Standing Committee Presentation
Jan. 30, 2006

Good afternoon, Mr. Chair, Committee members and honoured guests. My name is Jade Campbell and I am a healthcare provider and healthcare user.

I live in Cambridge, Ontario where I was born, raised and work. My parents were immigrants from China and built a family business in Cambridge.

As part of the Sandwich Generation, I have witnessed the evolution of healthcare firsthand. My parents and godparents had to shoulder the cost of their healthcare in the 50's. I remember my godfather as a single income earner paying his bill to the hospital every month. He did his doctor's landscaping on weekends to pay down his bill. My grandfather contracted tuberculosis and succumbed to the disease after a lengthy stay at a sanatorium. The bills for his care were borne by our family. My Mother and Father were the sandwich generation before there was a term for it.

I speak today to support a strong and accessible healthcare system that was a godsend for my parents and grandparents and to ensure that it remain a viable service for myself, children and their future generations.

I live in a small community, Cambridge, which has a growing population of 120,000 people. Presently, Cambridge Memorial Hospital provides its citizens with services that are essential in raising a family and taking care of its elderly.

The LHINs legislation has the ability to change the landscape of my community healthcare. I know that in my community, there is mistrust in this government's ability to listen to our healthcare needs. In the fall there was a great hue and cry from the Cambridge citizenry when our capital project was denied. Kitchener-Waterloo received approvals for their projects.

From the Hansard of November 24, 2005 the MPP Elizabeth Witmer responded to the Honorable George Smitherman:

"For example, let's take Cambridge hospital. Maybe the reason the money is not flowing to Cambridge because there is a secret plan in the minister's office to do away with the Cambridge hospital and shift services to one of the other Kitchener or Hamilton offices."

Despite petitions and pressure from our community groups, the government placed our project on hold. But just before Christmas, the Cambridge capital project was approved. Cambridge people were elated and duly noted that it was impeccably timed with a hotly contested federal election in our riding. (What is the saying? "You can fool some of the people some of the time?)

The proposed LHINs are not "local", they are not based on communities, and they do not represent the community's interests. It will be very difficult for the people living within a LHIN to have a significant voice over the direction of that LHIN.

The autonomy of the LHINs from the government will be negligible. The provincial government appoints the LHIN boards, and LHINs will be required to sign memorandums of understanding and performance agreements with the government.

So LHIN boards will be responsible to the provincial government rather than local communities. It's a senate type thing but with some accountability. Without a code of ethics and conflict of interest blueprint the potential for a train wreck remains to be seen.

This is in contrast with a long history of health care and social service organizations in Ontario, which as a rule, are not appointed by the provincial government. For example, the provincial government does not appoint hospital boards and they have effectively and doggedly fought for better funding for their communities, with great success.

The LHIN structure puts up significant barriers to local community control of health care. Conflicts between communities within a single LHIN are likely. Small communities are particularly threatened. Too often rural communities have seen reductions in service shift with the centralization of services to the larger regional centres. Likely, the provincial government will respond to complaints by stating, "it was not our decision – it was a decision of the LHIN." Yet, the LHIN will largely be unaccountable to local communities.

Access to Health Care Services

A key goal of this reform is to reduce costs by "integrating" services. But this also raises questions about cutting services.

At first, the government talked only of integrating *support* services. But cutting back support services is:

1. dangerous (example: our recent SARS infection crisis and threats of pandemics)
2. Inefficient (example: the recent elimination of PSWs at Cambridge Memorial resulted in their patient assists being downloaded to our RNs and RPNs).

Major steps are now being taken to integrate support services on a regional level. New organizations are being established to take over and centralize support services formerly provided by hospitals, homes and other non-profits, with many of the services then contracted out to for-profit corporations. This is a major

change in the structure of health care and social services that may have far ranging consequences for workers and local communities.

The hospitals have balked at an exclusive focus on support services. Simply integrating support services cannot satisfy the cost savings demanded by the government – the savings would also require clinical cuts. I know that my hospital has considered eliminating paediatric and obstetric programs, its cancer clinic and laboratory services.

Certain populations in my community are going vulnerable and easily marginalized by decreasing the accessibility of services. These communities include: gay/lesbians, racial minorities, isolated seniors, the homeless, underemployed and underhoused, people with cultural or linguistic barriers, single parents, and those who are in a lower socio-economic group.

In Ontario, where distances are particularly large, this could add in a lot of travel. But even where distances are measured in several miles rather than hundreds, specialization creates special problems for patients. Instead of being able to deal with all of their problems at one centre, their health care services are spread out over many health care providers – creating a real problem for those with multiple health issues and especially for the elderly and the poor.

Conflict within the LHINs

The large, socially diverse areas covered by the LHINs also suggest that there will be significant conflict over resource allocation within the LHINs. With cost cutting a key goal for the provincial government, the question will arise: what services will be provided in each area of the LHINs?

It is ironic that individuals in middle and upper socioeconomic groups design programs that are intended to provide assistance to the lower socioeconomic groups with little or no input from their target population. It is common knowledge that those individuals from lower socioeconomic groups have a lower health status, and higher morbidity and mortality rates from most diseases.

We need:

1. Strong representation of all stakeholders from communities on the Boards and committees to give voice for all citizens
2. Equitable access to services for smaller communities
3. Ensure that funding does not shift away from smaller communities
4. Transparency in Board appointments so that positions are based on skills and ability and not a partisan political designation
5. Focus on community needs as opposed to cutting services

We need to address:

1. Inadequate acute care programs

2. Easy access to services for patients who have ongoing chronic care illnesses which reduce their ability to live in their own communities
3. Provide the proper funding to promote health and prevent illness

Conclusion:
The Canadian health care system is founded on the principles of universality and accessibility. The state of our healthcare is significantly compromised if services in our community are integrated or cut.

Principles of the *Canada Health Act*

I would like to refer to the five principles of the *Canada Health Act* that is committed to ensure that all levels of government uphold:

1. **Comprehensive** coverage of all medically required services.
2. **Universal** coverage for all Canadians regardless of income.
3. **Accessibility** to all residents uninhibited by user fees.
4. **Portability** of coverage from province to province.
5. **Public administration** of health care on a non-profit basis.

I thank you kindly for providing me with the opportunity to make this presentation to the committee.