For:	The Standing Committee on Social Policy
Regarding:	**Bill 36, Local Health System Integration Act, 2005**
Presented by:	Ethel Meade, Co-Chair of the Ontario Society (Coalition) of Senior Citizens' Organizations
Date:	Monday, February 6, 2006
Time:	10:45 a.m.
Location:	Committee Room #151, Main Legislative Building, Queen's Park, Toronto

The Ontario Coalition of Senior Citizens' Organizations, for whom I speak today, is a coalition of 150 Ontario seniors' organizations with a combined membership of over half a million seniors. Our mandate has been, from our beginning 20 years ago, to **enhance the quality of life** of Ontario's seniors, including their top concerns which are about **affordable housing** and **health care**.
We appreciate the opportunity to participate in these hearings on Bill 36, a Bill of particular concern to seniors, who, as we all know, are the major recipients of health care.

OCSCO stands strongly **opposed** to any move that increases the "creeping **privatization**" in our health care system. We **support** a completely public system which allows **no room for the profit motive** to drive any decisions concerning our health care

Integrated health care has always sounded attractive. While the Canada Health Act, which Canadians value so highly, never contemplated anything beyond the cost of doctors and hospitals, current experience has shown that health care today has many more sectors, including:

- pharmaceuticals;
- rehabilitative care delivered in the community, in-home or at dedicated hospitals;
- in-home care for post-acute patients;
- supportive community-based care for the chronically ill, the disabled and for older persons with age-related functional deficits;
- long term care homes.

Every Canadian will, at some time, need care from one, two, three or more of these sectors, often simultaneously.

Integrating all sectors of our system could produce what many of us have dreamed about and talked about for years, a **seamless continuum of care**, within which patients could move as their health needs require, among various levels of care, and move without delays or hassles. With our currently fragmented health care system, integration means a lot of changes.

Change is never easy. Transformation, the current buzz-word, means very complicated and, by definition, very difficult changes. The work of everyone involved in health care will be affected and the experience of ordinary citizens who need care may be affected even more. In examining Bill 36

we are looking at **how** its provisions would **affect** us as seniors and what **opportunities** it would provide for **input** from all of us, including ordinary citizens and organizations that serve and advocate on their behalf.

1. Our first concern is about **NOT-FOR-PROFIT DELIVERY** of health care.

   Many of our members are wondering if the whole LHINs project is a back-door way to bring in two-tier medicine. We trust this is not the government's intention, but there is not much in the legislation to reassure them. Is the **purchaser-provider** split merely a more palatable word for **managed competition**? We have not forgotten how **public-private partnerships** were given the more palatable name of **alternate financing initiatives**.

   What is missing is a clear prohibition against allowing shareholding companies to invest in any sector of our health care system. Experience in various parts of the world have made it abundantly clear that when the profit motive drives decision-making in a public program, the cost goes higher and the service to the public goes lower, in both quantity and quality.

   OCSCO believes that the **managed competition** model in home care is a case in point. It has resulted in for-profit agencies squeezing out more and more non-profit providers. The **quality of care** has **suffered** and communities have suffered from losing community service agencies that have, for many years, played a substantial role in promoting caring and coherent communities.

   Moreover, the **contracting out** of so-called "non-clinical" services to for-profit providers has been a disaster in many jurisdictions, leading to an unstable workforce, lack of continuity in the services received, as well as a dangerous worsening of sanitation in health care institutions.

   We believe that Bill 36 should include an **EXPLICIT COMMITMENT TO THE CANADA HEALTH ACT** and a pro-active stance on **STRENGTHENING AND**

INCREASING THE PROPORTION OF HEALTH CARE SERVICES ALLOTTED TO NOT-FOR-PROFIT ENTITIES.

2. Our next concern is about **PUBLIC CONSULTATION**.

    a. We have noted the provision, repeated several times in different sections, that LHIN Boards and organizations of health providers must make **no decisions** that are **not in accord** with the **Strategic Plan** being prepared by the Minister of Health. That plan has not, however, been made public so that we are, in effect being asked to comment on the **means** to an unknown **end**. Another way of saying this is that with Bill 36 we are being asked to buy a pig in a poke. We have heard no indications that public consultation about the Strategic Plan is being contemplated. Does the government consider the Minister of Health to be infallible?

    We have not forgotten that the crucial matter of defining LHIN boundaries, as well as eliminating District Health Councils and their traditional boundaries, was carried out through a method chosen by the Ministry. Public input was invited only on minor adjustments to the boundaries selected. Yet this may have been the most critical decision in the whole transformation process.

    b. While we welcome the inclusion in Bill 36 of a section called "Community Engagement", we are not at all sure when and by what means such engagement will be allowed. **Open Board meetings** is an excellent first step. But it is qualified in the legislation by the provision that the Cabinet will determine by regulation which subjects should be discussed behind closed doors. And instead of a specified number of days of public notice being required, the legislation requires Boards to give the public "reasonable" notice of Board and committee meetings. **EXPLICIT PARAMETERS FOR PUBLIC ENGAGEMENT SHOULD BE INCLUDED IN BILL 36.**

c. We welcome, the end of Cabinet appointment of Board Chairs and Executive directors of **Community Care Access Centres** and their return to **community** control. But, again, the way this will be effected is murky and obviously will take a long time; the legislation makes clear that we are not to expect any provision under the "Community Engagement" section to be actualized until at least a year after the legislation has been enacted

d. The provision for **health professionals' advisory** committees seems reasonable, but it is disappointing that no provision has been made for **seniors' advisory** committees, which the many community and health provider organizations affiliated with the Elder Health/Elder Care Coalition have been urging for well over a year.
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The integration of care for the elderly should be an immediate and crucial undertaking for LHINs Boards because we all know that seniors are, proportionately, the major users of health care. Priority-setting workshops across the province recognized that senior health care and care for the mentally ill should be the top priorities for service integration. The voices of seniors need to be continuously available to every LHIN Board. Bill 36 should explicitly mandate **SENIORS' ADVISORY COMMITTEES for EVERY LHIN and, at the MINISTERIAL LEVEL, for the development of the contemplated Strategic Plan.**

3. Our next concern is with the foundation of all policy-making, which is **FUNDING.**

No policy can be put into effect unless adequate funding is made available. There has, so far, been no indication of the basis on which funds will be allocated to the Local Health Integration Networks. Will it depend on population viewed through an age/gender lens? Will it be considered with a more finely differentiated lens? Will it depend on the persuasiveness of the Board Chairs? Will it be adequate to meet the actual health care needs of each region's population?

We know from experience over the years that government **policy may be unarticulated but made fully effective by government funding decisions**. Home care is a flagrant example. The previous government gave responsibility to the Community Care Access Centres to provide both post-hospital care and supportive care for the disabled, the chronically ill and persons with age-related functional deficits. The **funding** provided was **never adequate** for the Access Centres to carry out both functions and, with patients being discharged from hospitals quicker and sicker, the available resources were absorbed more and more by the needs of discharged patients, who were, indeed, sick enough to need in-home care urgently. Supportive in-home care has thus virtually disappeared, without anyone in government ever admitting that their policy was to eliminate it.

The government must ENSURE that **LHINs' FUNDING IS ADEQUATE to meet the actual health care needs of Ontario's population.**

In conclusion, we hope that the government will give serious and respectful attention to the problems raised in these hearings and the recommendations proposed to deal with those problems. Transforming our public health care system is a huge undertaking affecting every Ontarian, and it will succeed only to the degree that the public, as well as health care providers, buy into it.

We have, therefore, concentrated our attention in this submission to three crucial questions:

- Will there be adequate opportunities for public input before changes are made?
- Will there be adequate guarantees that our health will be delivered by non-profit, public health entities?
- Will there be adequate funding to meet the actual health care needs of the people of Ontario?

OCSCO appreciates the opportunity to place our views before this committee and we will be glad to answer any questions from committee members.