress, that small hospitals are a thing of the past and have to go, and that anyone standing up for them has his or her head screwed on backwards—unless the small hospital in question is further up the QEW, nearer to the big health care hub of Hamilton.

Residents of Lincoln county were understandably devastated when plans to replace the aging West Lincoln Memorial Hospital were shelved in the 2012 budget. But last year, West Lincoln and Hamilton health services amalgamated, with the blessing of the ministry and our LHIN. At its meeting this Wednesday, our LHIN board will endorse the proposal to revive the planned replacement of the West Lincoln Memorial Hospital. It seems that the rebuild was a key negotiating factor. The LHIN says, "The future redevelopment of the WLMH site was an important consideration in garnering support for the amalgamation."

1000

These are not LHIN decisions, I realize; these are ministry decisions, but from these decisions, all others flow. Yet it seems to us that the major players in the hospitals are poised to take over control of other services. In our corner of Ontario, Kevin Smith has announced the end of his supervision of the NHS and has been appointed as CEO by a board that has yet to meet. He will continue as CEO of St. Joseph's Healthcare, a network of health care

institutions that includes long-term-care homes. Although he states he does not foresee an amalgamation of the NHS with St. Joseph's, he is clearly anticipating some sort of further consolidation between the two, one that will also involve Hamilton health services, creating some form of sub-LHIN.

The moral of this story is this: Hospital consolidation looks like a money-saver, but it's also an empire-builder, especially if the power over non-hospital health services is going to reside within those hospital systems.

The entire face of health care is changing entirely, and we cannot afford to vest such power in the hands of a few mandarins from the Ontario Hospital Association. For my part, I see the LHIN system as merely obscuring the scope of these changes and getting in the way of meaningful discussion in the media and in the community about how we preserve any kind of human scale, any sense of community, in the delivery of health care in Ontario. When we see—

The Chair (Mr. Ernie Hardeman): Thank you. Your time has expired. Obviously, you have presented a copy of your presentation to the committee.

Ms. Fiona McMurran: Yes, I have.

The Chair (Mr. Ernie Hardeman): The committee will read that part which you were unable to get into the 15 minutes.

We very much appreciate your presentation. Thank you.

Ms. Fiona McMurran: Thank you so much.

FOYER RICHELIEU WELLAND

The Chair (Mr. Ernie Hardeman): Our next presentation is Foyer Richelieu Welland, Sean Keays, director general. This next presentation will be in French, so we have the translation on the desk, and we will start the machine.

Thank you very much for coming in. We very much appreciate it and we look forward to your presentation.

Mr. Sean Keays: Well, I—

The Chair (Mr. Ernie Hardeman): If I could, as I mentioned previously, you will have 15 minutes to make your presentation. Any time left, if it's less than four minutes, will go to the government caucus. If it's more than four minutes, it would be divided to the three caucuses together.

Mr. Sean Keays: I just wanted to thank you for the opportunity to do my presentation in French. It means a lot to our organization. I'm the CEO of the only French long-term-care home in southern Ontario, called Foyer Richelieu, and I see some good friends.

So if you don't mind, I'll just start in French. If there are any questions and you prefer to ask them in English, I don't mind.

Il y a plusieurs points que j'aimerais toucher aujourd'hui pour votre considération. Comme vous voyez, je vais vous donner des solutions possibles, des prochaines étapes.

D'abord, la première considération est de—

The Chair (Mr. Ernie Hardeman): Excuse me, we don't have any sound.

Ms. Helena Jaczek: Press the one.

The Chair (Mr. Ernie Hardeman): One? Okay.

M. Sean Keays: And please feel free—if you need me to repeat something in English, I'd be happy to do it.

Ma première recommandation ou considération principale est de laisser faire n'importe quelle idée qui a affaire avec l'élimination des RLISS, c'est-à-dire les « LHIN ». Ce qu'on devrait faire, c'est regarder à leur donner plus de pouvoir. Ce qui est important pour nous autres, c'est si on éliminait des RLISS et on les donnait au ministère à Toronto, ça veut dire qu'on créerait d'autres jobs quand même. Nous autres, ce qu'on aime, c'est quand on fait affaire avec des gens locaux qui connaissent notre communauté, connaissent nos besoins et nous connaissent comme des « service providers », si je peux le dire. Comme j'ai dit, c'est le temps de leur donner plus de pouvoir.

Puis, une des considérations que j'aimerais vous donner, c'est d'amalgamer les centres d'accès avec les RLISS, c'est-à-dire les « CCAC » et les « LHIN ». Puis, ce qu'on pourrait faire ici, c'est de créer des sites pilotes où peut-être vous trouveriez deux ou trois leaders dans la province qui pourraient entreprendre ce défi. D'abord, je sais que la directrice générale du Toronto Central a déjà géré, comme directrice générale, un centre d'accès, et maintenant elle est directrice générale d'un RLISS. C'est la même chose avec notre directrice générale ici à Hamilton-Niagara où elle a les capacités, une très bonne équipe et un site « beta », c'est-à-dire un site pilote. Ceci, comme vous pouvez l'imaginer, réduirait les coûts d'administration—moins de bureaucratie, et en même temps, moins de conseils d'administration.

L'autre est d'éliminer la duplication des services dans les RLISS. Par exemple, je sais que dans l'endroit de Sault Ste. Marie, il y a environ cent organismes qui représentent les services de soins mentaux ou de dépendances, c'est-à-dire « addictions ». Là, amalgamer ces services-là, avec peut-être un ou deux directeurs généraux ou directrices générales, puis éliminer plusieurs conseils d'administration—ça sauverait des gros dollars. Puis, j'imaginerais que ces exemples-là pourraient être reflétés à travers la province.

Celui-ci est proche à mon coeur parce que je suis directeur général d'un foyer de soins de longue durée. This one's close to my heart because, obviously, I manage a nursing home for francophones. On a plusieurs lits disponibles. Ici à Niagara, en 2008, 96 lits de soins de longue durée ont été promis. Puis, ce qui est arrivé c'est qu'ils ont tous été mis de côté. On aurait pu construire ces lits-là plusieurs années passées. D'abord, ce qu'on pourrait faire c'est de donner plus de pouvoir aux RLISS. Avec ce pouvoir-là, ils ont la capacité de dédier ces licences. Quand il y a des lits « in abeyance », si je peux dire, qu'est-ce qu'on pourrait faire? Mon foyer, on a deux places libres dans le sud de Niagara. Vous avez déjà entendu que c'est là où il y a une urgence à cause d'un manque de lits.

Ce qu'on pourrait faire c'est de donner aux RLISS le pouvoir de redistribuer ces licences-là sur une base intérimaire, jusqu'au temps que ces lits-là sont construits. Puis, ce qui peut arriver s'ils diront dans notre RLISS : « On n'a plus de places à les dédier. Il n'y a plus de "service providers" qui ont de la place pour »—ce qu'on pourrait faire c'est de trouver, avec le ministère des Soins de longue durée, des RLISS où il y a un manque de lits de soins de longue durée et, encore une fois, de dédier ces lits-là sur une base intérimaire.

C'est de l'argent qui a été déjà « budgeté » à travers le gouvernement, mais ce sont des lits qui sont, comme j'ai dit, « in abeyance ». C'est un bon mot anglais.

Mon dernier point est de considérer « l'accountabilité » avec les entités de planification. D'abord, c'est un projet sur lequel la ministre Deb Matthews et la ministre Madeleine Meilleur ont travaillé très fort plusieurs années passées. On a des entités de planification à travers la province. Avec ça, je pense que ce serait intéressant s'il y avait des réunions régulières entre les deux directrices générales, c'est-à-dire « CEO on CEO ». Je comprends que les « CEO » des RLISS sont du monde très occupé, mais s'ils ne peuvent pas se rencontrer de temps en temps, il serait important qu'ils dédient quelqu'un de haut niveau comme un vice-président ou quelqu'un avec du pouvoir décisionnel. Moi, ce que j'aimerais voir, et je pense que ça va un peu dans la mission de la ministre Meilleur et de la ministre Matthews, où on pourrait avoir un pouvoir égal où ils se rencontrent avec un consensus et des buts atteignables pour trouver comment on pourrait améliorer les services pour les francophones dans notre RLISS.

Ça, c'est ma présentation. Je voulais vous donner cinq bons points. Si vous avez des questions, ça me ferait plaisir—if you have any questions, I'd be happy to answer them in French or in English.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about nine minutes left, so we will divide it equally: three minutes for each caucus, with the government caucus first.

1010

M^me^ Helena Jaczek: Merci, monsieur Keays. Je vous demande pardon, mais c'est plus facile pour moi de vous questionner en anglais—

M. Sean Keays: Il n'y a rien là, mais vous parlez très bien en français.

Ms. Helena Jaczek: Merci. We've heard a diversity of views this morning, as I'm sure you're aware. Overall, I would hear from you that you are firmly in the camp of supporting local decision-making within a geographic area such as the LHINs provide. Is that sort of an overall theme?

Mr. Sean Keays: Yes, absolutely. A couple of things I mentioned: It's great that we have these local leaders that we get to know, who know us and know our communities.

At the same time, the one thing I was cautioning is that if there was an elimination of the LHINs, they would have to create these jobs in Toronto anyway, and then we would lose that personal touch. You wouldn't be saving any dollars. What I'm saying is, if there's any buzz going around, just completely dismiss and eliminate those kinds of talks—and give them more power.

Ms. Helena Jaczek: I think, given the history across Canada of regionalization of health care, every province has come to the conclusion that local input is really important. So as long as we're in government, you can rest assured that we will continue.

But of course, what we're here to do is to improve, or potentially make some suggestions. You've made one suggestion related to the amalgamation of the CCAC and the LHIN. By that, I'm assuming you mean that you would disband the board of the CCAC.

Mr. Sean Keays: That's right.

Ms. Helena Jaczek: And it would simply be a direct service provider of the LHIN. Is that how—

Mr. Sean Keays: That's exactly right, and to evaluate, to look at maybe a couple of beta sites, a couple of places where you could pilot. I mentioned two names here. In Toronto Central LHIN—I put her name there—she was CEO of the CCAC and the LHIN. I know that our team here within the Hamilton Niagara are very capable of doing it, and it would be a good example of a beta site where they would have more power in regard to the CEO and her team here or in Toronto, or wherever it is decided, where they could manage both the LHIN and the CCAC together.

Ms. Helena Jaczek: Yes. Now, we heard earlier today a suggestion about primary care becoming, perhaps, part of the responsibilities of the LHIN. Do you have any view on that?

Mr. Sean Keays: Yes, absolutely; that's basically the crux of my presentation. I'm not sure how much we want to throw at the LHINs at one point. But I think that a good strategic plan over time is to evaluate which ones would be more priority and then to see what we could do to give them more responsibility, like the primary care. I think that that's a great point too.

Ms. Helena Jaczek: So you see the trend in that direction—

Mr. Sean Keays: Absolutely.

Ms. Helena Jaczek: —expansion.

The Chair (Mr. Ernie Hardeman): Okay, thank you very much. To the official opposition: Ms. McKenna.

Mrs. Jane McKenna: Thank you so much for coming in here today. I had a bit of a hard time—I don't know if anybody else did—hearing it in English. Nevertheless, you say that the LHINs are very effective and efficient, and yet when I read your recommendations here, it kind of puts me in a bit of a panic that there's a lot of waste going on here.

My first question is, if you say "elimination of duplication of services within the LHINs," does that not worry you that there's a lot of money that's being wasted, if there's so much duplication going on that you have through your whole presentation?

Mr. Sean Keays: You've made a good point. I appreciate you bringing that up. In regard to what I was saying,

I think that the LHINs are very efficient. I think they're doing very well.

I've been back in Ontario for four years, and I think it's about 10 years or so, give or take a couple of years, that the LHINs have been in place. I think there's a lot more that they can do. For the first decade, we've been doing very well, and I think that there are other things where there is duplication. This is the areas—a few that I've mentioned, and our colleague here mentioned primary care—that would be definitely things to see if we could create beta or example sites and then, from there, continue to improve, because there's always room to improve. I think that that's what the purpose of this meeting here today is.

Mrs. Jane McKenna: Yes, there are a lot of improvements that you're recommending here.

For seven years, they have been measuring their performance and trying to be effective and efficient. Do you think that's a long time, seven years, to try to iron things out?

Mr. Sean Keays: I know that most businesses—when I look at our little place, we usually do a strategic plan for about five years. Right now, I think they've had one or two, and it's time to move it along and get some of these services amalgamated or see how we could improve. I think we've done well, but we could do better.

Mrs. Jane McKenna: Okay. Now, my next thing was, I was kind of wondering why this isn't happening now. Your very last "next step" is "Emphasis that all LHIN CEOs meet regularly" with you and that the CEOs "achieve goals determined upon consensus." Is that not happening now?

Mr. Sean Keays: I know some LHINs are doing very well there and I know others can do better. So I think it would take a responsibility where LHINs, the CEOs, their board—they just had a meeting a couple of weeks ago, I think, for what they call the tripartite committee; I don't sit on this organization, but it's something that's close to us because they do help service providers that are francophone. And, absolutely, I think this is something that was introduced a couple of years ago, maybe two and a half years ago, and I think we have to go to the next level where there's a consensus on decision-making.

There need to be responsible goals too. We can't just say, "Let's build a French hospital in Niagara." That would be maybe a long-term goal, but to at least have short- and medium-term goals and try to attain—I think that some LHINs are doing very well at it and then others are not doing as well. I'm happy to say that our LHIN here is doing very well at it.

Mrs. Jane McKenna: One thing—

The Chair (Mr. Ernie Hardeman): Thank you very much. The third party: Ms. Forster?

Ms. Cindy Forster: Thanks, Sean, for being here today. Maybe you can expand a little more on the relocation of the long-term-care licences.

For the committee's information, in 2008, Welland was awarded beds by the government: 96 new beds. It's now 2014 and those beds still haven't been built. So it is problematic in Niagara. We do have a wait-list, which I'm sure Sean can update us on. The problem seems to be that these licences just sit out there in an abyss, where they could have actually been reallocated to other agencies within Niagara.

Mr. Sean Keays: Thank you, Cindy. Yes, I appreciate you bringing that up again. For us, it's so important because in our home we have two open beds that are ready to go. All it would take is a little bit of paint, and we have staffing. It would almost be a sunk cost to us.

When I look at south Niagara—there are probably other regions throughout Ontario that have been going through similar challenges where there's a shortage of beds and they've been identified as an emergency area. where when you think of Ontario, there are about 77 long-term-care beds and there are maybe about 20,000 to 23,000 people waiting. In Welland, there are approximately 400, and there are 400 people. So it's a big gap in regard to the waiting time. We get calls every day—if it's not me, my assistant—"How can we get in quicker? What can we do to get on the list?" When I see that there are these 96 beds—it's great that they've been awarded and there are plans for them to be built, but in waiting, these are dollars that have already been budgeted. We should look at finding out where there are homes that have availability on an interim basis, if it's a one-year. They already have that LHINs give out so many interim licences, the ministry, where they've noticed there are places in emergency—but to maximize on these dollars that have already been promised and to give the LHINs those powers, because they know if it's within the LHIN. After they've been through every home and there's no more place for these interim licences, then maybe see if there are places outside the LHIN, and maybe that would be a joint effort with the Ministry of Health and both LHINs, and then they could designate those licences on an interim basis.

The Chair (Mr. Ernie Hardeman): Thank you very much, and thank you very much, sir, for your presentation this morning.

Mr. Sean Keays: Thank you.

MS. PAT SCHOLFIELD

The Chair (Mr. Ernie Hardeman): Our next presenter is Pat Scholfield.

Ms. Pat Scholfield: Good morning.

The Chair (Mr. Ernie Hardeman): Thank you very much for coming in this morning and being with us, sharing your thoughts. As with previous presenters, we've allocated 15 minutes for your presentation. You can use any or all of it for your presentation. If there's time left over, if it's less than four minutes, the government side gets that. If it's more than four minutes, we'll divide it evenly among the three caucuses for questions. So with that, the floor is yours.

Ms. Pat Scholfield: Thank you. My name is Pat Scholfield and my topic is a grassroots view of LHINs.

What is a LHIN? I would venture to say that 95% of the people of my community of Port Colborne have no

idea what a LHIN is or what they do. I would be in that 95% had it not been for a couple of letters to the editor in our local paper around 2006. The letters stated that a new hospital was going to be built in St. Catharines and it was probably eventually going to be the only major acute in-patient hospital in the region of Niagara, and they were planning on building it in the wrong location. It should be more central to the region. I decided to jump in and write supporting letters, as it was clear to me the far northwest corner of Niagara was not the geographic centre of the region.

1020

While I loved my Port Colborne hospital and had received nothing but the best of care there through the years, I understood the benefits of consolidation of specialties, such as critical mass, equitable access, best practice and all those pet phrases that are thrown around willy-nilly. But if you are going to consolidate major acute specialties into one hospital, it is critical that the hospital is located to provide everyone equitable access. This was definitely not the plan in Niagara. It was time to battle to get a common sense solution to this problem.

I then discovered our hospital no longer belonged to the people who paid for it, but was an asset of the Niagara Health System, the NHS, which had been amalgamated in 2000, operated all the hospitals in Niagara and had their head office in St. Catharines. I tried to talk to them but got nowhere.

Around 2007, the NHS made various moves to close departments at Port Colborne hospital, and riled up some of our local people. To keep them quiet, the NHS CEO, Debbie Sevenpifer, sent a letter to the city of Port Colborne in December 2007 that the NHS was fully committed to our full-service hospital and a vital 24/7 ER. The Ministry of Health and Long-Term Care further backed this up by approving a $400,000 renovation of the emergency department at Port Colborne.

You can imagine our surprise when, in July 2008, the NHS dropped a bombshell on us by announcing they were releasing the Hospital Improvement Plan, also referred to as the HIP, which proposed converting the 24/7 ER to a 14-hour prompt care centre, and closing the operating room and all acute in-patient medical beds at Port Colborne hospital. That is when I discovered the LHIN. They were the body that had ordered the NHS to prepare the HIP, as the NHS had been running serious deficits since their inception.

The LHIN's job was to fund, oversee and integrate our hospitals and make sure hospitals did not run deficits. From 2000 to 2007, the NHS had run up a long-term debt of $160 million, and in 2007, an annual deficit of over $18 million. The LHIN ordered the NHS to prepare the HIP to get their budget balanced by 2013.

Are LHINs local? Our LHIN was called the Hamilton Niagara Haldimand Brant Local Health Integration Network. They claimed they were our local voice. I decided to attend some of their meetings. It took me between an hour and an hour and 15 minutes to reach their headquarters in Grimsby. It didn't seem very local to me.

Are LHINs open and transparent, and believers in public consultation? They will tell you they are, but I believe it is all window dressing and a sham.

Apparently, our LHIN had the final say as to whether to approve the HIP. At one session, the LHIN board members asked some pointed questions. At the next meeting, the LHIN staff had answers that would encourage the board members to endorse the HIP, which they did. It was a jerry-rigged deal, or, as a local mayor said, it was a predetermined decision.

A number of us were incensed with the system which led to the approval of the HIP, and contacted the Ombudsman with our complaints. The Ombudsman then did an investigation into the HNHB LHIN and eventually released his report: The LHIN Spin. The report showed the LHIN public consultation process was severely flawed and at times illegal.

Has this changed anything? Not really. They act like they want to hear from the public, but in reality, their minds are made up. The following is an example:

The LHIN included me in an ACTION committee in the fall of 2012. We were supposed to discuss innovative ways to improve the health system. I believe we were fed questions to guide us to supply answers that would fall in line with the LHIN's predetermined direction. For instance, they tried to convince us health care should be taken out of the hospitals and into the community. I sent through an email, basically expressing my thoughts, that in many cases the hospital is the heart of the community, and that rather than have private clinics set up which would require rent to be paid, it would be better to locate these services in the hospital, where many of them were fully paid for, with no mortgages, and pay the rent to the hospital system, thereby generating revenue.

I also made the point that rather than have private clinics distributed all over the community, it would be better to have them housed at one location: the hospital, where there would be one-stop shopping.

The LHIN CEO put my comments on her blog, but the ACTION report did not reflect any of my suggestions but continued the predetermined mantra to move services out of the hospital and into the community, as though that was what we all agreed on.

Now, you are allowed to attend LHIN board meetings once a month but do not have access to many reports. Several times I would ask for a report to no avail. Finally, in April 2011, I sent an email to LHIN CEO Donna Cripps, asking for a specific report, which had been received and filed. She said she would get back to me.

In May, I had not received anything and emailed her again, and got the following response from CEO Cripps: "Our governance working group of our board of directors is working on a protocol to determine how best to share information with public who are at the board meeting both during the meeting and following the meeting.... I will not lose your request and I will respond as soon as I have direction." To date, I have not received this report.

Are LHINs temporary or permanent? When the LHINs were first set up in 2006, they were supposed to

be reviewed in five years. That never happened, and now it is eight years. The first HNHB LHIN meeting I attended in 2008 was held at the town hall in Grimsby, as the LHIN's offices were in leased rooms in a small mall. A few years later, they constructed their own building across the street. It looks permanent to me.

Now we are told urgent care centres at our hospital must be taken out of our hospital and placed in free-standing, leased facilities, and yet the LHIN has their own nice, new digs. Explain that.

Should we take politics out of health care decisions? Definitely. If we had, the only new acute in-patient hospital to be built in Niagara in 50 years, and probably the last for the next 50 years, would have been built in the geographic centre of Niagara, but a prominent Liberal cabinet member lives in St. Catharines.

Mistakes were made, which the LHIN approved, that were not based on best practices. The LHINs were appointed by a Liberal government. Over $1 billion should not have been committed to a project without absolute assurance by the LHIN that this was the best possible medical decision for all the citizens of Niagara. This was their mandate. Had the right decision been made, everyone in Niagara would have been within one half hour from a full-service acute in-patient hospital.

The HIP was approved by the LHIN and implementation began. Within a couple of years, the hospitals in Niagara were plagued with a serious C. difficile problem and enormous public anger and mistrust brought about by the drastic cuts of the HIP. Health Minister Deb Matthews sent Kevin Smith as supervisor of the NHS to supposedly restore trust, but I believe the main goal was to divert the public's attention while the remainder of the HIP was put fully in place, with obstetrics and pediatrics consolidated into the new St. Catharines hospital.

He created the diversion by proposing another new hospital for south Niagara, but it is in the north and Liberal riding of Niagara Falls, and many people feel it is because of the by-election to be held there next month. Is this another political decision? I personally believe, once the election is over, that enhanced efforts will transpire to consolidate the remaining acute in-patient services to St. Catharines, and we will never see another new hospital anywhere in Niagara.

Now, this should be a serious issue for our LHIN, as the residents of south Niagara will not have reasonable access to emergency hospital services, which may result in untimely deaths and poor patient outcome.

Interestingly, the main point of the HIP was to address the serious $18-million annual deficit, and with Smith overseeing the NHS, the annual deficit by October 2013 was $12 million. It was supposed to be balanced by this date.

Where do we go from here with the LHINs? I wish I had a solution. Obviously, LHINs have made certain they are firmly entrenched and are busy building a permanent empire. As it stands now, it seems to me that the Ministry of Health sets policy, funnels it down to the LHINs and they, in turn, funnel it to the various health systems under their umbrella. They are a very expensive middleman. I personally am concerned they are an unnecessary level of bureaucracy that is constantly writing reports and creating plans ad nauseam to justify their existence. It is not likely there will be anything we can do to remove them.

Bearing this in mind, I would recommend they be held to a very strict budget and do some severe pruning, as they do with the hospitals, and a local person from each municipality be appointed to the board who is elected by the municipality, with the responsibility that they must appear at council on a regular basis, once a month or quarterly, to inform the public as to the LHIN's direction in layman's terms.

1030

The biggest challenge will be to keep politics out of health care decisions and to include the phrase "common sense."

I put in a little addendum here. Since the preparation of this report, I discovered, because of an investigative report, that our LHIN would not release requested reports. The LHIN has now decided they will make board meeting packages available to the public a few days prior to board meetings. They should, in my opinion, not only share information, but webcast their meetings and invite citizen participation during open-mike sessions, as they do at the Erie St. Clair LHIN.

I should also mention that I went on the site on Friday and noticed the board meeting package, but I noted that there were reports in there—there was a big, long memorandum of understanding between the LHINs and the ministry and another template of multiple sector use. But there were some reports that had been received and filed, and there was no report there. I'd like to see some of those reports that are received and filed.

Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about three minutes. With that, the government side: Mr. Colle.

Mr. Mike Colle: Yes, I'm just trying to figure out the difference between what the last speaker said and what you said. You're basically saying you'd like to see things centralized back in Toronto for decision-making; you don't want to see any regional or local say in health matters—because if you get rid of the LHINs, who's going to decide and give input to the Ministry of Health?

Ms. Pat Scholfield: I'll leave that up to you expert people, but I don't believe the LHINs—in my opinion, from a grassroots view, I haven't seen huge improvements. I realize there's a need for consolidation, but there was no common sense used in that here. We were like guinea pigs here. They decided they were going to put this big new hospital up in the far northwest corner of the region, and then everything was going to be sucked up there and they're going to do it gradually. The public was not informed.

The public doesn't know what LHINs are. Everybody I talk to, they have no idea what LHINs are. So they've done a very poor job at explaining to the public what

they're all about. If they want to give them an opportunity for input, come to some of the council meetings and have them come and ask questions. Explain what they're doing.

As far as the centralization, I won't profess myself to be really knowledgeable on that, but I have read reports where they said they've tried these ideas, like LHINs, in other provinces and have found out they didn't work. They've gone back to centralization. If you have a good local voice that speaks to the centralized power, maybe that might be the answer; I don't know. But that's what you're here for.

Mr. Mike Colle: Anyway, I agree with you that many people don't know what a LHIN is, unless they're involved in health care delivery, like yourself. You went to the extra effort of getting involved, which is really what is good about what you did.

Ms. Pat Scholfield: Yes. But it costs money to travel there, too.

Mr. Mike Colle: No, I know; it's not easy. That's why I think we're here today: to get those kinds of recommendations for you. I lived through the centralization thing. I had three of my local hospitals close in the middle of the night—emergencies closed—in the old centralized model. We didn't even know it was going to happen; they were gone. I think people have said, "We need something to have some kind of local say," so that's how they came up with the LHINs. They're far from perfect—

Ms. Pat Scholfield: But they're not local.

Mr. Mike Colle: I'm saying, then, if you don't have them, what do you have? You're back to Queen's Park making all the decisions behind—we've got the biggest health ministry in North America. How can a person in Wainfleet ever have anything to say on what's happening at Queen's Park in that huge—so they're trying to bridge the gap, I guess. That's why I think your recommendations of how to make them more local, how to make them more, let's say, accountable, are good ones. We're here to listen to those proposals, like you've made, and I think they're very good ones because there is a gap between the public and the LHINs—I agree with you—and I think there should be a lot more transparency and connection, as you've just demonstrated.

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

Ms. Pat Scholfield: Thank you.

RETIRED TEACHERS OF ONTARIO, DISTRICT 14 NIAGARA

The Chair (Mr. Ernie Hardeman): Our next—uh-oh; it seems I've lost my agenda here. McMaster University, Niagara Regional Campus: I believe they're not here yet.

Is the next one here, the Retired Teachers of Ontario, District 14 Niagara, Bill Doyle, chair? If he's here, we'll carry right on by the last one. Hopefully they'll arrive to take your spot. Thank you very much for coming in.

Mr. Bill Doyle: Thank you very much.

The Chair (Mr. Ernie Hardeman): As with the previous delegations, you'll have 15 minutes to make your presentation. You can use any or all of that time. If you don't use it all and leave less than four minutes, the questions will go to the official opposition. If you leave more than four minutes, it will be divided equally among the three parties, starting with the official opposition. So thank you very much again for coming in and the floor is yours.

Mr. Bill Doyle: I guess I'll have to speak fast.

The Retired Teachers of Ontario represents over 3,000 members in the Niagara Peninsula. Our district is one of 46 districts in Ontario with a total membership of approximately 70,000.

Since the inception of the Hamilton Niagara Haldimand Brant LHIN, RTO/ERO District 14 Niagara has had representation in attendance at most board meetings. Because of our familiarity with the public workings of the LHIN, we feel we must use this opportunity to address the following points, as we note how they affect the Niagara Peninsula sector, which includes Grimsby, St. Catharines, Fort Erie and Port Colborne: decision-making, ongoing conversation among residents, accountability, access, quality and sustainability.

Decision-making: We appreciate the creation of LHINs to plan and decision-make for health care closer to home rather than having decisions made outside the community. In theory, the creation of a home base LHIN is positive. It empowers people within the community to make decisions for the community in which they live rather than have one unfamiliar with the environs decide on our behalf. Unfortunately, local decisions do not always have a positive effect on the whole community. In its own documentation, the HNHB LHIN acknowledges that it covers a sizeable area. The complexity of the HNHB LHIN is not advantageous to the successful implementation of decisions that would improve health care in Niagara. Since the HNHB LHIN serves a large area with many disparities, our presentation focuses solely on health care for seniors in the Niagara Peninsula.

The HNHB LHIN recognizes that there is a large and growing senior population within its boundary. A study would show that the majority of seniors currently within the LHIN live in the Niagara Peninsula. In addition, seniors moving to the area will choose the peninsula rather than the Hamilton area. The presence of these new seniors places an immediate additional strain on required services within the peninsula. The expectation is that even more services will be required as the senior population increases disproportionately to the rest of the province. Therefore, we would expect that the funding would increase to match the unique needs of the area.

Possible solutions could include funding following seniors moving to Niagara; expanding the satellite program that trains doctors in our area; implementing a mandatory geriatric component in training for all health care personnel; increasing geriatric services; increasing services through the partnership with Hamilton Health Sciences; and, changing the focus from NHS deficit

problems to a focus on patients in desperate need of quality care.

Ongoing conversation between the LHIN and residents: According to the vision for local planning and decision-making, there is to be ongoing engagement and conversation among residents. There is no ongoing engagement or conversations at board meetings in our LHIN. Although our RTO/ERO regular representatives provide both a name and contact information when we sign in for the meetings, we have never been invited to share our feedback about any issues. Usually our regular members are the only interested parties in attendance and we do appreciate the opportunity to learn what is happening in health care. We share the information with our members in Niagara.

We recommend that the government oversee all LHINs throughout the province in a way similar to the method in place in Erie St. Clair. That would mean that all LHINs in Ontario would:

—provide opportunities for engagement and conversation within the community;

—provide presentations and/or materials prior to meeting to aid understanding of issues to be discussed. Curiously, our LHIN has just announced that it would intend to change their practice of keeping such information secret and begin sharing it publicly. I checked the Internet, and it's on there now;

1040

—provide the opportunity for those present to seek clarification; and

—encourage ongoing rapport through communication between LHIN members and those who provide contact information.

To provide information on what is happening regarding health concerns in our community, we hold workshops. We have invited members of the HNHB LHIN, local CCAC and other providers to carry out these workshops for our members. We would appreciate an opportunity to give input back to the HNHB LHIN.

Accountability for public expenditures and health outcomes: Although there may be improved accountability for bookkeeping for the purposes of balancing budgets, our concern is more specific to patient outcomes. We are concerned about what happens when clients do not get the services they are supposed to be provided. We recommend that the LHIN have a body where concerns can be expressed and that the LHIN act as an advocate on behalf of patients.

Access: It has been our experience that there is a discrepancy in wait times for cataract surgery. Some patients, in order to receive timely service, have had to go outside our LHIN. For elderly patients, transportation is a serious impediment to access.

The CCAC health care workers are constantly being changed for a variety of reasons. Because of differentiated staffing, one client may have to see several workers for assistance in the home. There have been incidents where two clients in the same home are being assisted by two different persons at the same time. We suggest that improvements be made so that more attention is paid to the grouping of patients within geographical areas; that, as more patients are managed in their homes or long-term-care facilities, more funding is needed for CCAC; and more training of PSWs, and that that training be expanded to include more areas of care.

Quality: Hospital-borne bacteria are of great concern to patients and their families. Although prevention policies have been developed, the LHIN should review those policies and make improvements where necessary based on best practices, and have the mandate to enforce that these procedures are being followed.

Sustainability: RTO/ERO has a long-standing position on P3 hospitals and privatization of services. We believe in universal, comprehensive, portable, accessible care, administered and managed publicly. We believe in a health care system that operates for the benefit of all citizens of Ontario. Privatization and P3 hospitals are not congruent with these principles.

At the present time, according to the Canadian Institute for Health Information, Ontario has the highest share of private health care expenditures in Canada: 32.3% of total health expenditures. Private providers need to make a profit. That takes money away from the services that are direly needed by our citizens.

To allow the removal of services from hospitals into private clinics would dismantle our community hospital system. Cutting specialized services such as thoracic surgery, vascular surgery, cardiac care, birthing and maternal care, mental health services, cataract surgery and hip and knee replacements from local hospitals and centralizing them into fewer regional centres forces patients to travel greater distances for care. In addition, to transfer day surgeries, diagnostics and other services out of public hospitals into private clinics would further destabilize our public community hospitals and our access to service while increasing the cost to the taxpayer in order to provide revenue for the private providers.

P3 hospitals cost more in the long run because of higher interest rates and fees paid to the management company. These hospitals do not open with the full range of services that were promised. For example, in St. Catharines, the new hospital, which was supposed to replace the St. Catharines General, became, for all intents and purposes, a regional hospital. Although it is supposed to have 410 beds, it only opened with 325. Some departments are operating at a minimal level. There is a $15-million shortfall in the Niagara Health System budget due to higher costs. This has an impact on staffing levels and the delivery of services at all hospitals in the region. The same holds true for the P3 hospitals in Brampton and Sault Ste. Marie.

In short, to close hospital services and expand private clinics is not supported by the evidence. There is a significant body of academic research showing poor quality, safety concerns, higher user fees, cream-skimming of the most profitable and easiest cases at the expense of local hospitals, higher costs and a host of other problems associated with the fragmenting of community hospital services into private clinics.

In conclusion, we continue to monitor the LHIN on behalf of our members, as we hope it will help improve the health care for seniors in the Niagara district. We appreciate this opportunity to express our views, and hope that improvements can be made, as we encourage our members to live healthy lifestyles. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have five minutes left, so with that, we'll start with the official opposition, and we'll each have about a minute and a half.

Mrs. Christine Elliott: Thank you very much, Mr. Doyle, for appearing before the committee today. We appreciate your comments and suggestions. I just wanted to go back to the ongoing conversation between the LHIN and the residents, and the workshops that you have. You've mentioned that you've invited people to come and speak to you. Have you found the LHIN personnel to be helpful in coming to your meetings? What's the situation at present?

Mr. Bill Doyle: Yes and no.

Mrs. Christine Elliott: Okay.

Mr. Bill Doyle: I guess I could be a politician.

The idea here is that, yes, the information has been provided. I would say that the present structure of the HNHB LHIN might be more—how would I say it?—open than with the previous person in charge. We found that it was a one-person show in the previous administration; let's put it that way.

But since then, when we do go to LHIN meetings, we're cordially welcomed—things along that line; no problem. But because we go there unknowing as to what's happening and everything else, I personally will take down maybe eight or 10 pages of notes, hopefully to try to figure out what I'm saying when I write up my report for our meetings.

But the fact that the LHIN has opened up to have the documents on the computer and accessible for people willing to go to the LHIN—I find that that's positive.

Mrs. Christine Elliott: Thank you.

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

Ms. Cindy Forster: Thanks, Mr. Doyle, for being here. Is it your impression that the LHIN has only become more transparent because we're in the process of doing this review?

Mr. Bill Doyle: I would say that it would possibly be the result of the work done by a reporter with the St. Catharines Standard.

Ms. Cindy Forster: Okay. You talked about the issue of cataracts in Niagara. Certainly, that's an issue that I hear about in my constituency office on a regular basis, particularly with respect to one physician who happens to have privileges at a hospital in Cobourg as well as in the Niagara Health System.

I've had some discussions with the LHIN with respect to that, and have been told that there probably are 500 cataracts being done per year, at least in the last fiscal year, outside of Niagara, and that is over and above the numbers that were actually allocated within the budget. What is your sense, in talking to seniors here in Niagara?

Mr. Bill Doyle: It was amazing that you mentioned Cobourg, because that was one of the sites.

With regard to going outside, Burlington, even though it's part of the LHIN, is outside of the Niagara Peninsula, and this is where I feel that the LHIN is concentrating most of its business with regard to the Hamilton area and, hopefully, it spreads out of Hamilton.

Now, Cobourg and Burlington are the sites. They can have cataract surgery, I've heard, immediately or within up to a week. Follow-up appointments can be made locally at the doctor's office.

The Chair (Mr. Ernie Hardeman): Okay. To the government side: Mr. Colle?

Mr. Mike Colle: Thank you for your presentation. I guess that in the time given, you can't cover everything. But it seems that, finally, we're starting to understand that good health care isn't just about hospitals, that it's not just about hospital beds. It's about community health centres, medical health teams that come in place and also the home care, to keep people at home as much as possible and getting that care at home.

1050

So what about on that side? Are you seeing the complaints about the CCACs and the amount of care they're getting at home? Is that still mounting from what you are hearing from your members?

Mr. Bill Doyle: I can give you two or three scenarios. One scenario is that, well, on my street, for example, we had two people with heart problems and two different providers going at almost the same time. Now, this is, I would say, due to the privatization of services rather than having the public nursing system that used to be in place, because I guess what happens is as the patient's name comes up, then—you know, next on the list—you're assigned to it, with regard to the privatization. If it were one body instead of piecemeal, that would not be.

Another thing that we did find, and this was with regard to a member: CCAC assigned the provider for service. In this particular case, the provider was supposed to go daily but did not show up for a period of time. The wife complained, or when she tried to complain, she would break down in tears. So she asked a neighbour to call. The neighbour called and basically was told, "You have no business calling."

Mr. Mike Colle: The CCAC?

The Chair (Mr. Ernie Hardeman): Okay, okay. The time's up. Thank you—

Mr. Bill Doyle: Can't I get the story?

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It wasn't for the presenter; I noticed that my colleague was going to get into another question.

Mr. Bill Doyle: Oh. No, Mike is not that type.

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

MCMASTER UNIVERSITY, NIAGARA REGIONAL CAMPUS

The Chair (Mr. Ernie Hardeman): Our previous delegation has arrived, so we will revert back to McMaster University, Niagara regional campus: Karl Stobbe, regional assistant dean. Welcome this morning. Thank you very much for coming in. As with all the 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 less than four minutes, it will go to the official opposition for the questions. If it's more than four, we will divide the time equally between the three caucuses. With that, thank you again for coming in. The floor is yours.

Dr. Karl Stobbe: Thank you, Mr. Chair, members of the committee and the audience. I'd like to speak from the first-hand experience that I've had engaging with our LHIN, and, first of all, to explain who I am.

I'm a family doctor. I've been in Niagara for 29 years. I practised family medicine in Beamsville and at the West Lincoln Memorial Hospital in Grimsby for over 20 years. Besides working in my office, I looked after patients in hospital, in the emergency room. I delivered babies. I looked after my patients when they were in nursing homes, and I occasionally did house calls.

Since then, I've worked at Quest Community Health Centre, caring for some of St. Catharines's more marginalized people. During my time, I started working at McMaster to create its first rural training program for family medicine residents, and since then I've spent my time with McMaster working to further develop medical education outside Hamilton, in the last six years as regional assistant dean of the Niagara campus of the school of medicine. I just want to tell you a little bit about that so that you can understand where I'm coming from.

The Niagara regional campus has been in operation since 2008. To date, we've graduated 62 doctors and currently have 84 students in our three-year program and 24 residents in family medicine, general surgery and emergency medicine, all based in Niagara. In addition to that, over 200 residents from McMaster and other medical schools have come to Niagara for part of their training. This has had a significant impact on the physician supply and people's access to care.

McMaster's vision: Within a culture of innovation, courage and collaboration, we lead by challenging what is and embracing what could be. McMaster is committed to the community. Therefore, we will adapt to changes in the local health care system. We value interdisciplinary collaboration and we've developed close working relationships with Brock University and Niagara College. Together with our partners, we have worked to promote quality of care through education. Students from Brock and McMaster work together with hospital staff on many quality improvement projects. In addition, we are able to teach interprofessional collaboration through the creation of an innovative interprofessional education unit in the hospital.

To have a high-quality education program, it is important to have a well-functioning health care system. To that end, McMaster has a vested interest in Niagara to promote the quality of care and to ensure there are enough doctors, not only to look after the population but to have additional time available to teach our students.

I've had other interactions with the LHIN. I've served on the board of directors of the CCAC, the community care access centre, one of the agencies funded by our LHIN. I have served on two occasions on planning groups organized by the LHIN to plan the future state of the health care system in our part of the province. In addition, I've served a term as president of the Society of Rural Physicians of Canada, and in that capacity met with most of our nation's health ministers, asking for policies to ensure that rural people across Canada have fair access to health care. As a result, I have some understanding of the health care systems and of the LHINs.

If I recall times before LHINs existed, I have felt some frustration, and I'm not alone, feeling that the Ministry of Health in Toronto was not very aware of regional issues in places like Niagara; it was hard to get their attention. Toronto was very far and the perception was that all the resources were concentrated in the city.

As currently constituted, I've seen both positive and negative sides to the LHINs. I'll talk a bit about both. On the positive side, for planning the future of health care, the LHIN has a more local view, has consulted widely, I believe, and has invited numerous experts, leaders and front-line health care workers from Niagara to provide input into the direction the LHIN-wide system should develop. The final directions, in my opinion, were an accurate reflection of the actual discussions that took place. It did not appear to be an engineered solution.

The LHIN has participated in planning some positive health care developments in Niagara. Their work promoting health links I think has been helpful, and the interprofessional education unit at the St. Catharines hospital was done with the full participation of the LHIN.

Bringing health care planning to a more local level seems like a good idea. I believe there is need for improvement. In my opinion, one of the major functions of government is to fairly allocate resources. Without government intervention, the rich could buy the health care they want and the poor would suffer from not having access. We know of a nearby country where this is the case. I believe that LHINs should be held accountable for fair and equitable distribution of health care funds. If this is part of the LHINs' current mandate, it could be more transparent. Clear explanations in the reallocation of health care dollars would be welcome.

Health care inequity is emerging as a major cause of ill health and shortened life expectancy. This is as true in Canada as in every other country. Even with our universal health care system, people with higher incomes have better access to care and better health. Only government can allocate resources so that people in need are served. This must become one of the major functions of the LHINs, and any assessment of their performance should include this metric.

I believe the LHINs have demonstrated potential and some success in bringing health care planning and organization to a local level. Increasing the focus on equity, both within and between LHINs, and improving transparency will increase their effectiveness and acceptance.

I want to thank you for the opportunity to speak. I could say more, but I think I wanted to provide some focus. I want to also thank the local community for continuing to welcome McMaster—we're new on the health care scene; they've been welcoming our students to particularly Brock University and Niagara College, the Niagara Health System and West Lincoln Memorial Hospital. They've all worked with us to promote an exciting educational environment for young doctors-to-be and encourage them to remain in the community after they finish. I am excited about our work together, advancing health care in Niagara.

1100

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. I want to say that half of my family graduated from Brock.

The questions will be split all three—we have about eight minutes left, so we'll start with the third party. Ms. Forster.

Ms. Cindy Forster: Thanks for being here today. There have been a couple of presenters before you—I don't know if you were here for all of the presentations—but the question came up about primary care: Should primary care fall under the mandate of the LHIN? I want you to speak to that in relation, perhaps, to your comment as well around the fair and equal distribution of health care dollars within and across LHINs.

Dr. Karl Stobbe: Right. I think people need the care that's required depending on their illness. The direction of health care is shifting very significantly from the hospital into the community. Most systems in developed countries around the world are looking at improving access to primary care, because that's the best predictor of good health. Access to specialty care does not appear to impact on population health.

To that end, it makes sense to consider the health care system as a single system. Having the LHIN responsible for one part and some other entity responsible for primary care doesn't make a whole lot of sense. There are some political implications of trying to control doctors and I think that there may be some difficulties in implementation, but in terms of planning, we should have a single health care system. The current silos between hospitals and primary care need to be changed in a major way.

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

Ms. Helena Jaczek: Thank you. I was going to ask the exact same question as Cindy just did, so I'll expand it a little further. I'm a former medical officer of health and I'm wondering what your thoughts are about the integration of public health within the LHIN, how you might see that. Obviously, boundaries might be an issue, but do you, in your promotion of health care to rural communities—how are you engaged with public health? Could that be facilitated with some sort of integration within the LHIN?

Dr. Karl Stobbe: I've done some international work. I think that some places where populations are particularly well served is when public health becomes better integrated with the primary care system and when primary care takes some responsibility for public health. That would be a significant and major shift. It would require quite a concentration of resources, and I think some sober discussion has to take place as to whether that change is warranted. Better integration between hospital and primary care absolutely has to happen.

Whether some changes need to happen to better integrate public health with primary and hospital care: I think there is some opportunity to make that shift, but I would say it's perhaps not the most pressing issue of our time.

Ms. Helena Jaczek: Thank you.

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

Mrs. Jane McKenna: Thank you so much for coming today and for your presentation. We're always grateful for all that you do in the community, so I want to thank you first and foremost.

My first question is going to be this: People always use the word "transparency"—"They need to be more transparent." Can you actually just give me something specific that they need to be transparent about?

Dr. Karl Stobbe: My perception in Niagara is that we have a feeling that we lack resources and that we're disproportionately under-resourced to the rest of the province and the rest of the LHIN. That's a feeling.

We have been in a position to create some innovative program proposals that would be pilot projects that could change the direction of care going down the road and serve as examples to others. I've proposed that to various bodies, including the LHIN, only to get polite encouragement and then find out that health care dollars were spent instead creating a program that had a very well written proposal from a part of the LHIN that's already well resourced, in our opinion—Burlington and Hamilton. The optics of that aren't great, without a whole lot of explanation, except that they're better prepared. Well, they are better prepared because they're better resourced. Then we end up with the rich getting richer and the poor continue to suffer.

I think there is an opportunity to redress that. I don't think the LHINs are constituted to deal with marginalized people. Those in power seem to be able to get more out of the LHIN because they have a voice. That is something, I think, that we need to look at somehow.

Mrs. Jane McKenna: Okay. And then the next thing I was going to say was that Mrs. Scholfield, in her presentation—I don't think you were here to hear that—was just saying that there isn't any consultation at the LHINs. For an example, even though they were speaking about the monies being here, it went over to St. Catharines because she felt there was a cabinet minister there that

encouraged that to go over there. So do you find that the consultation at the LHINs is at the level that it should be?

Dr. Karl Stobbe: I was very impressed with the consultation around planning the future state of our health care system, so planning for what our targets are five years out, 10 years out. I thought the process was remarkable. I thought that the right people were engaged and the mechanisms used allowed for everyone's voice to be heard. I thought that was a remarkably well done process.

In terms of reallocating funding, it's not entirely clear to me—and I've had some interactions with the LHIN; it seems that there are some channels of communication—what money is available, how much and what direction the LHIN would like it to be spent on. When they do allocate money to one project and not another, it's not clear why. So having been on the outside of the funding allocation benefits, I've never been told why we were not funded or why another project was, except of that fact. So I think that there are some opportunities for better explanations to take place.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much for your presentation. We very much appreciate you coming in and sharing your thoughts with us.

Dr. Karl Stobbe: Thank you.

QUEST COMMUNITY HEALTH CENTRE

The Chair (Mr. Ernie Hardeman): Our next delegation is Quest Community Health Centre: Chris Bittle, chairperson, and Coletta McGrath. Thank you very much for coming in to make your presentation this morning. As with the previous delegations, you will have 15 minutes. You can use all or any of that time. Any time that's left over, if it's less than four minutes, will go to the opposition. If not, it will start with the third party, going around using up what time there is spread evenly, if it's more than four minutes.

With that, the floor is yours, and we look forward to your presentation.

Ms. Coletta McGrath: Good morning and thank you, Mr. Chair, and thank you, committee. I am Coletta McGrath. I am the executive director for Quest Community Health Centre. Chris Bittle, our chair, is joining me this morning.

Quest Community Health Centre is a LHIN-funded not-for-profit organization that provides a community-based interdisciplinary model of service delivery, including primary health care, prevention, health promotion and community development. We work with individuals who do not have a primary care provider, and within that context, we focus on marginalized or poor populations who are challenged in accessing the regular health care system. Our model of care includes physicians, nurse practitioners, registered nurses, physician assistants, social workers, dietitians, health promoters, community outreach staff and client coordinators, among others. All of our staff are salaried, including our physicians.

Quest has been delivering services since January 2011. We do so in partnership with a wide variety of organizations, including the Canadian Mental Health Association, Community Addiction Services of Niagara, the Niagara Health System, Niagara public health, Start Me Up Niagara, Pathstone Mental Health, the school boards and McMaster University's DeGroote School of Medicine, to name a few. This year, we anticipate serving over 3,000 clients and providing over 13,000 visits to those clients. We have several points of service, in addition to our main office on 145 Queenston Street in St. Catharines. We have a community drop-in centre. We have a point of service at a local high school. We also provide services to migrant workers in Virgil over the summer, and we visit clients in their homes. We have now developed two volunteer-based programs, a dental program for marginalized individuals and a chiropractic program.

This morning, as representatives of Quest, we would like to provide the members of the committee with our understanding of LHINs, the rationale for their establishment, their strengths and accomplishments, the challenges and obstacles they face, and some thoughts for the future. Our comments primarily reflect our experience at the Hamilton Niagara Haldimand Brant LHIN from the perspective of Quest CHC.

Before we go any further, we feel it is helpful to provide some contextual information. Governments around the world, as well as across Canada, are at various stages of development and using a wide variety of initiatives to implement new paradigms and structures intended to improve health outcomes. There is a widely held belief that these paradigms and structures show great promise in providing more effective services for clients and improved health overall.

1110

These initiatives should be applauded, as should all initiatives that attempt to move systems forward, explore how they can be improved, and take the time and resources to evaluate the outcomes and generate strategies for next steps.

In Ontario, LHINs represent one of the government's major strategies to improve health outcomes. They were introduced into the health infrastructure in 2006 through the Local Health System Integration Act. The purpose of the act is to provide for an integrated health system to improve the health of Ontarians through better access to quality health services and coordinated health care in local health systems and across the province. These are laudable goals.

The role of the first partner, the Ministry of Health and Long-Term Care, in this new structural paradigm is to provide strategic leadership, planning and central oversight as the steward of the health system in Ontario.

The role of the newest partner, the LHIN, is to plan, coordinate, integrate and fund specific parts of the local health system. In our case, this local system has the third-largest population of all the Ontario LHINs, encompassing Hamilton, Brant, Burlington, the region of Niagara, Haldimand and most of Norfolk county, and covering 7,000 kilometres.

The LHIN is also responsible for monitoring, evaluating, reporting on and addressing the performance of certain health service providers within their jurisdiction.

Finally, the role of the third partner within this new structural paradigm, not-for-profit health service providers, of which Quest is one: Many community-based health service providers have been delivering services for well over 30 years in the communities for which the LHIN is responsible. Their staff and board mandate is to ensure that local community and neighbourhood perspectives are brought to the table and that community-appropriate, cost-effective and successful services are available as a result. These service providers have also tapped into local leadership, commitment and support—professional, financial and otherwise—as we promote innovation, systems improvement and enhanced health outcomes for our community residents.

CHCs specifically have operated in Ontario since 1974. New funding for new centres has been introduced by all government parties during that time frame. As a result, there are 75 centres, as well as an additional 12 aboriginal centres, across the province. Quest is one of four in the Niagara region.

Serving the greater St. Catharines community, Quest focuses its efforts on individuals with mental health, addictions and concurrent disorders; isolated seniors; members of the lesbian, gay, bisexual, transgender, queer and questioning populations—we do that on a regional basis; people who are homeless or at risk of being homeless; and low-income children, youth and families.

This review of the Local Health System Integration Act would indicate that the government has decided it is time to begin connecting the revised system design with data and information that will inform the progress of the LHIN initiative, demonstrate how well it is working with the Ministry of Health as well as with local providers, and give direction in terms of future steps and if there is a need to revise or amend.

Quest would like to commend the government and the committee on the timeliness of this review and on giving LHINs some breathing space and an opportunity to get a firm grip on their mandate, prior to research or consultation happening.

Achievements to date: Having been established in August 2007, according to organizational theory, LHINs are still at an early stage of development. Much of their initial work has centred on developing structures, processes and relationships. They have done this well, and continue to, seeking input from the community and from LHINs in other jurisdictions.

In addition, when one steps back and considers the new structural paradigm introduced through LHINs and what benefits it brings to the health care table, one sees a number of very positive changes, both from a governance and a service delivery perspective.

I'd like to ask Chris, Quest's chair—he's going to take a look at these changes from a governance perspective first.

Mr. Chris Bittle: Thank you. Since its inception, our LHIN has introduced and supported the introduction of the concept of best practices into governance, serving as a model for those agencies that it funds. For example, with respect to governance, the LHIN has provided system-wide leadership quickly, despite the challenges of the large LHIN geography; diverse populations; relying on stakeholders, many of whom are not funded by the LHIN—physicians, for example; and having to work with multiple levels of elected governance.

The LHIN has also begun to develop strategic relationships and initiatives to help move local communities toward LHIN-wide goals related to improved quality, client-centred care, innovation, accessibility and accountability—for example, training workshops on quality improvement; workshops regarding aboriginal populations; webinars regarding agency multi-sectoral accountability agreements; and making LHIN staff available to attend board meetings and update members on specific LHIN initiatives.

The LHIN has begun to engage the community at multiple levels in planning and setting priorities for the system, including establishing formal channels for community input and consultation. This was most recently experienced in the development of the LHINs' strategic health plan for 2012 to 2017.

Within the context of planning, the LHIN has begun to align their funding priorities with wellness as well as outcomes related to specific populations rather than illness and the provision of services and treatment, once again as reflected in their strategic plan and in funding envelopes that focus on chronic disease management, keeping residents out of the ER, and aging in place, for example.

There is formal communication-sharing across all LHINs which has increased awareness of what is taking place in different jurisdictions, thus improving their planning capacity and that of the agencies they fund. LHINs have promoted greater transparency by implementing public board meetings and educational sessions.

However, the LHIN faces a number of challenges as well when it comes to governance, and we have summarized a few of these for the committee.

LHINs function in a complex governance environment, with multiple stakeholders and partners. This creates a type of complexity that is new and quite different from your typical corporate or not-for-profit governance experience. The balance required between the independence to generate goals that are relevant to the local community—in Quest's case, St. Catharines and Niagara—as well as take into account those of the broader LHIN-wide system while being accountable to the provincial Ministry of Health and integrating the ministry's vision and priorities into planning as well as funding allocations is challenging to develop and maintain.

This observation regarding the system's complexity emphasizes the need for clarity with respect to expectations placed on the LHIN as well as for the appropriate resourcing, tools and supports to ensure that LHINs can effectively respond to local needs identification, local planning, local service delivery philosophies and local resource requirements while delivering on their system-wide and provincial mandates.

At present, some of the stakeholders needed to effectively plan and support the coordination of the local health

system are not funded by the LHINs. Physicians, family health teams and public health come to mind. So while the LHIN effectively identifies needs and gaps across the health care system, the downside is that the LHIN board does not have the control or authority to address these needs and gaps. The capacity for planning, service design and decision-making that will result in a locally comprehensive and responsive primary health care service continuum is limited by the fact that some health care providers are funded by the LHIN while others are funded by and directly accountable to the Ministry of Health.

Because it is working at a local systems level rather than a provincial level, the LHIN has a strong capacity for relationship-building with community-based service providers. While the LHIN has initiated this process, it does not appear that they have made significant headway at the board and staff level across many agencies. Once again, given their stage of evolution, it may be that relationship-building has taken place with larger organizations, such as hospitals, and will eventually take into account both regionally- and municipally-based organizations and those they represent. The three new community health centres in Niagara, for example, are relatively small compared to agencies that have been operating for some time. This places us at an immediate disadvantage with respect to having our perspective heard. It is also important that staffing at the LHIN be sufficient in number and expertise to support relationship-building.

As we noted, in addition to governance, we would like to speak to the LHIN's impact on service delivery, which Coletta will address.

Ms. Coletta McGrath: The LHIN has promoted principles and service delivery philosophies that have been operationalized by locally based organizations in a variety of ways and with positive results.

Health care has been largely structured and organized around a hospital-centric health care system. Also, it has traditionally focused, to a significant degree, on the needs of health care providers rather than clients. While many health care providers haven't moved away from this model altogether, LHINs are playing a significant role in helping them to do so and move towards a continuum of services that is more heavily focused on wellness and prevention services in the community and less so on the services that hospitals traditionally provide.

Since its inception, the LHIN has been an impetus for agencies to build relationships and a greater understanding of their respective roles. This, together with the LHIN's funding approaches, has created an environment that is becoming more conducive to coordination and change. Working in silos is starting to become a thing of the past. Sharing buildings, spaces and resources—hubs, for example—thinking collaboratively, considering innovative ways to work together, adapting a broader perspective and considering issues from multiple viewpoints are now the common mode of operating.

1120

While the LHIN has promoted important shifts with respect to service delivery, there are some challenges. One of these has to do with being the messenger for ministry-wide thinking and priorities, and integrating them into planning and investments across the LHIN jurisdiction, while at the same time being responsive to local needs identification, local planning and local service delivery.

There is also a need to provide a clear message regarding the definition of "integration" and the definition of "local." Integration has multiple definitions. There is a sense that the LHIN is moving from a facilitator and listener to an integration catalyst on behalf of the ministry. Where integration focuses primarily on decreasing the number of funded organizations, thus eliminating or risking eliminating the community-based nature of the health system, it is important to keep in mind that these community-based agencies and boards have played a fundamental role in ensuring the development of services for those who are marginalized and would not otherwise have voices. It is also important to keep in mind that bigger is not necessarily better or less expensive. In fact, it rarely is.

The definition of "local" also deserves some attention. There is a risk that the definition of "local" as it applies to local health integration networks—I remind you, 7,000 square kilometres—will be used to redefine the parameters for local service providers. Ontario's not-for-profit service system evolved over time, has incorporated research and best practices, and is envied around the world. In that system, "local" is defined as community and neighbourhood.

In summary, the new paradigm—the Ministry of Health and Long-Term Care, the local health integration networks and community-based service providers—ensures that the system will benefit from a variety of perspectives. Local agencies represent and promote local and neighbourhood perspectives and needs. The LHIN creates a systemic viewpoint that those local agencies can benefit from; it also has the potential to quickly bring issues of regional importance to a provincial LHIN-based table and to the ministry. The ministry provides an overarching framework that is province-wide, and that enriches and guides the ministry as it listens and supports.

One final observation to keep in mind: No matter how good a new health system paradigm is, for it to work effectively and be supported by residents, people must identify with some component of the paradigm. The average person does not identify with the Ministry of Health and Long-Term Care. The average person, quite frankly, does not identify with the Hamilton Niagara Haldimand Brant LHIN.

People identify with municipalities. They identify with St. Catharines. They identify with Fort Erie. They identify with Hamilton. They identify with Brantford. They identify with their local communities. They identify with their neighbourhoods. With that in mind, organizations that provide services at this level need to be encouraged, need to be nurtured and need to be maintained. The LHIN will require the ministry's support from a policy and funding perspective to ensure that this happens.

Quest CHC has a final recommendation, and Chris, our chair, will share it—

The Chair (Mr. Ernie Hardeman): Thank you very much. That does conclude your 15 minutes—in fact, slightly over it—but we thank you very much for your presentation. I can assure you that you have given copies to the committee; they will read the rest of it and get all the information. We thank you very much for taking the time to come and present to us this morning.

Ms. Coletta McGrath: Thank you.

PLEASANT MANOR RETIREMENT VILLAGE
MENNONITE BRETHREN SENIOR CITIZENS HOME

The Chair (Mr. Ernie Hardeman): Our next presenter is Pleasant Manor Retirement Village and Mennonite Brethren Senior Citizens Home, Tim Siemens, executive director. Thank you very much for coming this morning to make your presentation.

Mr. Tim Siemens: You're very welcome.

The Chair (Mr. Ernie Hardeman): As with previous ones—we don't always follow it to the letter, but it's 15 minutes for your presentation. You can use any or all of that time. If you leave some time, if it's less than four minutes, it will go to one caucus; if it's more than four minutes, it will be divided equally among the three caucuses for questions to your presentation. With that, the floor is yours.

Mr. Tim Siemens: I trust that the time is appropriate. I timed it before I came, and it was just around the 15-minute mark.

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

Mr. Tim Siemens: As was mentioned, my name is Tim Siemens, and I am the executive director of Pleasant Manor Retirement Village and of Tabor Manor in St. Catharines, the Mennonite Brethren Senior Citizens Home. I've been in this role since March 2000.

In addition to my role with these two senior citizens' homes, I also serve on a number of local committees, LHIN-wide networks and provincial boards of directors, including the Niagara seniors' supportive housing network as a member, the Hamilton Niagara Haldimand Brant Community Leaders Council as a member, the HNHB long-term-care-homes network as co-chair, and the Ontario Association of Non-Profit Homes and Services for Seniors, currently as the chair of the board of directors.

Additionally, I have been involved in the LHIN's clinical services plan, the LHIN's Behavioural Supports Ontario committee, and the alternate-level-of-care—ALC—workgroup, and I was a board member of the Niagara Regional Housing board of directors.

Pleasant Manor is located in Niagara-on-the-Lake, and Tabor Manor is located in St. Catharines. We have both private and not-for-profit continuums of care, campuses of care, providing supportive housing, apartments, life-lease units and long-term care all on the same site, in a range of apartments and life-lease units. The nine-member board of directors is elected annually by the Ontario Conference of Mennonite Brethren Churches.

Our relationship with the Hamilton Niagara Haldimand Brant Local Health Integration Network is captured in two primary agreements. Our individual long-term-care service accountability agreements, or L-SAAs, govern the relationship between the LHIN and each of our long-term-care homes. The multi-sector accountability agreement governs the relationship between the LHIN and each of the homes for the delivery of supportive housing services at both sites. In total, Pleasant Manor and Tabor Manor collectively serve approximately 600 senior citizens.

In terms of the review, to the extent that I am able and based primarily on personal and professional experience, my review of the LHIN will be measured against the objects of the local health integration networks in their role to plan, fund and integrate the local health system as set out in the Local Health System Integration Act, the foundation on which the LHINs were created and implemented throughout the province of Ontario.

Firstly, since its inception, the LHIN continues to promote integration of the local health system to provide appropriate, coordinated, effective and efficient health services. Toward achieving this objective, the LHIN has strongly encouraged health service providers to network and collaborate with each other to identify areas within the health system that can be better coordinated, ultimately to benefit the local population. As a result, the LHIN model has created a supportive environment in which health service providers who would not typically have come together under the former district health model meet and discuss better ways to deliver health locally. It has been exciting to meet other people within the local health system and to work concertedly toward a common aim.

Over the course of time since the LHIN model was implemented, I have witnessed the evolution of the LHIN's role to identify and plan for the health services needs of the local health system in accordance with provincial plans and priorities and to make recommendations to the minister about that system, including capital funding needs for it.

The LHIN model was touted as the pre-eminent model to ensure local planning was encapsulated in local health delivery models. In the early years, many of us health service providers were invited to meet with the LHIN to plan out the local health system. Several years later, provincial priorities, particularly hospital avoidance and responding to ALC pressures within hospitals, came to dominate local service delivery models, making it challenging to fully actualize and realize the local mandate the LHIN model was designed to achieve.

I feel the LHIN has performed highly in its role to engage the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal

channels for community input and consultation. The current CEO and her predecessor, Pat Mandy, strongly encourage engagement of health service providers, either through invitation around a particular purpose or focus, or affirming the formation of like-minded individuals and entities to create functional networks within the LHIN.

I believe the HNHB LHIN is doing a great job in its engagement role. In my capacity as the chair of the OANHSS board of directors, I have had the recent pleasure of touring this fine province, attending the annual general meetings of the nine OANHSS regions. I can share with you that a high LHIN engagement is not always a shared experience across this province. In some cases, it is challenging for health service providers to be given any speaking time with their LHIN. It's not the case here in HNHB. In a model that places such high value on the LHINs to engage their community, this is one area where I would suggest the government make changes.

As an example of the high level of engagement of the HNHB LHIN, I would like to share with you the LHIN's support in the creation of the local long-term-care-homes network. The HNHB long-term-care-homes network was founded in 2006-07 and consists of 87 long-term-care homes within this LHIN. A council of 10 members, representing all 87 homes, meets monthly to discuss shared issues and concerns with the local long-term-care sector within our LHIN. When the LHIN is faced with issues pertaining to long-term care, their first response is to consult this network. LHIN staff attend and participate in discussion with the council. In fact, this model was identified in Drummond's report as the preferred model to be implemented within each of the LHINs across the province.

Without the strong support of the HNHB LHIN, the long-term-care-homes network model would not have received the traction that it has and would not be honoured to hold such high rank by the LHIN and government.

1130

Additionally, the LHIN, together with members of the Niagara senior supportive housing network and the applied research department from Brock University, has recently completed a set of standardized performance outcome measures that is used by these local providers in effectively measuring the delivery of this vital community service in a consistent and uniform manner.

In supporting this initiative, the HNHB LHIN was able to meet their objective to develop strategies and to co-operate with health service providers, including academic health science centres, to improve the integration of the local health system and the coordination of health services.

I do not feel best equipped to comment on the LHIN's performance to ensure that there are appropriate processes within the local health system to respond to concerns that people raise about the services that they receive. Any comment I could make on this issue would be influenced by recent local media attention on the apparent lack of transparency of our LHIN and comments made about citizens within this LHIN not even knowing about the LHIN or its existence. I do not share this perspective, as I am fully immersed and engaged within the local health system.

However, I do feel equipped to share that the HNHB's recent mandate that all health care providers within this LHIN incorporate into their operations a balanced scorecard approach is a move toward strengthening the relationship between health service providers and their customers. An inherent assumption of this model is based on an organization's focus to better understand and measure its customers' levels of satisfaction in a quasi-scientific manner and establish performance benchmarks from which to launch any number of quality initiatives in an effort to improve customer satisfaction.

While this is a very new mandate and initiative for us, I suspect that in coming years we will collectively be able to better ascertain the performance of our local health system in terms of patient and customer satisfaction. Personally, implementing this approach has brought a breath of renewed energy within the organizations I operate, as we rally together to better understand our customers' needs and improve our service delivery to our customers.

A strong role of the LHIN is to evaluate, monitor and report and be accountable to the minister for the performance of the local health system and its health service, including access to services and the utilization, coordination, integration and cost-effectiveness of services. To accomplish this, the LHIN has implemented a process for health care providers to report quarterly on financial and a range of clinical corridors.

Additionally, when new funding is allocated for special LHIN initiatives—Emergency Department Action Plan funding, Aging at Home etc.—health care providers are required to report separately on these health delivery funding pots, which adds considerable administrative burden to the organizations. Couple this together with the reporting requirements of the Ministry of Health and Long-Term Care, and it should be no surprise that health service providers are growing increasingly weary in responding to the high burden of reporting within the health system.

As an operator and member of OANHSS and its board of directors, it is our hope that through this process of review, action will be taken immediately to seek ways to reduce the administrative and reporting burden of health service providers.

The LHIN is responsible to participate and co-operate in the development by the minister of the provincial strategy and in the development and implementation of provincial planning, system management and provincial health care priorities, programs and services. From the perspective of a health service provider in long-term care and supportive housing, we see by experience how the LHINs have worked with the minister in establishing the L-SAA and M-SAA agreements to fulfill the system management piece of this broader mandate. While this methodology has, at its broadest level, been successful in

standardizing the formal relationship between the funder and program providers across the province, we have seen numerous examples of inconsistencies across the LHIN in the context of performance outcome indicators within these agreements.

For example, in most agreements, the quality agenda forms an inherent standard component of the LHIN's and ministry's interest to improve quality within the system to the highest degree. This is something no one can, nor should, contest. We are all interested in creating the highest-performing health system. However, in some cases, LHINs have incorporated into their agreements mandatory clauses forcing organizations to become accredited. Mandating something that is typically optional for organizations will place undue financial burden and hardship on organizations required, through their formal agreement, to become accredited.

In summary, going forward, it will be important for the ministry to ensure there is a consistent approach in the delivery of health services by all LHINs, particularly when it impacts funding and limited resources, as it will create inequities in service delivery from one provider to another. Imposing conditions that take added resources will impact the provider in providing the same service as another home that does not have the added financial burden.

Another object of the LHINs is to allocate and provide funding to health service providers in accordance with provincial priorities so that they can provide health services and equipment. I have witnessed the concerted effort of the HNHB LHIN to allocate funding toward hospital avoidance and reducing ALC levels, from which the organizations I have and other organizations have benefited. As a result of this funding and focus, we have been able to increase capacity for housing and supportive housing, which will help many more seniors stay in their homes longer and out of hospitals and long-term care.

As an operator, it has sometimes been a challenge responding to the LHIN's requests for proposals for new funding, based on the speed at which funding announcements are made and the expectations of turnaround times. However, the LHINs' timelines appear, in many cases, to be a function of how quickly the LHINs need to respond to the government's announcements for funding for LHINs.

The LHIN has worked effectively to enter into agreements to establish performance standards and ensure the achievement of performance standards by health service providers that receive funding from the network. In the context of the M-SAA, when it was in its formative stage, we were invited to meet with the LHIN to work collaboratively to establish reasonable clinical performance corridors and standards. Since that time, our processes have evolved to refine our approach to performance measures up to and including the shared development of a standardized set of quality outcome measures for supportive housing, as previously described. Also, as previously mentioned, the mandated balanced-scorecard approach will assist health service providers to establish additional performance benchmarks from which to launch intentional quality-based strategies to improve overall satisfaction within the health system as a whole.

In closing, I would like to paraphrase a brief talk I heard presented at a past OANHSS convention by Hugh MacLeod, the then associate deputy Minister of Health, who likened the LHIN model to a parade. At the parade, there are many people playing different roles. There are floats at the front of the parade, there are floats in the middle of the parade and there are floats at the end of the parade. There are spectators standing on the sidelines watching the parade go by. Each person in attendance plays a particular role of engagement. Some are content to be involved, while others are content to just watch. The LHIN model is like a parade. To make the LHIN model successful, we must be fully engaged in the parade, for if we are not and remain content to sit on the sidelines as spectators, the parade will pass us by and we will have lost the opportunity for involvement and influence in shaping the excitement of the parade and the parade itself.

Perhaps there is not one successful model for the delivery, funding and management of a health system, particularly one that is so highly complex. The province of Ontario was the last province to embrace and implement a regional health model. In their effort to move toward a health system that responded directly to local health needs, the government of the day implemented the local health integration network model. This model is by no means a perfectly running example. Since its inception, there have been much evolution and challenge in getting it to the state where we see and experience it today.

My experience and professional involvement leads me to believe that we still have a long way to go in tweaking this model to achieve its stated mandate and result. Personally, it has been a pleasure for me to be encouraged and welcomed to join the parade and to participate in shaping the delivery of health in my community.

I thank you for this opportunity to present to you my perspective as part of that journey.

The Chair (Mr. Ernie Hardeman): I should have taken your word for it when you started: It was 15 minutes. Thank you very much for your presentation. It's much appreciated.

Mr. Tim Siemens: You're very welcome.

PATHSTONE MENTAL HEALTH

The Chair (Mr. Ernie Hardeman): Our next presenter is Pathstone Mental Health: Ellis Katsof, chief executive officer. Good morning. Thank you very much for coming in. We have the presentation here that the Clerk will pass out to the committee. Thank you very much for coming in. You will have 15 minutes to make your presentation. At the end of the 15 minutes—you can use all or any of it—if it's more than four minutes, we'll have questions from each caucus. If it's less than four

minutes, we will give it to the official opposition caucus for the four minutes. Thank you very much for coming in, and the floor is yours.

Mr. Ellis Katsof: Thank you very much, Mr. Chair and committee members. I appreciate having the opportunity to be here today.

Pathstone Mental Health is a not-for-profit mental health agency for children and youth from birth to their 18th birthday, and their families. We have been in this community of Niagara since 1968. We are in our 46th year providing services to the community. Pathstone Mental Health is funded by the Ministry of Children and Youth Services and is the only accredited children and youth mental health agency serving all of Niagara region. Last year, Pathstone served 7,362 children, youth, adults and caregivers, who received almost 32,000 treatment sessions.

Adult mental health services are provided by agencies funded through the LHIN and are for individuals once they turn 16 years of age. Therefore, there is an overlap for 16- and 17-year-olds. We call this group the transitional age group, with one foot in children and youth services and the other in adult services.

1140

Our agency works in partnership with adult mental health agencies to serve this transitional age group. We also work closely with addiction agencies which are also funded by the LHIN and deal with this transitional age group. The LHIN recognizes the overlap between funders and service providers, and encourages inter-agency collaboration for this challenging transitional age group.

Niagara is in a unique situation at this moment in time. Niagara has the highest unemployment rate in Ontario, the highest low-income levels, the highest percentage of seniors in its population, one of the highest obesity rates in the province, a very high intensity level of child mental illness etc. All of these indicators affect our citizens' health. This alone is a very strong argument for health planning at a local level.

Although the Ministry of Health and Long-Term Care is responsible for setting provincial policy, standards and strategic directions, the LHIN is then able to take into account local needs and receive input from residents and service providers and integrate this information into local health plans that not only address provincial standards, policies and strategic directions but also take into account local issues and needs. From my perspective, as a partner with these adult mental health and addictions agencies that are directly funded by the LHIN, the LHIN fulfills this role well.

Another reality that makes the LHIN important to our community is the geographic size of Niagara. Niagara is 296% larger than the city of Toronto, which makes it very challenging for service providers to meet the needs of Niagara residents. The local planning perspective brought to Niagara by the LHIN helps create decisions that address these geographic challenges.

There are no simple solutions to delivering services across Niagara. The LHIN has worked diligently, I believe, at encouraging ongoing community engagement and input from residents and health providers across Niagara into each planning priority that it addresses. This would be very difficult to accomplish at a provincial level.

The one area that I would like to highlight for your consideration when reviewing the LHINs is the policy that the LHINs will not fund any new agencies. Although in principle this policy makes sense, I believe some flexibility is required when implementing it. Both the Ministry of Health and Long-Term Care, through the LHINs, and the Ministry of Children and Youth Services fund mental health services. Last year, Pathstone provided treatment to almost 4,500 children and youth; 50% of those children and youth had at least one parent—one adult—with a mental health challenge. Although it makes sense to provide seamless treatment to the entire family—both parents and children—due to funding anomalies, Pathstone is only able to access funding from the Ministry of Children and Youth Services to provide treatment to the children and youth, while funding to provide treatment to the parents, available from the LHIN, is not accessible to Pathstone Mental Health, forcing the parents to go to a completely different provider.

Here is another example where being unable to apply for funding from the LHIN does not make sense to our agency. The Niagara LHIN's mental health and addictions 10-year strategic plan includes the following proposed strategy: Stop stigma—bring mental health and addictions out from behind closed doors.

In 2013, the LHIN issued a proposal call addressing the LHIN's mental health and addictions strategies. Three years ago, Pathstone Mental Health took the lead in developing a community-wide anti-stigma campaign. Pathstone struck a community advisory committee comprised of 35 Niagara professionals and community members who developed the anti-stigma campaign called Shatter the Stigma Mend the Mind. Adult mental health agencies are among the members of the community advisory committee. Although Pathstone Mental Health has taken the lead role in implementing the anti-stigma campaign, it was ineligible to apply for or receive LHIN funding through the LHIN proposal call because it was not a LHIN-funded agency. To the LHIN's credit, they did encourage us to put the proposal in just to keep them aware of what we were doing, but no funding followed. No allowance was taken into account that Pathstone has been a provincially funded agency for 45 years, currently through the Ministry of Children and Youth Services—although originally it was funded through the Ministry of Health, until ministries were changed and all the children's services were moved into one ministry, so we do have our roots in the Ministry of Health—nor that it has a working relationship and a strong partnership with the adult mental health sector on our anti-stigma campaign and in the services that we deliver to the transitional age group.

In closing, the LHIN states that it "works with other stakeholders, including primary care providers, housing

providers, health and social services and other funders to help link care and supports for healthy people and healthy communities." From my experience as CEO of a children and youth mental health agency funded by the Ministry of Children and Youth Services, the LHIN works hard at linking funders and other service providers so that care and supports for healthy people and healthy communities can be a reality in Niagara. They fulfill a role that is challenging and very crucial to the residents of our community. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We will have enough time for two minutes from each party. I think we start with the third party.

Ms. Cindy Forster: Thanks for being here today. I've heard from a number of presenters today, and a couple of them fed right into your comments about the high unemployment rate, the high number of seniors, the fact that parents with mental illness and children with mental illness are not being seen together, and the lower income levels for families here in Niagara. There was a suggestion that there's a sense that Niagara is kind of the poor sister, whether it's within the LHIN or across LHINs. Can you give me some comments on that?

Mr. Ellis Katsof: I'd have to agree with a previous speaker—I was here for the past few speakers—that it is very difficult to get concrete statistics on funding on a per capita level, whether it's for children's mental health, adult mental health, hospitals or other types of services. Statistically, in a concrete way, I cannot say absolutely; in a perceptual way, the entire not-for-profit sector—or all the colleagues that I work with all have that perception that Niagara is underfunded on a per capita basis, no matter which sector you look at. When we have local planning bodies like the LHIN, hopefully that will be an opportunity to begin rectifying that in the future, but there has always been a feeling that once you cross that Skyway, somehow, Niagara is the forgotten poor sister.

Ms. Cindy Forster: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. The government, Ms. Cansfield.

Mrs. Donna H. Cansfield: Thank you very much for your presentation. It was very well received and very balanced.

Mr. Ellis Katsof: Thank you.

Mrs. Donna H. Cansfield: I'd like to ask about the transition times. One of the biggest issues we have is when young people turn 18 and then they hit that adult wall, barrier, transition or whatever you want to call it. In fact, if what you're proposing were to occur, we could eliminate some of that, because you could transition over. I really would be interested in your perspective on how we could do that. How do we move forward on this?

Mr. Ellis Katsof: There are a number of different transitional points. As I mentioned, in the health sector, one becomes an adult at the age of 16. In the Ministry of Children and Youth Services sector, you become an adult when you turn 18. If we look at international theory and if we look at brain development theory, people are not really considered an adult until they're 24 or 25, and governments around the world are beginning to plan their services for children and young adults up until the age of 24 or 25.

Ontario and Canada lag behind. It's a major challenge, from a policy perspective, when you have ministries that are structured, often, with age guidelines. It is a significant challenge to take that into account and make those changes, I believe, over time. Not in my career, but over the next 20 years, I think that is the way we will see things go in Canada, because it's happening around the world.

In a small way, how could that happen? As I mentioned—and I'm just talking about mental health—if children's mental health services could be funded by both ministries, then that would allow agencies to have services across the lifespan and deal with that transitional age from 18 to 24, because we would be able to get funding for mental health services for that age group and then have a seamless system.

If we're able to get services for adults as well, for the parents, then we'd really have an integrated system, because in systems theory it's much easier to deal with children and families who are both dealing with a depression disorder, because the children go home after therapy, and if the parents aren't dealing with their depression disorder—if one of the parents has one—then it's really difficult. You're going back into a home where you're surrounded with certain behaviours that reinforce the behaviours.

All it is, in learning to deal with depression as an example—you have to develop the strategies to deal with your depression disorder, because you're going to have that your whole lifetime.

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

Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation, Mr. Katsof, for being here today and for the wonderful work that Pathstone is doing in the community for children and youth.

Mr. Ellis Katsof: Thank you.

Mrs. Christine Elliott: You've raised some really interesting points. One of the things that we talked about—Ms. Jaczek and I had the pleasure of sitting on the Select Committee on Mental Health and Addictions a few years ago, and we noted some of the concerns about having children's mental in one ministry and adult mental health in another ministry. We ultimately recommended that it be folded into the Ministry of Health, with some interministerial co-operation.

But I think for the purposes of what's going on with this committee, you've really raised the issue about having some important parts of health care being outside of the LHINs, and it looks like children's mental health—just because it's in a different ministry—isn't being included.

Children's treatment centres, I think, are another valuable component that also aren't included.

So would you recommend that we include all of the service providers, particularly, in your case, children's

mental health? Obviously, you're advocating for some funding, so I'm assuming you feel that it should be rolled into LHIN funding and resource planning.

Mr. Ellis Katsof: I won't comment on which ministry children's mental health should be in. I think that's a political decision. I don't think there's any right ministry that children's mental health should be in, but I think there's a much easier way of accommodating the funding anomalies, that children's mental health agencies should have access to funding from both ministries. There are very strong arguments for it being in either ministry, and I think it really would end up being a political decision rather than a rational decision, because there are good arguments on either side.

It's a simpler way of just allowing funding to flow. And if funding flowed to the children's mental health sector from the Ministry of Health for the adult portion, then the children's mental health sector would also have to come under the planning responsibilities of the LHINs, as it comes under the planning responsibility of the children's mental health sector.

Both ministries are working very, very diligently at the policy level and the senior bureaucratic level to do cross-planning around children's mental health already. Our ministry is working very closely with the Ministry of Health around planning issues, so I think it would be a much easier fix as far as having funding accessible from both ministries.

The Chair (Mr. Ernie Hardeman): Thank you very much. Just before we say thank you for coming in, I would just like to point out that I've heard it a number of times in the deputations this morning, and I'll take the Chair's prerogative: I totally agree. I don't come from the Niagara region but we, too, think we're being shortchanged in all these services.

Thank you very much for your presentation.

Mr. Ellis Katsof: Thank you.

The Chair (Mr. Ernie Hardeman): And with this, the committee is recessed.

The committee recessed from 1156 to 1259.

NIAGARA HEALTH COALITION

The Chair (Mr. Ernie Hardeman): We'll call the meeting back to order. I hope everyone noticed that our lunch did not include turkey, because turkey has a habit of making people sleepy after lunch. I wanted to make sure we were all bright-eyed and bushy-tailed.

Interjection.

The Chair (Mr. Ernie Hardeman): Now you're getting so technical.

Anyway, thank you very much for coming back. I think our first delegation is at the table. Our first delegation is from the Niagara Health Coalition: Ron Walker. Thank you very much for coming in.

Before we start on it, I just want to point out to the committee that the 1:30 delegation has called in and, because of the weather, is not going to be able to be here today.

With that, Ron, we get back to you. As we have done with the others, you get 15 minutes to make your presentation. You can use any or all of that time. If you leave less than four minutes, we will have one party ask questions and comments. If it's over four minutes, we will divide it in three and have each party have an opportunity to question. If you use it all, we won't have to do either. With that, when you have two minutes left, I will just go like that. But with that, thank you very much for coming in, and we look forward to your presentation.

Mr. Ron Walker: Thank you. You should have copies of our presentation in front of you, but I'm just going to have a sort of stream-of-consciousness introduction here.

Dear members of the standing committee conducting a review of the form, function and legal competence of the local health integrated networks: Ultimately, the delivery of health care in Ontario is your responsibility, and perhaps the LHIN is the best way to do this. Your review will determine this.

First, I must mention the importance of having a new health care accord to ensure federal participation and health care delivered by this and other provinces. Second, I draw your attention to the Canada Health Act and its provisions to provide seamless and roughly uniform health care throughout every jurisdiction in Canada. Third, when considering the long-term projection of health care delivery, I am forced to ask you to reject the arbitrary 1% increase in spending limits under the austerity budget, because it's unrealistic going forward.

Perhaps the most salient point to make when discussing the LHIN system is its transparency and accountability. We were happy to see the local LHIN, an area much larger than the Niagara region, recently announce that it will post relevant information about its decision-making process online. But why has it taken so long to get to this point?

Our local LHIN is not even operating with a full complement of board members, and I don't believe it ever has. How can local interests be represented on the board? This is unacceptable. When there is a full board, I believe it would be wise to have a delegated citizens' advisory committee to recommend to the board ways to meet a broad range of health care needs. Of course, the LHIN's function would then not only be disbursing funds within the existing framework of health care delivery but recommending, itself, ways to improve health care delivery to the ministry.

I must mention the political games being played with respect to a new hospital being built to replace existing ones in this area. This made the Globe and Mail, so it's of national interest. The Niagara Health Coalition rejects the views of some journalists, who misrepresent the question of access to services as simply a political gambit of the NDP. Access to service is a fundamental demand of the citizens of Niagara, even as represented by their city councils at Welland and Port Colborne.

Just recently, a 20-year-old man's life was saved by the quick action of friends and paramedics. He was gotten to the Welland emerg in five minutes and resuscitated

after an hour. We do not know if he would have survived a trip to the Falls. Fortunately, we don't need an inquest to determine it.

A few years ago, there was an inquest that determined, in that case, that it made no issue; the amount of time getting to any of the facilities in the area wouldn't have made a difference. But that case did raise the issue—which hasn't been addressed yet in all the reforms being talked about—of the need for a trauma centre in our region. I think the LHIN has missed on that, because they don't hear what the needs are.

Speculation is that we can link with Buffalo and deliver all the trauma cases there, and I don't really find that a reasonable solution. I think that for trauma cases that occur in Canada, it's good to have the access here. If special care is needed, then Buffalo accessibility is good. I think the two countries should co-operate, but it shouldn't be the baseline.

Our hospital foundations are merging, and that's good, because we know that they provide for the medical equipment which goes into our hospitals. The LHIN really doesn't play any role in that. The foundations have to raise money and come up with that for the equipment to put in the buildings to allow the health care to be delivered, and I don't see any changes on that front.

Recently, new funding has been provided to the local LHIN which will slash home care waiting lists and provide more retirement services, but remember that most of these are provided by privatized companies and, really, there is little oversight over them.

The government announcement of this increased funding was made—to show you the disconnect—in the middle of a home care workers' strike, when those services were not even being provided. They make an announcement about expanding the provision of health care services, and the ministry is so out of touch that they didn't mention, "But we can't do anything at this time, because the community care access can't refer anybody, because no services are being delivered right now, because the Red Cross workers are out on strike."

That has been resolved, to a point, because they're going to use the other traditional health care services' arbitration procedure. So, hopefully, that will be resolved in this area as well as across the province.

Finally, there are many other issues. Maintaining existing services using the Welland operating room: When the announcements were made in St. Catharines, access to the Welland hospital operating room dropped, because people thought it was closed. They actually had to make an appeal—"Book your operations in the Welland operating rooms, or they'll have to close"—because if you can't operate, you can't provide anaesthetists. If they can't work, then the whole operating room will be shut down. We don't want that shut down until it absolutely has to be, and we actually don't want it shut down at all.

Birthing services: There's some progress there. I don't know the role the LHIN is playing in that, but there will be a role because if they develop the ongoing birthing services, the LHIN will fund them. It will be a new format.

Shared services are being developed in St. Catharines under the NHS, and it's been approved by the LHIN. When they build that new hospital, it wasn't mentioned that the health care providers are actually not going to move from Hamilton or other places to here, but they'll work out of Hamilton and come down here and deliver those services. That may be a synergy but I don't know if it's the best synergy. At least there is treatment close to home right now.

Along with that, you know we've recently had a new CEO appointed to ours, and he happens to be also the CEO of St. Joseph's, so we don't know if that will be a case of one CEO means, really, you have now one hospital system, not separate hospital systems.

If we look locally, Port Colborne is stressing very hard in the review, where are these urgent care centres that are promised? What's the information forthcoming on those? There are improvements in family doctor areas, so hopefully a LHIN will do that and won't let those services go into private networks.

Public health raises the issue of dental care; that's something not provided for. Maybe if LHINs were hearing input about community health, they could make some recommendations on that, because it costs the ministry more money down the road to treat people whose teeth are deteriorated and as a result they have more serious health problems.

Finally, there are externalities: You can make the best plans but other governments in local areas also have budgets and these things. When they built the new hospital in St. Catharines, an idea was put forward of having a third street access because there was already congestion on Fourth Avenue where the new hospital is. Now we see that's postponed because they had to build a new bridge, Burgoyne Bridge, over the Twelve Mile Creek, so the new exit from the QEW is going to be in the next 10-year program. A decision like that may affect long-term health care delivery.

I think, basically, we're saying that the LHINs should play a more proactive role in inputting information into itself and then forwarding that information to the ministry, and not just simply deliver services within the existing health care framework according to a budget set by the ministry, and then including all kinds of mergers and cost savings as its main feature, instead of really expanding the delivery of health care. That's essentially what our local health coalition wants to bring to your attention.

The Chair (Mr. Ernie Hardeman): Okay. I don't know who to start with here. We have five minutes. We'll have a minute and a half from each one. We start with the government party: Mr. Colle.

Mr. Mike Colle: Okay, thank you.

So overall, you're generally supportive of this local decision-making structure through the LHINs, as opposed to having everything centralized in Toronto.

Mr. Ron Walker: Essentially, yes, but it needs that added sort of citizens' advisory committee created that could put input—

Mr. Mike Colle: Yes, so that citizen advisory function has to be more formalized, right, in the structure?

Mr. Ron Walker: Yes, locally—on the board, there seems to be only one person. She works in aboriginal health, so I know the aboriginal health needs are being addressed because they have a member on the board who is serious about addressing those questions. But I think they have five out of nine potential board members, so just even on the board itself, there's room for a lot more community input.

Mr. Mike Colle: In a formal way.

Mr. Ron Walker: In a formal way. I think, in a formal way, they really need to create some structure of a citizens' health assembly that would get together and discuss and make recommendations that they would send to the LHIN, and then the LHIN could take the information they're garnering through this process to the ministry and make recommendations.

Mr. Mike Colle: And as you know, Dr. Smith has recommended, I guess, that there be a new regional comprehensive hospital built in Niagara Falls. Is that a problem for Niagara region, to have it built there?

1310

Mr. Ron Walker: There's no problem with a hospital built there to service all the communities along the river. It doesn't adequately service the main part of Niagara south, which is Port Colborne, Welland and Wainfleet, and that's just within the Niagara region. Remember, the LHIN actually deals with that Haldimand district too, so if the Dunnville hospital closes down there won't be any medical facility in a huge rural area. That's a rural community basically. And I gave just one example where, if we didn't have a Welland hospital, there's a young man who might have died going down to Niagara Falls.

The Chair (Mr. Ernie Hardeman): Okay, thank you. The official opposition, Ms. Elliott.

Mrs. Christine Elliott: Thank you very much, Mr. Walker, for coming to the committee today and for your presentation. You mentioned that you weren't against the idea of the new hospital, but what do you think about the existing hospitals? Do you concur that there should be urgent care centres or would you rather see two fully functioning hospitals still out there in addition to the new hospital? What's your view of that?

Mr. Ron Walker: My own view, and this is my view, not necessarily the coalition's view, is that because of our area and geography, we could use three full-service hospitals. That would mean not closing the Welland one now or any time soon and actually making provisions long-term, let's say within 25 years, to have a hospital in that area of the region built. But again, it's long term. This new hospital in Niagara Falls, it will be probably 10 years before it materializes. But if everybody thinks the Welland services are already shut down, they will get shut down, so we don't want that.

There are other ideas. Some people propose to turn it into an ophthalmology centre, which would be okay as long as it's not privatized. Other people are saying Welland hospital could be converted to one of these birthing centres I've talked about. There are no specifics about the urgent care centres, but that would be an option, that Welland could become an urgent care centre for the next 25 years until it has to be replaced. There are many options, but they're not for consideration. All the excitement is sort of about the Niagara hospital. And then the announcement appears in the Globe and Mail. This announcement means five hospitals in Niagara are closing, and we don't agree with that.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much. The third party, Ms. Forster.

Ms. Cindy Forster: Thank you, Chair. Thank you, Ron, for being here today. I'm glad you raised the issue of dental care because we all know that dental care can lead to many huge medical issues. Are you suggesting that the current dental care programs that are administered perhaps through community and social services or the Ministry of Health should be part of the mandate of the LHIN?

Mr. Ron Walker: Anyway, the LHIN can't take that power unto itself, but I do think the Ministry of Community and Social Services should look at that question. If you study politics, the first thing they say is that the biggest communication gap is between the ministries. All the ministries operate independently, they all fight for their little piece of the budget and there's no wide, comprehensive—but it would save money for social services and for health care if that kind of dental care was provided.

There is a little truck that goes around that does a little bit—you know, a little van. The statistics still show that a lot of cases show up in the Niagara Health System because people haven't had proper dental care.

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

Mr. Ron Walker: I had just one thing briefly, and it's just a concern. Pathstone Mental Health made a presentation. I wasn't here for that, but I'm concerned because the new hospital is providing a wing for mental patients—quite a big wing—and facilities and so on. And then a short time later, it's announced there will be a big, new building, Pathstone Mental Health, which is a not-for-profit, but still, it's private health care delivery. Will people in that facility have the protection they would in—

The Chair (Mr. Ernie Hardeman): I appreciate the question, but I think it goes beyond the scope of our hearing today, as to what they're going to do with individual hospitals. But we thank you very much for your presentation.

Mr. Ron Walker: Thank you very much.

NIAGARA SOUTH WEST HEALTH LINK

The Chair (Mr. Ernie Hardeman): Our next presenter is Jeff Remington from the Niagara South West Health Link; I should say Dr. Jeff Remington. Thank you very much for coming in. We welcome you. As with the

others, you will have 15 minutes to make your presentation. You can use any or all of that time. If you have any time left over, if it's less than four minutes, we will give it to one caucus. If it's more than four minutes, we will split it between three caucuses for any questions or comments they may have to your presentation. At the two-minute mark, if you're still speaking, I'll put up my fingers to let you know that you have two minutes left.

With that, the floor is yours. Thank you.

Dr. Jeff Remington: Thank you, Mr. Chairman and members of the committee. I appreciate the opportunity to speak today to you.

I'm a family doctor. I grew up in the town of Fort Erie here several years ago. I've been practising family medicine in the city of Port Colborne for 19 years. I also practise emergency medicine in the Fort Erie hospital, in the Port Colborne hospital, in the Welland hospital and also in the Dunnville hospital. So I have a bit of a unique perspective as a front-line care provider that I'd like to share with you today.

I have also been teaching medical students, family medicine residents, physician assistant students and nurse practitioner students since 1997. I know my colleague and friend Dr. Karl Stobbe from the Niagara campus of McMaster came and spoke to you this morning and made comments about the important role of education and how the LHIN can work with that.

Let me start off by telling you a bit about a case that I think highlights a lot of my perspective on the LHIN. I was in the Dunnville emergency—Haldimand War Memorial Hospital emergency—approximately a year ago. Brought in to me was a nice older fellow, about in his eighties, who was having back pain. He'd been seen by his family doctor in Hagersville and had X-rays done, had not heard the results of those and, because of worsening back pain, came to the emergency to seek care. Clearly, he was distressed, and my goal was to both alleviate his pain but also find out what was going on.

I was able to pull up his X-rays on ClinicalConnect, a computer program that links all the hospitals' data in the LHIN, because he'd had those X-rays done at the Hagersville hospital, the West Haldimand General, and I wasn't happy with what I saw. I felt he needed a CT scan to further investigate was going on in his spine.

At the time, we were sending patients from Dunnville to the Welland hospital for CT. So I was able to pick up the phone, call my colleagues in the Welland radiology department, transfer the patient by ambulance to Welland for a CT, bring him back, and, unfortunately, those CT findings did not show good things. He had cancer in his spine.

A new program had just been set up called ED Critical Link. Through the CritiCall program, the Haldimand War Memorial Hospital had been paired with St. Joseph's hospital in Hamilton. I was able to pick up the phone and with one phone call be patched through to the emergency physician on duty at St. Joseph's hospital in Hamilton, have the patient transferred there to obtain urgent consultation with a spinal surgeon in Hamilton and refer on from there to the Juravinski cancer hospital on Hamilton Mountain.

Unfortunately, the end result was that the patient was not able to be cured, and he did pass away from his cancer. But the family of the patient wanted me to come today and talk to you about his case, because they felt it illustrated a lot of the good that the LHIN can do and has done, but it also illustrates a few of my frustrations with the LHIN.

So, as I said, I'm a family and emergency doctor from the city of Port Colborne, and that day I was working in the Dunnville emergency. Why was I in Dunnville emergency? Well, because in 2009, based on the hospital improvement plan of the Niagara Health System, which was endorsed by the LHIN, they downgraded the Port Colborne hospital into an urgent care centre and a chronic care facility. As a primary care physician, as someone who loves emergency medicine, I chose to continue my emergency medicine career by looking at the neighbouring hospitals and continuing to provide emergency care there.

My first introduction to the LHIN was not that great. I remember the former chair, during public consultations on the hospital improvement plan in this community, actually telling the community that Fort Erie and Port Colborne do not have emergency departments—this was in 2008 and 2009—they do not have emergency departments, and they never have. Personally, I was quite flabbergasted that such a senior official in health care could have been so arrogant and so ignorant to actually self-define emergency departments.

The fact was, the ERs in these cities were thriving. They were not as equipped and as staffed as, say, the emergency departments in the three larger cities, but as we all know, there are emergency departments in this province that see 10 patients a day, that are staffed by nurse practitioners, that don't have CT scans, that don't have specialist access. So, certainly, the first impression I had of the LHINs was that they were very heavy-handed, ill-informed organizations.

1320

My good news today is that that impression has changed. Several years ago—two years ago—I was approached by the leadership of the medical school, Dr. Stobbe; the mayor of Port Colborne; and Dr. Everson from our LHIN, asking me to set up a program called the Port Colborne Interprofessional Care Project, which personally I like to think is a bit of a prequel to the current health links project. We were asked to bring community providers together for the purpose of providing services to those patients who had high-demand care who seemed to be falling through the cracks and who seemed to have difficulty accessing community services.

I'm happy to say that our trial project worked very well. A wonderful example is the Port Colborne memory clinic, which has been running for a year now. It's a collaboration between my clinic; the Niagara Health System, who for a year provided a nurse practitioner; the Alzheimer Society of Niagara, which provides a social

worker; a local pharmacy; and the McMaster campus in Kitchener-Waterloo, which provided the training and mentorship. This program provides excellent, broad-based, community-based care to patients with declining memory and their families, who are clearly distressed as they are reaching this phase in their life. It's a great example of how the LHIN has helped facilitate bringing parties together all with the same goal but now under one roof providing care to vulnerable patients.

As was stated in my introduction, from this, I'm now working with the LHIN on health links. I am the primary care lead for the Niagara South West Health Link, which takes into account the municipalities of Pelham, Welland, Port Colborne and Wainfleet. We're currently working on our business plan, and I would say that there are a lot of very exciting initiatives in there that will certainly help the 5% high users in this area and also, I think, lay the groundwork for care programs that will change the face of health care in at least our health link for quite some time.

We're certainly co-operating and collaborating with the other two health links in the general Niagara region as well as the North West Niagara Health Link, and we are looking at projects to collaborate with our Haldimand partners in the Haldimand Health Link because, as the previous speaker said, the LHIN does incorporate a large geographical area.

As my patient example showed, the traditional lines of care, such as, "You're in Niagara only," "You're in Haldimand only," "You refer to Hamilton," are no longer there anymore. They're definitely blurred. Patients in Niagara seek care in Haldimand. Niagara is responsible for the care of patients in different jurisdictions, as is Hamilton. I would say that the health links project shows just what the LHIN can do when it's actually given the resources and the mandate to do good things for care.

In the end, I think caution does need to be waived at the LHIN. Unfortunately, there is still some disparity in the care that's provided throughout the LHIN. I know that with our Port Colborne project, resources are hard to obtain when you are a small volunteer organization that doesn't have access to the type of health policy writers and bean-counters that can help you make the grand proposals that the ministry likes to see in order to get funding for projects. My fear is that I still see lots of funding going to the larger organizations and maybe not to the small grassroots organizations, just because we don't have the infrastructure to make the proposals that I know governments like to see, especially in fiscally tough times.

I see the LHIN staff getting bigger. I am privileged to work with some excellent and fantastic health care planners and leaders there. But again, as with any bureaucratic organization, one has to be wary when it starts to get large and oversized and the cubicles get smaller and smaller at the Grimsby office.

I have worked with the district health council in the past on physician human resources, and great things came out of that work, including reforms to the underserviced area program, the minister's Expert Panel on Health Professional Human Resources that eventually led to the building of the satellite med schools, and the changes that we've seen in health human resources today. I think the district health council was a great grassroots organization.

I want the LHIN to carry on with that transparency and that community involvement, ensuring that it's not only people who are experts with diplomas on the wall but that they actually get grassroots involvement. The LHIN needs to be accountable to patients, to front-line providers, to the local health care leadership and also to the provincial ministry, and they need to remember that mandate.

I see their role as providing equity and accessibility across the LHIN. Just because a patient presents to the smallest emergency department or to a small front-line care provider doesn't mean that they shouldn't have the same access—maybe not at the same time, maybe not at the same location, but they should have access to all of the care that someone who presents to the largest emergency department has. It may mean transportation or it may mean getting patient advocates involved to get them there, but they should have that same accessibility.

The patient that I told you about: Due to great computer linkages like ClinicalConnect and program linkages like ED Critical Link—the LHIN was first-hand in making those happen, and I think that's a great example of the LHIN at work. Thank you again for your time today.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do have about six minutes left. With that, we'll start with the government. Ms. Sandals—oh, Ms. Cansfield.

Mrs. Donna H. Cansfield: One day, after 10 years, he's going to get this right.

It's okay, Mr. Klees.

Laughter.

The Chair (Mr. Ernie Hardeman): I'll never be forgiven.

Mrs. Donna H. Cansfield: Anyways, thank you. I really appreciated your presentation. It's refreshing to have someone who looks at this with sort of a clear vision in terms of the patient, which is really what it's all about at the end of the day.

I have the pleasure of having four LHINs in my constituency, so I'm well aware of the variance in standard of care. I would really appreciate hearing from you how you think we can find some process or some means—or does it have to be dictated? I recognize there's need for flexibility, but I also recognize there needs to be a standard of care, provision of care, for equity and equitable service across the different LHINs. Have you got any ideas?

Dr. Jeff Remington: Thank you for the question. I think we have to think about what equitable means. Does equitable mean that if I walk into the Dunnville hospital with a heart attack, I'm going to have a cardiac catheterization lab available at my disposal at that hospital? Or

does it mean that the system will be in place so that the emergency physician, recognizing the patient is having an acute myocardial infarction, will have an effective, efficient, fast and transparent network that gets that patient to where the care is, whether it's the new St. Catharines cath lab or the Hamilton General cath lab, without a lot of hurdles and without a lot of hoops?

Back in the day when I started, you could spend 20 minutes on the phone calling specialists, and they would say, "Well, I'm not responsible for Haldimand," or "I'm not responsible for Port Colborne." That's gone now, so I think that's a way of equity.

Here in south Niagara, again, as the speaker alluded to, we've talked about trauma care. Is it realistic to set up a trauma hospital in south Niagara? Probably not, but with my colleagues, we've set up a system based on the system that Windsor uses to get critical trauma patients across the border into hospitals in our neighbouring cities. You've got great level 3 trauma across the river, and they were very happy to work with OHIP to get those patients seen and then get them repatriated.

So, equity comes in a lot of different ways. Again, in health links—here in LHIN 4, we're working with LHIN 3 and finding out some of the ways that they've smoothed out the equity between rural and urban, getting the IT and computer resources into providers' and doctors' offices that may not have the same rapid Internet connection as you've got with fibre optic in downtown Toronto.

I think collaboration is a big thing. At our LHIN, we have a primary care committee where family physician leaders, health link leads, all meet every other month with Dr. Everson and we talk about equity—"What are you doing that's getting patients the care that we're not doing here?"—and sharing best practices, sharing what works in one community and bringing it into the other. You're probably fortunate in having four LHINs; that's a lot of brainpower.

Mrs. Donna H. Cansfield: Trust me—

Dr. Jeff Remington: Well, it's a lot of people with great front-line ideas. I think the LHIN needs to be accountable and listen to those ideas.

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

Mrs. Christine Elliott: Thank you very much, Dr. Remington. It was a great presentation. You mentioned, as part of it, that district health councils had been good grassroots organizations. I suspect they operated at a far lesser cost than LHINs operate at. Could you comment on, if you have an opinion on it, what the value-added is for LHINs vis-à-vis district health councils?

Dr. Jeff Remington: Well, I guess the way I understood district health councils is that they were strictly advisory. They did not have sort of the financial and fiscal responsibilities in handing out money and budgets that the current LHINs have. I think their strength was, as the previous speaker talked about, that they really did have a grassroots handle on what was going on in the community. I was brought in to deal with physician human resources in 1996 because of the perception that Niagara was losing family doctors and we were getting family doctors. They asked me to get on the ground, find out what's going on, count doctors and then get back to them so that they could make recommendations to the ministry.

The problem is, that's a very long-reach process. The question always was whether or not the district health council recommendations actually made it into the minister's hands. We were lucky at the time in that we did have a cabinet minister locally that we could work through, but in the absence of that, I don't know whether those recommendations would have made it up the flagpole.

So I think the LHIN has a much larger role, which does make it a lot more expensive because they're actually looking at things like budgets. I would hope that the LHIN could take on a better role in terms of even looking at the efficiency and the effectiveness of the organization that it's handing money out to. Let's say we've got two diabetic education programs in the community. Find out which one is doing the better job. Will the LHIN get the power to actually remove the funding from one and give it to the agency that's actually doing the better job?

1330

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

Ms. Cindy Forster: Forster.

The Chair (Mr. Ernie Hardeman): Forster. Oh, it's a bad day today.

Ms. Cindy Forster: Thank you, Ernie.

Thanks for being here, Dr. Remington. There seems to be a bit of a theme that I've heard today from a number of the presenters, that Niagara is kind of the poor sister in the scheme of funding. We heard a bit of that from you around the RFP process and the inability—because here in Niagara, we are made up of more small municipalities than large municipalities, such that we perhaps don't have the resources to be able to access some of those funds. Can you comment on what you hear in your neck of the woods?

Dr. Jeff Remington: Sure. Thank you. As I said before, it's hard being a group of small municipalities and being able to make the types of cases, either to the LHIN or to the ministry, to get funding for some essential programs.

Again, we've all heard about how there is conflict and there is infighting in Niagara. Twelve municipalities don't always speak with the same voice. I think in the past, our medical societies, the groups that represent physicians, have actually been very good at trying to speak with one voice, working with one voice. In the past, the majority of us supported one central hospital in Niagara, but that didn't happen.

I don't have easy answers. I think you're seeing more collaboration at our level. Certainly, the three health links are working together. We just had a meeting last week that Dr. Stobbe facilitated. Again, that brings in the Niag-

ara Health System and Ms. Boich; Ms. Riihimaki from the CCAC; your physician leaders and your nursing leaders. It's by communication that we'll start to work better together and work with a single voice.

But, certainly, having the resources to be able to make the type of proposals that a large university centre like St. Joseph's Hospital or McMaster University can put together—definitely, it's a challenge.

I can highly speak for the city of Port Colborne being a leader in health care—Joanne Ferraccioli is here with me today—and the fact that the city has enough foresight to actually put money into health care resources. Without her writing my proposals and speeches and making me look good, we wouldn't be anywhere.

Ms. Cindy Forster: Thanks very much.

The Chair (Mr. Ernie Hardeman): Thank you very much, and thank you, Ms. Forster. That concludes the presentation. Thank you very much for giving us your time.

NIAGARA HEALTH SYSTEM

The Chair (Mr. Ernie Hardeman): Our next presenter is the Niagara Health System: Marti Jurmain, vice-chair; Sue Matthews, acting chief executive officer; Kevin Smith, the CEO; Barry Wright, chair of the proposed board; and Brady Wood, chief communications officer.

It looks like there's no one at home minding the store.

We thank you all for coming in today to be part of this. We will have 15 minutes for the presentation. I would be willing to give you a few extra moments to fight it out as to who gets the time, but you do have 15 minutes. With that, you can use any or all of it in your presentation, and if there's time left, we will have questions.

Dr. Kevin Smith: Thank you, Mr. Chair. My name is Kevin Smith, and I'll undertake the presentation and we'll try to answer questions.

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

Dr. Kevin Smith: I think you have before you—or I hope you have before you—our quick presentation. I won't dwell on all of the details within, in the interest of time, but as you know, the Niagara Health System is a large, complex, multi-site hospital system. There are a large number of in-patient and outpatient services across multiple sites.

In the last two years or so, the Niagara Health System has been under a supervision. I have been the supervisor and then, recently, the minister transferred the authority through the Lieutenant Governor back to the board. Ms. Jurmain and Mr. Wright are here on either side of me to keep me honest. We're very pleased to see local governance has returned to the Niagara Health System.

We have about 4,100 or 4,200 employees and over 620 physicians. It's a large, complex organization, as you've heard.

Let me perhaps dwell on a few important issues, rather than background issues, on LHIN relationships and collaboration, and a few we'd like to start with in terms of the glass being very much half-full. We feel we've been very successful at the Niagara Health System, working together with the LHIN and partner hospitals to create a culture of collaboration amongst the many partners in health care. We see some results that we'll speak about in a moment that demonstrate that.

We've also enjoyed a strong working relationship with the LHIN and with their respective boards—Mr. Shea, I think, is here today, as well as Ms. Cripps—and they have been very fine colleagues for us to work with in this process, particularly during a period of supervision.

The LHIN has also, I believe, tried to strengthen relationships between provider groups. We've seen many, many fora bringing together clinician and non-clinical groups to look at how we, as a system, could function better, faster and cheaper in order to prevent loss of access for universal care. We also know that while the LHIN is not directly responsible, it's a very important player in capital renewal. We've seen unprecedented capital renewal in Ontario recently, I'm happy to say, with the minister's announcement recently of a large planning grant for continued development in the Niagara Health System.

In the next few slides in your package, titled "Integrations and Partnerships"—I won't go through them all—we tried to step back with a number of colleagues and just talk about: What has happened that's good in the LHINs? There are a large number of them available. I just want to particularly comment on a few related to Niagara. The cardiac care program, as you know, with the opening of the new St. Catharines site, brings a new tertiary service to Niagara and, as previous speakers discussed, prevents many Niagarans having to go to Hamilton or Toronto or other large centres in order to receive tertiary and sometimes quaternary care.

Similarly, we know that the fastest-growing group of illnesses include mental health and addictions. The development of mental health and addiction programs, with a recent infrastructure announcement, is also a very positive direction. We also, with the LHIN, have tried to attack some behind-the-veil activities, like our laboratory system, so that we can do a very good job of providing important services at a time when we were trying to get more and more money to the front line, so looking again at where we can not duplicate services, not duplicate infrastructure, and can build a world-class system has been something that the LHIN and the hospitals have worked very closely together on.

Last but certainly not least is the opening of the Walker cancer centre. As we know, cardiac and cancer are still the fastest-growing and most lethal diseases in our society. Niagara has now a state-of-the-art cancer centre, and that is coming up to speed and it's a very, very positive development.

The following few slides really talk to you about a number of other positives, as we see it: an important seniors' strategy; the importance of assisted living; talking more and more to keeping Ontarians where they wish

to be—in their homes; similarly, the importance of palliative care, end-of-life care and non-institutionally-based services; and the importance of bringing together providers across the continuum to ensure that for those who have needs, they are met most often at home or in a non-institutional setting, if possible.

We've also seen some very positive developments in small EDs partnering with larger EDs—we heard the previous speaker, Dr. Remington, speak about that—and see that as a very positive development as well. Similarly, health links and the infrastructure required for health links have really respected the view that we will not be looking for a solution for the province but working locally to look at individual solutions without trying to fit a square peg into a round hole. So far, our work with health links, I think, has proven very positive, both in a community-based setting and in a hospital-based setting.

On our page entitled "Opportunities," let me talk about where evolution might be possible and where improvement still has great opportunity. We've taken the view that the LHIN is not, nor should it ever be, a static organization, nor should our own—that this is a point in time, and we've seen evolution, and the continued evolution of the LHIN in the following areas would be productive.

In ensuring better transitions across the care continuum, the LHINs and institutional partners, particularly primary care and hospital partners, have been very active in talking about how we break down walls between the often-siloed system of health services. We believe that there is a great deal more to do to integrate both within primary care and from primary care to institutional and community-based services. While the LHIN, I think, has started a very good track on this one, it may need some help and assistance and clarity from the ministry on how that goes and how quickly it might move.

We also believe that there could be improved consistency across LHINs in clarifying the authority and scope where there are divergent approaches. One of your committee members mentioned earlier that she has four LHINs in her riding. I work in two LHINs and I can sympathize that sometimes the variation is very healthy, like in health links, and sometimes it's very unhealthy, like where a policy, one would hope, would be applied in a very similar way. In a moment, we have a suggestion where we believe the ministry might be more helpful on that one for LHINs.

1340

We also believe that LHINs can be and are increasingly being data-driven and that data really is informing the discussion. That's a very positive development. The interface of LHINs with other provincial bodies like Health Quality Ontario and other quality bodies is also an equally important ingredient, so that we know the arms of government are aligned in a common agenda, as opposed to multiple agendas, which will put those on the front line of care provision in some degree of challenge in terms of many, many, many challenges and no great clarity as to which ones we're working on at one time.

We also know that the opportunity for LHINs to play an even larger role in helping to determine and then to disseminate best practice—the previous speaker talked about a couple of examples in terms of when one program is much more effective than the other. First, can we coach and mentor? In the absence of success, can we then consolidate? While LHINs have some opportunity to do that, I'd again go back and suggest that the Ministry of Health and Long-Term Care might work more closely with LHINs to better understand those opportunities and how quickly one can move within them.

We know the challenge for the LHIN is that, while it is planning, it also has to do funding, and recognize that with limited resources we won't make everyone happy, so brave decisions are important—brave decisions tempered by strong processes for engagement and demonstration of fairness and equity in process. That doesn't mean that we'll all like the outcome, nor should it. It does mean that fair process has been followed. Again, I believe that the ministry could help the LHIN in terms of defining what standard best practice might look like and what is acceptable.

In terms of policy and operations, increasingly I think the Hamilton Niagara Haldimand Brant LHIN is very much moving in this direction, but for all LHINs the opportunity for LHINs to focus on the "what" and the "why" and completely remove themselves from the "how" would be a great advantage. I want to compliment the local LHIN. Having worked in more than one, I see that as an objective they are taking seriously. That isn't necessarily the standard across the province and it really does need to be. If we're asking provider organizations to deliver, then we need to give them some autonomy in terms of how they deliver, not what they deliver and why they deliver and with what resources or outcomes they deliver.

We also know that the importance of aligning incentives is incredibly robust, but yet incomplete. Again, all of my comments and opportunities really refer mostly to the interface between the LHIN and the ministry and, increasingly, as we begin looking at how resources are flowing, the consolidation of those resources and ensuring that we are rewarding what we suggest we want. Unfortunately, we can all find examples where the right and the left hand aren't perfectly aligned, and we believe that that process can be improved, particularly between the ministry, the transfer payment agencies and the LHIN.

The budgeting process: I think you'll hear from all transfer payment agencies that it would be ideal to have a more robust timeline that is really predictable. All too often—I believe this applies to the LHIN as well as to the transfer payment agencies—the annual in-year spend or budget isn't as clear as early as we'd like it to be. So when we need to make changes to services, it may or may not be easy to do so with in-year. An earlier budgeting cycle with great clarity about the full envelope of resources would be a great desire.

Our final thoughts on the last page of our package: As we say, the glass is very much half full. We've seen en-

hanced collaboration and collegiality, particularly in this LHIN. We've seen support for all health facilities, not only hospitals, in capital renewal and community engagement. We've seen significant, concrete outcomes in terms of programmatic integration; a number of those are available. We talked about a number of the clinical ones earlier—cancer, cardiac, mental health, laboratory services and more to come.

We also would like to recognize the importance of streamlining our system so that the patient really is first, and that a great patient experience, which is this LHIN's objective, is fulfilled. We would complement the great patient experience with a great quality of work life. We know we don't have satisfied patients if we don't have satisfied providers. Again, I would say the LHIN has been very receptive to working with us in that regard.

We also believe that we want to encourage the LHIN's continued evaluation of outcome and engagement, perhaps with the academic health science centre; all LHINs are associated with one. Are the relationships between the academic health science centres and the host LHIN as robust as they could be? We've heard a number of discussions here today with regard to the Niagara campus of McMaster—perhaps another opportunity going forward.

We recognize that form and function must be aligned. Whatever the outcome of form and function, a number of the processes and alignments we've talked about today we believe should be reflected in the evolving LHIN system.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have three minutes left, so we will send it over to the official opposition.

Mrs. Christine Elliott: Thank you. Thank you very much, Dr. Smith, for your presentation. It was very helpful.

I just wanted to highlight one of the items that you mentioned under opportunities, where you said that the Ministry of Health should be clearer to the LHINs where they have autonomy and where they do not. I would say that's probably the single biggest issue of frustration that's raised to us by constituents: that they go to the LHIN and they're told, "You need to go to the ministry," and vice versa. Could you suggest ways that we could minimize that and what we should do about that?

Dr. Kevin Smith: Yes. I think that one of the models is to really begin talking at a policy level about what LHINs can do best and where we'd like to see variability in the 14 regions, or however many there end up being. That might be health links and clinical delivery models; it might be in recognizing how service is delivered. What I don't think we want to see is a different application of the funding formula.

And are there some core programs—for example, emergency services comes to mind because of the sensitivity of it—where we are extremely clear about what should be available and what will be delivered? Then, laterally, here's where great flexibility occurs. So I think for us, the model would be tremendously helpful if we could say—the LHIN folks can talk about this much better than I—"Here is where you have some autonomy for movement." It might be in how you deliver clinical care; it might be in a hub-and-spoke model versus a more regional model. But the delivery, the measurements, the outcomes that we've agreed upon shouldn't be different—and the mechanism of funding so that LHIN A and LHIN B can actually rationally say to residents, "You don't pay a differential tax rate; you can expect the same basis of a system."

The Chair (Mr. Ernie Hardeman): You have another half a minute.

Mrs. Christine Elliott: And maybe perhaps, as a physician, if you could comment on the fact that primary care is not currently included and how you think it could be included. What would be the mechanism for doing that?

Dr. Kevin Smith: I should clarify: In the Dark Ages, I was a medical educator; I now am but a mere administrator. So I just go back and let my clinical front-line colleagues talk about the specifics.

But I think when we look at the potential lack of integration around some of the funding models in primary care and institutional care, and the lack of a consistent scorecard that spans the continuum—many silos are working very hard to get really good data and really good scorecards. What we haven't yet created is, what's the scorecard across the continuum? We could talk about diabetes from primary care through to speciality services, if required, or, similarly, other services that require a broader continuum of care than one provider group. I think the scorecard is the place to go, and clearly evidence of best practice and opportunities for improvement with, I think, Health Quality Ontario being the coach and our LHINs and ministry being the critic, is probably a very robust model.

Mrs. Christine Elliott: Thank you very much.

The Chair (Mr. Ernie Hardeman): That concludes the time, and we thank you for being here today. I'm sure it will be very helpful in the committee's review.

Dr. Kevin Smith: Thank you very much.

The Chair (Mr. Ernie Hardeman): That also concludes the presentations today. There being no further business of the committee, we will adjourn, and we will meet tomorrow morning in the great city of Hamilton.

The committee adjourned at 1351.

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CONTENTS

Monday 27 January 2014