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My name is Jill McIllwraith and I have been an RPN, working in Ontario's Health Care system for the past 32 years. I am currently President of OPSEU Local 260, Grey Bruce Health Services, in the Southwest LHIN. I represent 934 health care workers in an amalgamation of 6 hospital sites. I also sit as an executive on the Health Care Divisional Council and as Chair of the Health Care Support Sector.

In 1998, under Bill 136, our 6 hospitals voluntarily amalgamated to form the current corporation.

Before the hospital cutbacks in the 1990's, our 6 hospitals had a total of 800 beds. Our current corporation has 140 beds. Long term care was removed from our hospitals as well as a complex long term care unit which took care of patients that were not requiring an acute hospital bed but did need care above a level that could be provided in a "nursing home".

The replacement beds were not put into the communities to cover the number of beds that were closed. This has had a major impact on wait times in our region as more than 50% of our medical beds are taken up by patients that are waiting placement in a long term care facility.

Under our amalgamation, the board of the corporation has attempted to move services around within our communities. This has been met with strong resistance from the Doctors and Surgeons providing these services that did not want to move to a different town to practice in their field of expertise.

Under the restructuring of the LHIN, we may lose many of the professional services and the doctors and health professionals that provide these services if they are relocated from one area to another.

We cannot afford to lose any doctors or professionals from our area as we are already facing a critical shortage. And what of the impact on the patient and their family? Who pays for flights, hotels and time off work to assist patients to travel to distant cities for treatment? For those

who cannot afford these expenses, we are creating a two-tier system. What is the difference between charging user fees and creating conditions whereby access to health care is dependent on high personal expense?

If services are to be moved out of our area then what is the impact on the employees? Workers are not always as portable as the government would like to believe. Two income families are often faced with a dilemma when the workplace for one is suddenly shifted to a location hundreds of kilometers away.

The impact on the employees during the restructuring of the new amalgamation was very stressful as bargaining agents had to vie for representation rights. It left most employees feeling uncertain as to the role they would have in a much larger workplace, than they had originally been hired for. There have been layoffs every year in the past 6 years and job security has become a thing of the past to most of the employees of GBHS. Workers are tired of all the changes

When workers feel under threat of job loss or major change, morale plummets. This can't help but have an

effect on patient care.

Health care Support workers are a very dedicated group of people. In our smaller communities we take pride in the work that we perform and the services to our fellow community members.

During the same period of this restructuring while front line workers were reduced in proportion to the bed reduction, there was no comparable reduction in management personnel.

More managers now direct fewer workers. Might I be so bold as to suggest the possibility of significant cost savings potential going unaddressed?

We now have food that we feed our patients outsourced. While we are assured that it is nutritionally complete, I would have to doubt that a patient is getting the proper nutrition when many meals are returned to the kitchen uneaten as the food is unpalatable to ill or elderly patients. It is unpalatable to relatively healthy people and only those with a strong constitution and well anchored teeth can consume it.

We cannot understand why non-clinical services are being targeted by the government under Section 33 of the Bill. Dietary and building maintenance are inherent parts of the health care system.

Other health systems have made these services the focus of privatization and restraint, creating more hospital borne infections and increasing the likelihood of the transmission of viruses in the health care environment. The issue of hospital infection has been well documented in our media yet the LHIN restructuring thinks that a private-for-profit service would be able to do an adequate job.

Our staff have been well trained and know the necessity of keeping a high level watch on the hygiene of our buildings with the ever present germs that live in a hospital.

Our staff take pride in their work but their numbers have been cut so much that it is a battle that is not always won in controlling the spread of infection.

I do not believe that a third party, for-profit company, taking over the responsibility of maintaining

the cleanliness of our hospitals is going to do as well as the dedicated staff that now do it. It is another case where the government's idea of integration is contrary to the good functioning of the health system.

The added stress of having to compete for your job every time the competitive bidding process is renewed can only result in less focus on the job for the employees.

Five of our six hospitals had no deficit at the time of our amalgamation. Now we all enjoy a yearly deficit and the most common topic is budget. How can we trim more from supplies or how can we do more work with less people. There has been no financial advantage to our amalgamation, and if the hospital is believed, the ministry did not take into consideration the vast distances between our sites, there being more than a 100 kilometre spread from one end to the other.

Our LHIN has a major centre being the city of London but we are at the opposite end and need to have our rural issues addressed. While it may be efficient from a delivery standpoint, it is not efficient from a user standpoint.

Who pays for flights, hotels and time off work to assist patients to travel to distant cities for treatment? What is the difference between charging user fees and creating conditions whereby access to health care is dependent on high personal expense?

We will see fewer nurses, fewer MRI technologists, fewer cleaning staff, fewer pharmacy technicians, fewer RPNs, fewer dietary staff, fewer clerical workers... smaller communities and even medium sized ones will likely lose services. In most of our communities the hospital is the largest employer. There would be an impact on our communities by further downsizing or privatizing of our services , leading to economic loss. Our small towns and businesses depend on having our services close to home.

Patients will have to travel further. In our counties, winter travel is not always an option and we do not have the necessary public transit. It simply does not exist. Under fiscal pressure from government, the LHINs could very well rationalize many health services under the integration plan, forcing patients to travel hundreds of

kilometers for services we presently receive in our local community.

The Local Health Integration Networks are being presented as the solution to problems in our health care system.

Ontario's health system is not broken and does not need such a massive and costly reorganization of that system. In fact, the risks outweigh any potential that we can reasonably see that would emerge from this restructuring.

The real cost drivers in the system are not addressed by this reorganization. Pharmaceutical costs made up 16.7 per cent of health expenditures in 2004. Drugs costs are the fastest growing expenditure in health care, yet pharmaceuticals are left out of this structure.

The large number of P3 hospitals the government has embarked upon also poses a serious threat to the future health care funding, as does the rising costs of equipment. We have been waiting for approval of a new hospital in our amalgamation.

The community raised their portion of the money, \$13

million and we have not heard yet if we can go ahead. Lacking in the LHINs legislation is any real human resources strategy. I wrote the report on the Human Resources issue for the Southwest LHIN.

One point that was clear with all the stakeholders that I had contact with during the information gathering for that report was that a Human Resources plan was needed and should be put in place before any restructuring begins. While the rules do provide a forum for unions to battle out representation issues, the process is going to create retention and recruitment problems. We already face difficulties in recruiting Health Care Professionals into small rural areas.

Speculation about amalgamations and transfers is going to enhance the existing problems of bringing needed health professionals to our communities. Who is going to relocate to a more remote community when the likelihood of having the service transferred to another center is rumoured or imminent?

The province needs to develop human resource adjustment plans, taking into account existing collective agreement language where applicable. It

should also be willing to substantially fund these plans.