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Mercredi 25 février 2004

Standing committee on justice and social policy

Commitment to the Future of Medicare Act, 2003

Comité permanent de la justice et des affaires sociales

Loi de 2003 sur l'engagement d'assurer l'avenir de l'assurance-santé

Chair: Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

COMITÉ PERMANENT DE LA JUSTICE ET DES AFFAIRES SOCIALES

Wednesday 25 February 2004

Mercredi 25 février 2004

The committee met at 1003 in room 151.

COMMITMENT TO THE FUTURE OF MEDICARE ACT, 2003

LOI DE 2003 SUR L'ENGAGEMENT D'ASSURER L'AVENIR DE L'ASSURANCE-SANTÉ

Consideration of Bill 8, An Act to establish the Ontario Health Quality Council, to enact new legislation concerning health service accessibility and repeal the Health Care Accessibility Act, to provide for accountability in the health service sector, and to amend the Health Insurance Act / Projet de loi 8, Loi créant le Conseil ontarien de la qualité des services de santé, édictant une nouvelle loi relative à l'accessibilité aux services de santé et abrogeant la Loi sur l'accessibilité aux services de santé, prévoyant l'imputabilité du secteur des services de santé et modifiant la Loi sur l'assurance-santé.

ONTARIO MEDICAL ASSOCIATION

The Chair (Mr Kevin Daniel Flynn): Ladies and gentlemen, if we could call to order, our first delegation of the day is from the Ontario Medical Association. I've got Dr Larry Erlick and Dr Ted Boadway. The time is 10:03. You have 20 minutes to use any way you see fit. At the end of your presentation we will share time among the three parties to ask you questions on a rotational basis. Welcome. The floor is yours.

Dr Larry Erlick: I'm Dr Larry Erlick, president of the Ontario Medical Association. Good morning. I'm here representing Ontario's 24,000 physicians with my colleague Dr Ted Boadway, OMA executive director of health policy, and Mr Jim Simpson, OMA legal counsel.

I would like to start by reminding members of the committee of the problems facing physicians and patients in the province today. Right now in the province of Ontario, there are nearly 118 communities that are considered underserviced and almost one million patients who don't have timely access to a family physician.

In a recent survey of 2,000 doctors in the province, we learned that one in six is considering leaving the province, one in five is planning to retire in the next five years and one in five is considering leaving the profession altogether. Doctors in the province are considering all of these things because they are concerned about their inability to provide to their patients the quality care they were taught to give and are frustrated at the obstacles they encounter each and every day trying to provide that care. Long waiting lists for treatment and tests are impacting on the ability of physicians to care for their patients.

I know that most of you on this committee must be seeing the direct impact this shortage is having on your communities as well. In the last few weeks, I have travelled to Peterborough, London, Sarnia, Barrie and Chatham. In each community, I have heard from families how this shortage is impacting on their lives, I have heard from businesses how this shortage is hurting their productivity and their competitiveness, and I have heard from local politicians how this shortage is hurting their communities.

We have reached a crossroads in health care today. We need to take immediate steps to improve access to health care for Ontarians. In short, we need to make Ontario an attractive place to practise medicine again. Doing this will allow us to recruit new doctors and to retain those already working hard to care for our families.

Bill 8, if enacted, will do the opposite. Doctors who are considering leaving the province will leave, doctors who are considering retiring will retire and the few doctors who are currently considering moving to Ontario won't come.

This bill has nothing to do with improving accessibility since it ignores the real problems in the system: chronic underfunding and a lack of resources. Issues like queue-jumping, block fees and opting out are symptoms of these chronic problems.

Bill 8 plainly states that the minister would become all-powerful in dictating anything he wished about terms of service, payment, working conditions or anything else he decided to put in a contract, because he can impose contracts on anyone, void previous agreements and take away the parties' right to recourse. The minister, under the bill, has decided to dictate a set of rules to govern and enforce these agreements, to use high and unsupportable fines, and if that fails, to throw hard-working doctors in jail. Bear in mind that this was not for some criminal offence, nor was it for some transgression of care to a patient. And it was not for performing your duties inadequately. No, rather it was for simple administrative matters.

The minister has stated that the bill needs to be amended, and we agree. The minister has announced to the committee some general approaches to the amendments to certain sections. However, these proposals do not go far enough and several important issues are left in the bill.

First let me address the part on accountability. The medical profession supports accountability and our track record on this is abundant and clear. We have been part of the group, along with the Ontario Hospital Association, in developing the accountabilities for physicians practising in hospitals. We were an integral part of the development of the Regulated Health Professions Act, which articulates the accountabilities of professionals to their college. Also, it was the OMA that over three years ago first called for accountability to be included in the Canada Health Act, a recommendation we were happy to see Mr Romanow embrace.

However, as drafted, this section is not about accountability at all but rather is a control mechanism for the minister. Furthermore, any accountability that might devolve from this part goes only one way: to the people who practise and deliver health care. Bill 8 speaks nowhere about the accountability of the Ministry of Health.

Doctors could support an accountability provision which outlined the commitments and obligations of all parties to the delivery of health care, including the ministry, and which had provisions for the regular reporting of progress, mid-course adjustment and corrective action where required.

The patients of Ontario expect us all to be accountable for what we do and they have a right to do so. This legislation should be rewritten to reflect that.

As a general statement, the provisions for penalties and punishments and matters of due process and fairness must all be redressed. This legislation treats all doctors as criminals and does not respect the hard work and dedication physicians show their patients.

Section 16 of Bill 8 deals with what are commonly called block fees. Block fees exist for things doctors must do to provide quality health care but that OHIP will not pay for. As such, they are not an insured service and are regulated and subject to enforcement by the College of Physicians and Surgeons of Ontario.

Ten years ago physicians, under the leadership of the OMA in collaboration with the College of Physicians and Surgeons of Ontario and the government of Ontario, set up guidelines to regulate block fees. The OMA has firmly established guidelines for third-party uninsured services for physicians to follow. Block fees should also not be confused with extra-billing, which has been outlawed in Ontario. We have provided the committee with a detailed package of existing CPSO regulations around block fees, the OMA Physician's Guide to Third-Party and Other Uninsured Services, and a detailed commentary on various sections of the bill.

We are prepared to work with the college of physicians and surgeons to enhance the transparency and access issues related to block fees as part of our commitment to rigorous self-regulation.

1010

Nobody knows and understands the frustration and negative impact wait times have on patient care more than doctors. The minister has proposed a mandatory reporting requirement for those paying to jump the queue, but fails to address the root of the problem, which is the underfunding of the system that results in unacceptable waiting lists in the first place. When you are waiting four months for a loved one to get a test to find out if they have cancer, people become anxious, desperate and look for ways to speed up the test. The government should focus its attention on fixing this problem by providing doctors and hospitals with the necessary resources to reduce wait times for patients. The problem isn't the patients, their families and those treating them; it's the wait lists.

If the government wanted to address queues, it would identify those tests and treatments for which there is presently a long waiting time and would take measures to address the urgent patient needs demonstrated by these long queues. It would enunciate to the public a mechanism and a procedure for addressing these and make promises on how long the waiting time would be for any particular item. That would address the problem of queues and wait lists.

So, as we look at Bill 8, we see a bill which does not do what it is purported to do. It does not address a common vision of shared responsibility; it does not address the queues and waiting lists for patients; it does not have fair and reasonable procedures in it. Physicians' civil rights are waived and they are denied protection under the Statutory Powers Procedure Act and Provincial Offences Act.

The process of dealing with physicians in Bill 8 is very similar to the MRC—medical review committee—process that presently exists. When in opposition, Dalton McGuinty and the Ontario Liberals condemned this unfair process and supported the OMA's call for a moratorium on MRC reviews pending an independent review. Experience has shown us that that kind of environment has unintended consequences. For example, just this past weekend at the Liberal AGM in Windsor I heard from a minister who lost three doctors last week because of the MRC process. This same community was already facing a doctor shortage that is now worse.

What Bill 8 does is change the billing practices of about 40 physicians, impose a draconian solution to the wrong problem, seize regulatory power of an already self-regulated matter and promise to bring chaos to hospitals. We have the minister's commitment to address some of these issues and we are prepared to work with the minister and address all of these issues. We would also work with the minister to address the issues facing Ontario's patients. We have real solutions to the doctor shortage and access. We can work with hospitals and government to address waiting lists for surgery. These should be addressed in any bill on accessibility, and, as a profession, we are committed to work with the government to this end.

We must change Bill 8 so that doctors who are considering leaving the province will stay, doctors who are considering retiring will continue to practise, and the few doctors who are currently considering moving to Ontario will come. Thank you.

The Chair: Thank you, Dr Erlick. You've used about 11 minutes and left us with nine minutes for questions, beginning with the official opposition for three minutes.

Mrs Elizabeth Witmer (Kitchener-Waterloo): Thank you very much, Dr Erlick, for your presentation. I find it rather frightening, because we've now heard from you, the physician community in the province of Ontario; we've heard from the Ontario Hospital Association and its members; and we've heard from the unions such as CUPE and others, and there seems to be widespread concern and anxiety about this bill. Despite the fact that the minister has said he's meeting with all of the groups and he has indicated there are some amendments he may be making, it does not seem to have alleviated that anxiety. I guess I'm particularly concerned about the fact that in surveying your members you have now learned that despite the fact that one million people won't have a doctor if this bill is passed as is, we will lose even more. This bill is not going to improve accessibility as the government claimed it would. It's not going to improve the commitment to medicare.

What changes do you need to see to this bill in order that your members will continue to serve the people in this province and not seek to retire or leave this province? What is it specifically that you must see in this bill?

Dr Erlick: We have to improve access to care and resources. That's how we're going to alleviate the problems facing our patients. We have provided a detailed recommendation on several of the amendments, but the underlying problem is access.

Mrs Witmer: So you don't see this, in any way, shape or form, as improving access to care?

Dr Erlick: No.

Mrs Witmer: What are the sections of the bill that you believe need particular attention? Are there some that should be withdrawn? Are there some that should be totally rewritten?

Dr Erlick: I'll turn to Dr Boadway.

Dr Ted Boadway: The accountability provisions need very vigorous redrafting. The accountability provisions really aren't accountability provisions at all; they're control mechanisms. On the other hand, they could be written such that accountability was really in it and they could also be written in a way that they did address access issues. So I believe that with some major redrafting it would be possible to do a pretty good job right in this portion of the bill.

I also think that if you look at some of the issues that are in part II of the bill, there needs to be some work there, but they're more technical.

Ms Shelley Martel (Nickel Belt): Thank you, the three of you, for being here today. You used some pretty strong language. I see, "This bill has nothing to do with improving accessibility ... it ignores the real problems in the system," "this section is not about accountability at all, but rather is a control mechanism for the minister," and then, near the end, "What Bill 8 does is change the billing practices of about 40 physicians, impose a draconian solution to the wrong problem, seize regulatory power of an already self-regulated matter and promise to bring chaos to hospitals."

The only thing I think you missed was in section 29, where it says that the minister can require people to hand over information within the meaning of the remedies for the Organized Crime and Other Unlawful Activities Act, which is also a pretty obnoxious section of the bill, which I don't see from the minister's letter he has any intention of taking out of the bill either.

You said to us that you saw what the minister proposed in terms of potential amendments that he released via the parliamentary assistant last week and your opinion doesn't seem to have changed. Am I correct in that assumption?

Dr Erlick: What we're addressing is the bill we have before us. We have not seen the final written amendments, so we can only comment on what we have in our hands to comment on.

Ms Martel: I apologize. We haven't seen final amendments either. What we saw is a kind of draft framework that the minister has put to us, which makes some suggestions regarding changes in some specific areas. The fact is, the minister will still have all the authority to bring forward compliance measures and orders and deal with CEOs, and nothing to deal with section 29 and organized crime.

Dr Erlick: I might only comment that the tone of the original Bill 8 is such that we will not feel comfortable until we see final amendments before we can comment.

Ms Martel: Yes, you want to see the actual wording. We all do.

Tell me, what should be in the bill regarding the accountability of the minister to the health care system and to patients? You've talked about accountability being a one-way street. We've heard that often enough. What has to be in here to show that the minister has some accountability back to the system and patients?

Dr Erlick: You're talking about shared accountability. I'll let Dr Boadway give a better example.

Dr Boadway: Actually, you can look a little bit to the British example, where Mr Blair made a commitment to patients to act on waiting lists and he actually did articulate in the context of each particular problem in the waiting list how he would address it. That says to the public, "I recognize you have a serious health care problem in this area; it's real; I will address this one," and he took them on one at a time, with some success. Quite frankly, that's a banner for everyone to read.

Ms Monique Smith (Nipissing): Dr Erlick, I'm just interested, as Ms Martel outlined, in some of the hyperbole in your address this morning. It is a bit rough. Have you not been in discussions with the ministry staff and

the minister for a number of weeks now on the possible amendments?

Dr Erlick: We have been in discussion on some of the amendments, yes.

Ms Smith: Yes, and you're aware of the proposed amendments, the general areas—we've discussed a number of areas in which you have concern, is that not true?

Dr Erlick: There are significant areas in the bill on which we do not have any agreement on changes.

1020

Ms Smith: But you're clear that the accountability agreements referred to in this legislation, when the proposed amendments will be put forward, do not apply to doctors or to physicians' group practices.

Dr Erlick: We have requested, obviously, those—

Ms Smith: Is that your understanding of the intended amendments, Dr Erlick?

Dr Erlick: Our understanding of the intended amendments?

Ms Smith: Yes. Is that your understanding of the intended amendments?

Dr Erlick: That physicians and group practices will be excluded? I'm not sure how integrated health care networks and other things will be affected. We do know IHFs and hospitals will be affected. Executive administrators within hospitals may be affected, which would be a problem with physicians taking on jobs as executive administrators within hospitals.

Ms Smith: That's a lot of "mays." I wanted to talk to you specifically about your comments about block fees, that, "The OMA has firmly established guidelines for third-party uninsured services for physicians to follow." How are patients able to access the list of block fees from their physicians?

Dr Erlick: First of all, block fees are strictly regulated by the College of Physicians and Surgeons. We support any physician who violates those guidelines being punished. Block fees are also an option. No patient in this province has to pay a block fee. They cannot be denied health care; any physician must provide the care, whether or not they choose to pay block fees or pay for uninsured services as they are provided.

Ms Smith: We've had three different depositions at this hearing from different parties who have outlined that when they've requested a list of fees from their physicians, they've not been available to them and they've been told to go to the OMA. When they've asked at the OMA, they've been told that there's a charge of $100 for that document. Is that your understanding?

Dr Boadway: No, that's not true. If you ask for the fee schedule, there is a charge for it, but that's not for the block fees. That's a fee schedule of everything. That's for the cost of appendectomies, the cost of—well, the fee schedule.

Ms Smith: So if a patient were to call the OMA asking for a fee schedule, they'd be told that there's a charge for that?

Dr Erlick: In fact, we have provided the committee with the third-party billing guideline that the OMA recommends to its members. My understanding of the block fee regulation is that the physician is to provide the patient with the two options: to pay a block fee for certain services, or otherwise a catalogue of services that the block fee includes.

Ms Smith: And the OMA recommendations are just such: recommendations, right? Doctors are not regulated as to what they can charge for those specific—

Dr Erlick: We are a self-regulated profession by the College of Physicians and Surgeons of Ontario. The guidelines for block fees are strictly enforced. There have been cases, which we could provide you with as well, of physicians who violated those guidelines and have been subject to—

Ms Smith: And there are third-party organizations—

The Chair: Thank you, Dr Erlick.

Ms Smith, your time has expired.

Thank you very much for attending today. Your presence and input were certainly appreciated.

PAUL MacDONALD

The Chair: Our next delegation is Mr Paul MacDonald, or perhaps it's Dr Paul MacDonald. Same rules as everybody else, sir. You've got 20 minutes. At the expiry of the presentation you make, if there is any time left over, we'll split that time proportionately among the three parties on a rotational basis. If you would introduce yourself for Hansard, the floor is yours. It's 10:24.

Mr Paul MacDonald: Thank you, Chair, ladies and gentlemen of the committee, for giving me this opportunity to discuss issues in regard to this proposed bill.

Hello. My name is Paul MacDonald, and I'm here on behalf of my unionized co-workers at a downtown Toronto rehab centre. As a registered practical nurse, I work on a daily basis providing direct care to my clients, who, through no fault of their own, cannot provide this necessary personal care.

Let me begin by stating that no company or corporation should profit from the illnesses of the citizenry of this province. For an individual company and its shareholders to make money on the backs of the disabled and acutely ill is obscene, to say the least. The public system that we are fortunate enough to have is what separates us from those to the south. As an employee of a downtown Toronto rehab centre, I have to say that employees, both unionized and non-unionized, have been fortunate enough over the past few years with our cutbacks and reorganization. People were displaced, shuffled and reclassified; however, no one lost their job.

However, we have not been immune from creeping privatization. Laundry and linen have been farmed out. Just recently we lost our hairdressing staff. As a result, this has put some stress on our complex continuing-care residents at another site, who now have to wait longer and pay more for hairdressing services.

Positions in our housekeeping department have not always been filled, for different reasons, mainly budget-

ary. This has created more work and stress for those left to pick up the slack. Our patient care units, as a result, are not as clean as they used to be.

I, with my coworkers at the rehab centre where I am employed, do not want to see these positions and others eroded further by a profit-generating private company. Staff in these and other departments would be further reduced to make a profit for the company. Fewer bodies on the payroll equates to a higher bottom line for company X but a reduced quality of services for Ontarians.

As front-line caregivers during SARS, references were made to us as the heroes of health care. This was only a few short months ago. Now, here I am, defending free collective bargaining and the spirit of universality. Does this make sense?

Passing such a heavy-handed, undemocratic, autocratic piece of legislation is beyond Canadian comprehension. To give the health minister such broad, sweeping powers under the guise of an accountability agreement or to issue compliance directives is not democratic.

Section 30 of the bill seeks to insulate the crown and minister from any legal liability resulting from any actions taken in connection with accountability agreements or compliance directives. Anyone who fails to comply will be fined $100,000. Thus my salary and benefits could be rolled back. In this bill, as it stands, we will have no choice. There will be—is—no dialogue. Take it or take it. My many unionized public sector compatriots and I have a problem with this dictatorial manner that is potentially being forced down our throats.

These provisions have been drafted in extremely broad and general terms. They grant the minister virtually unprecedented power to require individuals and organizations to comply with ministerial health care initiatives. Potentially, these steps could override collective agreements and other negotiated agreements.

As was the case in BC with the new Liberal government in place and a deficit of $2.5 billion, the government under Premier Campbell tabled a similar bill. Overnight, Bill 29 caused the layoff of several thousand health care workers in that province—several thousand who paid their taxes, had mortgages to pay and kids to be put into post-secondary. Thousands of lives were disrupted—lives of health care employees who believed in a system. It was the same system that we, the health care employees of this province, have: a public system.

Bill 8 as it stands requires revision. As previously said, the areas are part III, sections 19 to 23.

In closing, I and my many brothers and sisters in the health care sector would like reassurances to our concerns. As with many campaign promises that were not met by the current Liberal government under Dalton McGuinty, promises that were completely changed—for example, P3 hospitals and private MRIs and CT scans—we who work for a fair wage, with livelihoods that were determined under negotiation over these many years, would like the health minister to amend the flawed sections in this bill that the people and organizations of this province have brought to the attention of this government.

Since many promises and plans pertaining to health care have been broken, we, the stakeholders in health care in this province, not big-name multinational corporations with questionable labour practices like Sodexho, Aramark, Compass and Drake, wish for the health minister to declare in writing that the amendments have been made, not just for current collective agreements but for all future collective agreements. Thank you.

1030

The Chair: Thank you, Mr MacDonald. You've used up about eight minutes, leaving us with 12. So in between three and four minutes each, starting with Ms Martel.

Ms Martel: Thank you, Mr MacDonald, for taking time to come today. Let me say that the minister has told this committee that the bill will not impact on collective agreements, that trade unions will not be considered health care providers. We wait to see the amendments, because we don't have that yet. What was interesting, however, is that in the proposals the minister gave to the committee last week, there does not appear to be a change in the compliance directives that the minister has. Let me get to that in a roundabout way. You told the committee already that laundry and linen staff at your organization have been essentially contracted out; am I correct?

Mr MacDonald: That's right.

Ms Martel: And I'm going to assume that CUPE staff were affected. Were they unionized staff?

Mr MacDonald: They were, but they were reassigned to other departments or positions.

Ms Martel: In terms of that redeployment, did people's wages and salaries stay the same, or would you know that?

Mr MacDonald: I believe they would.

Ms Martel: They did or you're not—

Mr MacDonald: I'm not 100% entirely sure.

Ms Martel: Here's what I'm worried about. Under the compliance directives, the minister's powers are pretty broad. I can see that the minister could say to an institution—a hospital, a long-term-care facility, for example—"In order to make savings, we think you should contract out your housekeeping, your laundry." If successor rights don't apply, then a number of people could lose their jobs. You were lucky in your case because the organization was able to give people other jobs. I'm not sure that's going to happen everywhere else. So my concern is that while trade unions might not be considered health care providers and so they won't be part of the bill in that way, under the section on compliance directives, people and their positions could still be affected if the minister, for example, argues that services should be contracted out. Do you have any comments about that section at all?

Mr MacDonald: All I have to say, as with the previous gentleman, the physician, is that we're just waiting to see the final amendments. There were remarks by Mr Smitherman dated February 16, 2004, to the standing

committee. He's on record saying, "Then there's CUPE. Bill 8 can't open collective agreements, and unions have never been subject to accountability agreements, but we've agreed to make that more explicit." We're just waiting to see the final amendments.

Ms Martel: You want to know for sure what that says.

Mr MacDonald: Yes.

Ms Martel: I had one other question in terms of the sweeping powers of the minister. He may make changes that will not affect collective bargaining. There are still other provisions in the bill that you noted that provide him with some really broad, sweeping powers. Do you think it's appropriate for a minister to have those kinds of broad, sweeping powers essentially to take over boards of a hospital or to take over a management board at a long-term-care facility?

Mr MacDonald: No. That's why we have hospital boards and that's why we have unions in place to negotiate contracts, and there are dispute mechanisms in place if we can't come to an agreement.

Ms Kathleen O. Wynne (Don Valley West): I have a question and then I think Mr Duguid is going to make a comment.

Thanks for coming today, Paul. You have a copy of the proposed amendments and, you're right, the language of the amendments is not finalized yet because we're still in the process of committee hearings. Do you have a copy of the proposed amendments?

Mr MacDonald: Yes. I gave them to—

Ms Wynne: Yes, you gave us some amendments from Sack Goldblatt Mitchell. This was part of your presentation. But we have a letter from Mr Smitherman that has some language around proposed amendments, so we'll make sure that you get a copy of that just so you know the direction we're going, which is to confirm what Mr Smitherman said in his speech on the 16th around the accountability agreements not being between unions and the minister but being between the minister and hospital boards or the minister and organizations. So it's not between individuals and it has nothing to do with reaching into collective agreements.

I wanted to ask a question too. This bill is about making sure the dollars that go into public health care are spent where they should be spent. As a nurse, my guess is that there are some things that are going on in the health care system that you're not too happy about, that don't have anything to do with Bill 8, but have to do with practices and the status of nurses and the hiring of the nurses. Is that a fair statement? The number of full-time nurses, the number of contracted—

Mr MacDonald: Yes. Under the SARS situation that was apparent. That would be part of it.

Ms Wynne: OK. So I just want to draw your attention to the speech that Mr Smitherman made yesterday, and I think Mr Duguid may follow up on this. What he said was that he is going to put $385 million into the hospital sector to deal with current deficits, but "$50 million of that $385 million," he says, "will be targeted exclusively to create full-time nursing positions and improve the safety and working conditions for nurses. If hospitals fail to reach targets for creating full-time nursing positions, they will lose the funding." So there will be a consequence. In other words, what we're trying to do is target the money at the areas that we know and that we've been told by nursing associations—that's just one example—are real problems. What do you think about that strategy to address your issues?

Mr MacDonald: Not just nursing, but there are other departments that are critical to the running of a hospital and maintaining top-quality services. I did mention them in my report.

Ms Wynne: Sure, but I guess I just wanted you, as a nurse, to understand that those are the kinds of accountability mechanisms we're trying to put in place. We're trying to say, "This is an area that is in serious trouble." The health council would identify that and we're trying to tag the money to that.

Mr MacDonald: I agree, as long as the spirit of free collective bargaining isn't removed.

Mr Brad Duguid (Scarborough Centre): We've received a number of letters from front-line workers, a number of form letters as well, some of which are suggesting that somehow the minister would be allowed to strip their job security provisions from their collective agreement and roll back their wages and benefits. We're talking about a working sector that has been under incredible stress. There's still burnout out there from the SARS thing and we've seen it over the last couple of years. My sister is a nurse at North York. She was in the middle of the SARS crisis and she's told me about the burnout and stress that goes on there. I served on the board of Scarborough Hospital and I've seen that first hand as well.

It concerns me when there's misinformation out there that's going to a group of people who are already at the breaking point now in terms of stress. Given that misinformation has gone out and the president of your union was advised as of January 13 that labour unions were not going to be subject to accountability agreements, would you undertake to share with your colleagues that this is in fact what is going on right now? I know you don't have the direct amendments. You're going to get them; they'll be coming forward, I believe, probably in March.

Ms Wynne: March 9.

Mr Duguid: Even before then, would you please undertake to share with your colleagues that this is the direction we're heading in to try to reduce that stress level somewhat?

Mr MacDonald: That's fine, as long as the amendments are in writing and we can see the amendments before the bill is passed, because that's the concern we have.

Mr Duguid: Well, let them know the amendments are going to be coming in writing, but let them know what we've said as well so that they have all the information. Because as far as I know, Mr Ryan has yet to inform the membership of the direction that's taking place here and

the commitments the minister has made to him personally as of January 13, in a meeting they had. I think that's unfortunate, because this is a group of people who are working very hard in a very stressful environment.

Mrs Witmer: Thank you very much, Mr MacDonald, for coming. I really appreciate that you did take the time to come. Obviously this bill is causing a great deal of anxiety for yourself and for your colleagues. Some of the statements you've made certainly indicate this bill is flawed, it's heavy-handed, it's undemocratic, it's autocratic, it's dictatorial, it gives unprecedented power to the minister. Are these concerns and fears that you have really quite widespread within the organization where you work?

1040

Mr MacDonald: It is. All we have to do is look back at what happened in British Columbia after Bill 29 was passed: 6,000 unionized employees lost their jobs once the privateers came in; or if they were kept, they were kept at substantially lower wages with a gutted benefits package. The same seems to be happening in Quebec right now. With the prospect of the P3s, this bill seems to go hand in hand; especially the sections that I mentioned. A private corporation can't make a profit if CUPE employees move over to the new hospital with their collective agreements and contracting-out language.

Mrs Witmer: If you take a look at some of the comments that were made by the minister in his speech yesterday about funding for hospitals and the fact that they can't expect this funding in future years, obviously somebody's going to be looking at places where they can achieve some savings. So I think some of the points that Ms Martel has made and some of the concerns you have are really reason for concern. In fact, we've heard a lot about the fact that this legislation seems to base itself in some respects on the BC model, and so I think your concerns are quite legitimate.

I would ask the Chair, in light of the fact that this bill is causing such anxiety, are we going to receive the amendments from the minister long before we're going to have to debate them?

The Chair: I can investigate that. As I understand, we'll be starting our clause-by-clause on March 9. I will certainly undertake to find that out.

Mrs Witmer: I think it's really important that the stakeholders, who do have very legitimate concerns, have an opportunity to see these amendments and then have an opportunity to respond, because despite the fact that assurances have been given that some changes will be made, it appears to me that whether it's unions, doctors or hospitals, people are not feeling very reassured that this bill is going to change significantly to respond to their concerns.

The Chair: Just to be clear, the subcommittee has established March 8 at 5 o'clock as a deadline for amendments. That should be viewed, in my opinion, as a minimum as opposed to a maximum. I will check into it.

Mrs Witmer: Which would mean people would only have overnight, from 5 o'clock to 10 o'clock the next day.

The Chair: That's why I'm saying that would be a minimum deadline.

Mrs Witmer: That would be a pretty short timeline when we've heard such significant concerns from stakeholders.

The Chair: You've got about 30 seconds, Mr Arnott.

Mr Ted Arnott (Waterloo-Wellington): Thank you, Mr MacDonald, for your presentation today. Thank you for coming and offering us your views. Yesterday, the minister gave a speech, and this is the one where he encourages the deputy minister to ask health stakeholders to buy a table to attend at $650 a shot. Apparently afterwards, in an interview with the Globe and Mail, the minister said, "We're going to be pretty bloody-minded and determined about achieving results." How would the front-line health care workers that you represent respond to such an inflammatory statement?

Mr MacDonald: With concern.

The Chair: Thank you, Mr MacDonald, for coming today. We appreciate it.

ONTARIO ASSOCIATION OF SOCIAL WORKERS

The Chair: Our next delegation comes to us today from the Ontario Association of Social Workers—Drummond White and Gillian McCloskey—if you would come forward and make yourself comfortable. Thank you for coming today. Same rules as everybody else we're hearing from in Toronto: You have 20 minutes; you can use that any way you see fit. At the end of the presentation we'll apportion the remaining time amongst the three parties for any questions or concerns that need to be addressed during that period. I've got 10:46 and you've got 20 minutes.

Mr Drummond White: Thank you very much, Mr Chair. Good morning, ladies and gentlemen. My name is Drummond White and I'm the vice-president of the association of social workers. With me is Gillian McCloskey.

Ms Gillian McCloskey: I would like to introduce our association, although you have seen and heard presentations from three of our branches, the first being in Sudbury, then in Ottawa and also in Windsor. On Friday, one of our branches will be presenting in Niagara Falls. So you probably have a good sense of what our association is about, the fact that we have over 3,200 members who have social work degrees at the doctoral, master's and bachelor's level and that we are a member of the Canadian Association of Social Workers. That, in turn, belongs to the 76-nation International Federation of Social Workers, so we're all interconnected.

The other point that we would like to make as an introduction is that a major employer—perhaps the major employer—of social workers are hospitals and community-based health services. Increasingly, social workers are in private practice and serve in that capacity in a counselling role. Also, the major providers of psychotherapeutic counselling are social workers. Historically,

social workers have been advocates of the disadvantaged and vulnerable populations. The beliefs, principles and values behind that are that that would make a significant contribution to the health and well-being of society as a whole, that that really enhances and enriches the total community.

Mr White: What we were excited about as an association and as a profession was that the government was undertaking this new bill and there was an intent to put forth a commitment to the future of medicare. Of course, we've had a lot of discussion in the last number of years about where medicare should be going and the kinds of reforms that are necessary. This bill was introduced last fall. It creates some new mechanisms, but we have a concern that, as it stands, the bill may not further the implementation of the principles of the Canada Health Act nor provide adequate democracy, transparency or accountability. Additionally, it may not prohibit the further erosion of the scope of medicare and the increasing problems of privatization, profit-taking and two-tiering of those services that have been delisted.

Failing to address some of the critical issues relative to preserving and reforming medicare and moving its values into the 21st century might create a very serious missed opportunity for leadership at this crucial time. This brief will highlight some of our key values that are consonant with and expressed through the comprehensive set of standards, goals and values that inform medicare as we know it and indeed as is set out already in the preamble of the bill. And we will address one significant issue in the future of medicare, the enactment of primary health care.

We understand that presentations have been made by colleagues to this committee in other parts of the province. Those presentations set out a vision and called for changes in the bill that would ensure a commitment of the Ontario government to the following: rebuilding the universality, comprehensiveness, and accessibility of medicare; prohibiting two-tier medicine and extra-billing; creating a health quality council to report on compliance with the principles of the CHA; prohibiting block fees and charges that create a barrier to access; ensuring public accountability, democratic control and transparency; and putting an end to privatization and ensuring democratic and public, non-profit delivery of service.

I won't go into great detail into those issues because I think they have been made succinctly by my colleagues in Sudbury, Ottawa and Windsor. The issues are fairly clear. As social workers we're often working in the community, although as my colleague mentioned, more social workers are employed in health care centres than elsewhere.

But a lot of the community work is with community agencies: private counselling work, EAPs, a range of health care-related services. So there's a great sense that, as social workers, we are aware of the need for primary health care reform when there are literally hundreds of people in every region of the province on waiting lists for psychiatric or psychotherapeutic services through otherwise public agencies.

The issue about block fees and extra-billing is fairly self-evident. I want to focus primarily, as you'll see in the document at the beginning of page 5, on issues around primary health care reform.

Consumers want to be able to access health care services across the continuum of health and wellness, from preventative to curative to maintenance, in the least intrusive manner possible and in their most natural environment. We envisage that health care services will be most successful and accessible if based in the community, offered by a range of professionals and designed to work with natural support systems such as extended family and friends. Admissions to institutionally based care, either acute or long-term, should be the last resort. We recognize, however, that in some instances, hospitalization or institutionalization is the least intrusive intervention because of the complexity of needs. But in the vast majority of situations, it is the most intrusive and seems to be the bulwark by which everything else is compared.

We must work towards the enhancement and expansion of Canada Health Act principles and, at the same time, address the question of long-term financial sustainability of the health care system. A two-tier system of for-profit and not-for-profit health services existing simultaneously would create a financially unsustainable system. Primary health care reform can be both affordable and relatively predictable in costs, but it's unlikely to get off the ground if it is in competition with private for-profit services.

Ontario wants and needs a comprehensive, interdisciplinary, and universally accessible system of primary health care. Such a system must be delivered by not-for-profit organizations and be publicly accountable. It should be governed, in part, by community involvement in decision-making.

With primary health care reforms, it is imperative that there is an immediate ban on public-private partnerships and new health care services that are offered on a for-profit basis. It is a fact that P3s and for-profit initiatives can incur high costs, the burden of which is on the taxpayers in the long-term. We know that such services eventually create barriers to universal accessibility. Thus, Ontario's health care system must remain publicly funded.

The World Health Organization has long advocated for primary health care reform. The commission chaired by Roy Romanow also called for primary health care reform. Canadians and Ontarians have all expressed a need to press onwards with primary health care reform. These essential reforms can only happen within the context of a publicly funded infrastructure.

As an essential part of the revitalization of medicare, we would like to see primary health care reform anticipated by the present bill. A comprehensive commitment may be forthcoming and the costs have, of course, to be considered. On the other hand, a clear commitment to publicly accountable but not-for-profit health care would be a welcome prerequisite. For these reasons, we

are concerned that the present bill should lay the framework and the groundwork for the future of medicare, including primary health care reform.

We cannot emphasize enough the importance of continuity of care. This includes essential health care sectors that are out of hospital, based in the community, and not specifically covered by the original CHA, such as home care, long-term care and pharmacare. OASW recommends that these essential sectors be included through legislative amendments under the medicare umbrella and under the auspices of a public authority.

In conclusion, the Ontario Association of Social Workers applauds the intent of the bill and would like to see it propelled into the next phase of medicare reform. However, we are concerned that the commitment to medicare that is reflected in this bill may be somewhat tepid. Therefore, we urge that the government fully support a system of health care in Ontario that is comprehensive, multidisciplinary, publicly funded and fully accessible. Furthermore, it should be economically viable and, at the same time, exude the values associated with social justice.

The Chair: Thank you, Mr White. I understand you are the former chair of a standing committee in this building yourself, so welcome back.

Mr White: Yes, thank you.

The Chair: You've left about three minutes for each party. We're going to start this questioning with Ms Smith.

Ms Smith: I'm sorry I missed a portion of your presentation, but I did want to comment on the fact that we have had a number of presentations from the social workers and we really appreciate your team coming out and speaking to us. It's particularly helpful to have a different perspective in these hearings.

As you know, we brought this bill forward after first reading with the full intention that there would be amendments and changes. The minister made that clear from the beginning. We're very pleased at the number of presenters we've had and the amount of input we've had. So we appreciate your coming out and providing us with your review.

Certainly a number of the things that you feel we should be doing in this legislation we are doing. We're looking at ensuring that we have publicly funded, publicly accessible health care and putting an end to two-tier health care.

In your brief you have a bit of a synopsis on the health quality council and I just wondered if you had any input there on membership for the council.

Mr White: I think that the issue there is a very broad one and I wouldn't want to risk putting forth something off the cuff. However, I do think it's so important an area that the issues of transparency and representation need to be in the forefront. I know it would be very difficult to secure an elected body, but certainly we'd like to see a body that represents a broad, multidisciplinary representation of health care services but also, of course, an equal representation from the public, from patient advocates and patients. Obviously, with an electoral system people would tend to put themselves forward in reasonable numbers.

It's hard to ensure the level of accountability that would be necessary, but there's also a sense that it should be a body that speaks to the province and not to the government or the minister alone.

Ms Smith: You spoke about accessibility and a fear about private hospitals. We are opposed to private hospitals, just so we're clear on that. We believe that all hospitals should be publicly funded, publicly governed. So we appreciate your comments on that.

I also noted that you spoke a little bit about the continuity of care. In my other life these days, I'm doing a review of long-term-care facilities across the province, so I'm hearing a lot about continuity of care and at-home care and institutionally based care. So I appreciate your comments on that and certainly will take those to heart as we continue on.

I also just wanted to comment that in my review of long-term-care—it's kind of unrelated, but you'll forgive me, Mr Arnott, for a minute. One of the things we've noted is that the presence of social workers in the long-term-care facilities is a definite value-add. So I did want to comment on the good work that you're doing there.

Mr White: Thank you.

Mr Arnott: Good to see you, Drummond.

Mr White: Thank you, Ted.

Mr Arnott: I recall vividly your passionate speeches in the Legislature in support of public health care, and certainly what you've said today is very consistent with your public record when you were here as a member of the Legislature.

This is my first day subbing in on this committee and I've been following the debate through the newspapers and some other discussions that have been taking place. It seems to me that we have existing mechanisms to ensure accountability for the money spent for health care. Why do you think that those existing mechanisms aren't working as well as they should?

Mr White: We do have a number of existing mechanisms within professional services, obviously. Most professions within the health care field are governed by professional bodies. Social work is unique in the sense that here in Ontario we're governed under the Ministry of Community and Social Services, unlike other provinces. In other provinces, as well, there's been a shift to the Ministry of Health for the regulation of social work. As I mentioned, that is the primary employer.

That's one area that's very important, but the regulation of hospital-based services through hospital boards is not always seen by the public to reflect the local public's concerns. I know there have been many attempts in the past to look at some way of democratizing that, but that hasn't happened. Of course, for that to occur, it would be through an act of government.

1100

Ms Martel: Thank you for being here this morning, Drummond. It's good to see you. I want to say something

about P3s, because you heard the parliamentary assistant say that of course they're opposed to private hospitals. She didn't say anything about supporting hospitals that are publicly financed, because the hospital in Brampton and the hospital in Ottawa are going to be privately financed, which is a break in tradition in Ontario's history of how we fund hospitals through capital grants.

The prospect in Brampton and Ottawa is that a private consortium will privately build the hospital. That hospital will become a mortgage responsibility and, through its operating budget, which is also a first, will have to pay the mortgage payments. The public of Ontario is going to get dinged in two ways: first of all, we're going to pay more, because it costs more for the private sector to finance capital projects than it does for the government, and second, the private sector isn't going to do this as a charity case. Of course they want a profit. We can expect to pay 15%, 20% more for this construction because it will be built by the private sector, not by the public. Do you think that's a good use of taxpayers' dollars, to actually support private construction, private profit, instead of the government building this through public financing so we ensure that money that should go to patient services does, instead of to profits?

Mr White: It's my understanding that government can borrow at significantly lower rates than private industry can. It usually has a secure level of assets that can be used to borrow against. In consequence, the cost of public construction should be significantly less than private construction. Obviously, as well, there would be a need for the private consortium to make a profit above and beyond their borrowing costs.

I'm not quite sure how it is that a P3 endeavour can make financial sense. I know that in the Ottawa area the eastern branch was very concerned about the P3 initiative there and, I understand, has presented to the committee in regard to that.

On a personal level, I'm not quite sure that it makes a great deal of sense. We have seen P3 endeavours in other areas. There was a highway to the north of Toronto, for example, that started off as a P3 and now somehow it's gone some other way. It seems to be somewhat out of control and offers a somewhat basic service that's no longer accessible to all of the residents of this area. So I think there are a lot of danger points and concerns, but not having studied these things in great detail, I just have to be a humble social worker and question how it is that you could be saving money by spending more.

The Chair: Thank you for appearing before us today. Your input was certainly appreciated.

HALIBURTON HIGHLANDS HEALTH SERVICES

The Chair: Our next delegation is from Haliburton Highlands Health Services, Mr Keith Sansford and Mr Jack Brezina.

Mr Keith Sansford: I'm here by myself today. My board chair offers his apologies. He's about to become a customer of our service. When I attempted to pick him up this morning at 7 o'clock, he just couldn't make it to the bell. So he offers his apologies.

The Chair: Give him our best wishes. You have 20 minutes. You can use that any way you like. At the end of your presentation, we will use the remaining time split up amongst the three parties to ask you any questions.

Mr Sansford: I have Jack's notes. He had intended to be the presenter this morning. I'm going to try to incorporate his comments into my formalized presentation, so it may get a little disjointed. I apologize at the beginning for that.

Like you, Haliburton Highlands Health Services is committed to accountability and to the preservation of a universal public health care system in Ontario. To this end, we have reviewed Bill 8, the Commitment to the Future of Medicare Act, and believe that it is flawed. As written, portions of Bill 8 could significantly undermine the government's intent to protect medicare in Ontario.

We support the intent of part I of Bill 8, which establishes the Ontario Health Quality Council. We believe the Ontario Health Quality Council should not only report on the state of the health system in Ontario to the public and to the minister but should be empowered to make recommendations to the minister. We also believe that to promote enhanced public accountability, the council should report directly to the Legislature. Bill 8 as currently drafted prohibits board members and senior staff members of a health system organization from being members of the council. We suggest that the perspectives of the hospital sector will be critical to the council, and serious consideration should be given to formalizing a role for the hospital sector on the council.

Provisions in the accessibility portion of the act may potentially prohibit payments to hospitalists, laboratory physicians and other types of doctors to whom hospitals make direct payments. At a time when many hospitals are facing severe physician shortages, we are very apprehensive regarding legislation that would make physician recruitment even more difficult. The accessibility portion of Bill 8 paradoxically may have the effect of reducing access to health care services.

We are gravely concerned with respect to the provisions in part III of the bill, entitled "Accountability." We strongly believe that the bill fundamentally undermines the role of independent local voluntary boards in two significant ways. First, it usurps the role of the board in representing their local community needs by imposing non-negotiated accountability agreements with the hospital. Second, by establishing mechanisms to have hospital CEOs and other senior executives report both to the minister and the board, Bill 8 interferes with a fundamental principle of corporate governance.

We certainly support the notion of accountability, and to this end we respectfully suggest that the bill be amended to provide for a fair, transparent and freely negotiated accountability agreement process between hospital boards and the ministry. Further, the bill focuses exclusively on how to make health care providers accountable

to the government, yet is silent on the government's responsibilities with respect to ensuring the provision of health care. The bill should be amended to clearly state how both hospitals and government would be accountable to achieve the key principles necessary to a universal, publicly funded health care system.

We also suggest that the Public Hospitals Act provides significant measures for accountability of hospitals, such as provisions for the appointment of supervisors and investigators, the ability of the minister to impose terms and conditions on grants and to reduce or terminate grants, loans or any financial assistance. Further, under the Public Hospitals Act, subsection 9.1(1), in making a decision in the public interest, the minister may consider any matter he regards as relevant, including the quality of the management and administration of the hospital, as well as the accessibility to health services in the community where a hospital is located. Bill 8 removes the requirement of the minister acting in the public interest and therefore makes the minister less accountable to the public.

Local community board members and other volunteers provide thousands of hours of their time in order to benefit patient care and services. As well, hospitals depend on our communities for millions of dollars in contributions for patient care and diagnostic equipment, as well as for the local share of new or renovated hospital facilities. We are very concerned that the accountability provisions in Bill 8 will convert hospitals from charitable corporations governed by voluntary boards to government agencies and as a result will irreparably damage future volunteer recruitment and funding support. In fact, it is likely that passage of Bill 8 will result in the cancellation of substantial existing campaign pledges upon which hospitals are depending to finance current capital projects.

With respect to hospital accountability and the expectation that hospitals can control service volumes and costs, we must note a larger health care system issue, namely, that physicians are still the gatekeepers to hospital admissions, diagnostic tests and treatments etc. Payment for physician services provided in hospitals should be made congruent with hospital funding. The assumption that, under accountability agreements, hospital CEOs will ensure tight control of service volumes and related costs is incorrect and will be destructive to the relationships among hospitals and physicians.

1110

We fear that there will not be enough certainty in the bill about what results the accountability agreements are meant to achieve. As the British Columbia Auditor General noted in his 2003 report, if the government intends to hold a hospital accountable for meeting specified performance goals, objectives and standards, the accountability agreement and the legislation must make it very clear who makes the decisions, when decisions are to be jointly made, and how very sensitive or controversial decisions ought to be made.

The more control the government has over hospitals and their CEOs, the more the spectre of political—partisan—interference is likely to arise in the day-to-day operations of a hospital. We believe that with the introduction of accountability agreements, the hospital stakeholders are likely to perceive that the minister and local MPPS have greater accountability and control over the operations of the hospital. As a result, the stakeholders are more likely to seek the help of their local MPP and the minister in influencing decisions relating to the governance and management of the hospital. Contrary to the minister's intention of making health care organizations more accountable to their communities, we believe the more likely outcome is that the organized stakeholders in the communities, rather than the members of the community, will be able to exert greater influence on the hospital's operations.

In addition, further accountability to the community is lost because the minister will be able to issue compliance directives without considering the public interest or getting an order in council. What measures will be put in the bill to ensure that the minister acts in good faith and in the public interest when the minister issues compliance directives? This is a concern which we believe the British Columbia Auditor highlighted with his suggestion that performance agreements should provide for independent evaluations of health authority performance: "Experience in other jurisdictions suggests that there is a need for independent evaluation and audit, especially when incentives and consequences are involved."

Further, why is the minister fixated on issuing directives to the CEO? The hospital can be made to comply with the minister's requirements via directives to the board, leaving the CEO free of dual accountability.

Will Bill 8 turn hospitals into agencies of the government? The 2003 annual report of Ontario's Provincial Auditor outlines when an organization becomes a government reporting entity. When it does become a government reporting entity, the organization's bottom line is reflected in the province's own financial statements. Currently, the SUCH sector—school boards, universities, colleges and hospitals—is not considered a government reporting entity. There are several criteria that indicate when an organization becomes a government reporting entity, based largely on the power and control that the government holds over the organization's assets and decision makers. Bill 8 may tip the scales and result in hospitals becoming government reporting entities, a result that the government itself is likely not eager to entertain. As a government reporting entity, a hospital would be subject to restrictive Management Board policies and guidelines.

Another area of concern, also identified by the BC Auditor General's report, is whether the ministry has, or can recruit and attract, the kind of personnel who will be able to help the ministry carry out its more hands-on role under Bill 8. For accountability agreements to be effective, the ministry must be able to analyze and react to the issues that arise from the agreements. Bill 8 will create a great deal of potential new work at the ministry level. Does the ministry have this capacity? Can it afford

to retain this capacity? Does it want to expand the health care bureaucracy or downsize it? Will the bureaucratic costs outweigh any related benefits?

We have been encouraged by the minister's stated commitments to continue the ongoing partnership with hospitals and voluntary hospital governance. We share your commitment and are pleased to respectfully submit the above comments on Bill 8.

If I have a few minutes, I'd just like to add some personal comments from the former chair, who would have been able to make them himself had he been here. He refers to the Haliburton Highlands as a rural part of the province, tucked neatly below Algonquin Park. This is Canadian Shield country, with hundreds of lakes that today attract thousands of cottagers and tourists.

Prior to the influx of cottagers, the area relied on the economic return of lumbering and some marginal farming. The isolation of the area created a sense of self-reliance often found in frontier environments. The communities built and maintained their own health care facilities. The Red Cross Outpost Hospital in Wilberforce and the hospitals in Minden and Haliburton were examples of Haliburton county communities rallying to the support of their health care needs.

The facilities in Minden and Haliburton were under the management of the Canadian Red Cross until the 1980s, when they chose to withdraw from the business of operating hospitals. St Joseph's Hospital in Peterborough then took the facilities under their control. While the communities were appreciative of the efforts of first the Red Cross and then the Sisters of St Joseph in Peterborough, there was always an underlying desire in the community to bring the management of the two hospitals home.

A district health council report prepared in the early 1990s under the chairmanship of Jack Brezina reflected that sentiment. It recommended that the Minden and Haliburton hospitals be managed under a joint, locally elected hospital board. The report recognized the limited health care resources in the area and also recommended that the board take on more traditional hospital responsibilities and that it work toward an integrated system of health care that would serve the broad needs of our community.

So in 1997 the Haliburton Highlands Health Services Corp, with a locally elected board, was created. With its creation, the board also received a mandate from the ministry to manage a 92-bed, long-term-care facility located in new facilities attached to the existing structures in Haliburton and Minden. In addition, major renovations at two sites resulted in a modern, 14-bed, acute-care unit in Haliburton with an attached emergency department, and a state-of-the-art emergency department in Minden.

Responding to the call for an integrated health care model, these two traditional hospital facilities are, as was mentioned previously, physically linked to and share services with the long-term-care facilities in the community. They both have space for physiotherapy, provide a diabetes education program, serve as the base for our supportive housing program and are linked to our community mental health program. In an effort to stem the flow of doctors from our communities, we have worked closely with local health and business professionals as well as county government in recruitment efforts, including providing space at the Minden site for a medical clinic. Plans for further integration are in the works.

The Haliburton Highlands Health Services Corp has an application before the Ministry of Health for a community health centre in Minden, in space that was designed to accommodate such a service but is currently unoccupied, and expansion of the rehab programs at both sites. Haliburton Highlands Health Services is exploring the possibility of an outreach program utilizing the services of nurse practitioners, and through the mental health program is participating in the homelessness initiative. This organization has provided space for visiting specialists, pediatricians, cardiologists and internists, among others, to hold clinics, bringing health care to the people of our community.

All this has been accomplished in the last seven years by a locally elected board of directors, a board whose members reflect the needs and concerns of the community they serve. In a community our size, the accountability factor is already very high. Be it at the coffee shop, the curling club or the post office, our fellow residents are rarely reluctant to express their views. This high degree of interest is reflected in the fact that our local newspaper regularly sends a reporter to the board's monthly meetings and provides its readers with a detailed synopsis of our proceedings.

This intense interest is also obvious in the support the hospital has received from the community. During the recent construction and renovation program, the community provided $4.5 million as the public's portion of the $20-million project. The fundraising and support is ongoing and continues to be robust.

The residents of Haliburton county and the surrounding area served by HHHS value the health care services provided by the corporation.

I appear here today to express concerns about certain portions of Bill 8 that we feel could undermine the authority and dedication of the 14 individuals on the board and the thousands across the province who serve their communities and the health system in general. These are individuals with skills, expertise and experience who are vital to the good management of their local hospitals. These are people who give freely of their time for the betterment of their community and the health system. These are individuals who serve as a conduit between this key part of the health care system and the community, bringing the community's concerns to the attention of the board and explaining to their fellow citizens the hows and whys of health policy.

It is through this interaction that support for the system is built, maintained and grows. It is through this contact between a board member and his or her constituents that others are encouraged to volunteer their time, support and financial resources, all crucial to today's hospital system.

1120

Aspects of Bill 8 would allow for the direct and unimpeded intervention of the minister in the activities which are now the purview of the volunteer board. The provision that allows the minister to enter directly into accountability agreements with hospital CEOs without the involvement of the board also undermines the reason for volunteer service. It serves the community's involvement and certainly will make our hospitals less responsive to the needs of our local communities.

I won't read the last paragraph. I'll leave it open for any questions that you might have.

The Chair: Thank you, Mr Sansford. I appreciate it. You've left us with about three minutes for questions, so it's going to have to be a very brief one each.

Mrs Witmer: Thank you very much for being here today. I really appreciate it. I hope you'll extend my best wishes to Mr Brezina. I remember one of my first trips as Minister of Health was up to Halliburton Highlands, and I know that the community has worked extremely hard to provide services.

I guess your concern really demonstrates your fear of this shift of power from voluntary boards to the minister. Would that be the overriding concern you have, and the impact it might have on accessibility to health services?

Mr Sansford: Correct. I've lived and worked in large communities and cities as well as rural parts of this country, and it seems to me that, particularly in rural areas, there is far greater interest and involvement in what happens at the local health care organization. If it becomes merely an extension of the ministry, I think the interest and the input from local people will be lost.

Ms Martel: Thank you for taking the time to come here this morning. Your concerns are not new to us. They've been expressed by every hospital board that's come before us.

Let me ask you something else. The minister gave the committee some indication of the changes that he proposes to make in the accountability section. This was done last Thursday. I'm not sure if you've seen a copy of that document or not, but you can pick up a copy over here.

There are two areas I think I want to highlight for you. One, even though the minister has said that we need to negotiate these agreements, in the changes that he has proposed it's still very clear that the minister, and the minister alone, has the power to continue to issue compliance directives or orders. That doesn't sound like a negotiated settlement to me. Secondly, the minister as well can carry out CEO compensation clawback, which would still put your board in a difficult position of trying to be a master while the minister is also a master. Given that those provisions still remain with respect to the direction the minister now wants to take, does that alleviate your concern at all? Or are you still worried about the sweeping powers of the minister, where he can continue to impose orders and compliance agreements and in fact continue to do a clawback in compensation from your CEO?

Mr Sansford: I think our association, the Ontario Hospital Association, has responded to this as well, and we share and support the view that the proposed amendments don't nearly go far enough to allay our concerns.

Ms Smith: Thank you, Mr Sansford, for being here today. Your community is somewhat like mine of North Bay-Nipissing, a fairly broad area and lots of work to do to provide health care to everyone involved.

I just wanted to make sure that you were aware that the minister made a statement on the first day and has provided an outline of the proposed amendments, were you not?

Mr Sansford: Yes, I was.

Ms Smith: You are aware that the proposed amendments include the fact that the accountability agreements will be between hospital boards and the government, and not the CEO and the government.

Mr Sansford: It would be interesting to see how, from a practical perspective, this will unfold. We're still not satisfied that this is satisfactory or sufficient.

Ms Smith: OK. You made a number of mentions of the BC auditor's report. On what basis do you draw analogies between the BC situation and our own?

Mr Sansford: I think that in some respects British Columbia has gone through similar plans that are being proposed in Ontario. I think we might be able to learn from their experience.

Ms Smith: Are you familiar with the BC legislation that was passed?

Mr Sansford: I'm not entirely familiar with it.

The Chair: Thank you, Mr Sansford.

Ms Smith: It's actually quite different.

The Chair: Thank you, Ms Smith. The point's made.

Thank you for being with us today. I certainly appreciated it.

ONTARIO COUNCIL OF HOSPITAL UNIONS, AREA 3

The Chair: Our next delegation is the Ontario Council of Hospital Unions, area 3; Marc Vaillancourt, who is the vice-president of area 3. Welcome. You have 20 minutes, like everybody else. You can use that any way you see fit.

Mr Marc Vaillancourt: Thank you, Mr Chair. Good morning. My name is Marc Vaillancourt. I work at the Toronto Rehabilitation Institute, where I'm employed as a storesperson. I have been in the hospital for over 17 years. I'm also proud to serve as the president of CUPE local 1156 at Toronto Rehab. I also serve as a vice-president on the Ontario Council of Hospital Unions, representing area 3, which encompasses the greater Toronto area. In this capacity, I represent 9,500 hospital workers, at 13 hospitals, which have a total of 23 different sites. These hospital workers include registered practical nurses, health care aides, housekeepers, dietary staff, maintenance, clerical staff, occupational and physiotherapy aides, and a myriad of other positions—a list far too lengthy to name in the 20 minutes that's allotted.

I would like to preface my remarks on Bill 8 by telling you about the people I represent. Their average age is 49 years old and, on average, they have worked in the health care system for 17 years. Yet all these people, who come from diverse ethnic and cultural backgrounds, different educational levels and very different life experiences, share several common traits.

The first trait that they share is compassion. Our members are compassionate, caring, nurturing human beings. They have to be in order to do the work that they do. We do the work that most Ontarians would consider disgusting and demeaning. Our members are exposed on a daily basis to illness, disease, injuries and death. They work in very difficult conditions and deal with these hardships because the most important thing to the large majority of health care workers is the patients we provide care for.

The second commonality among health care workers is fear. Our members look west to British Columbia and see the devastating effects of Bill 29, which has resulted in the layoffs of over 6,000 qualified, predominantly female health care workers. In addition, another 12,000 positions face being contracted out in the next two years. These positions are being contracted out to multinational corporations that, in turn, offer the jobs at half the wages, with few or no benefits or pensions. This should be considered an affront to all working people in this country.

In recent contract negotiations, the Hospital Employees' Union in British Columbia offered a $3-an-hour wage cut, as well as a week's reduction in vacation, reduced statutory holidays, reduced sick time and other benefit concessions. The concessions were refused by the employers as not cutting deep enough. The wholesale contracting out continues unabated.

Next door to Ontario, the Quebec government, through Bill 27, removed successor rights from unions and made unions illegal in home daycares and in retirement homes. The Quebec government is now in the process of contracting out health care and other public services. Given Premier McGuinty's comments that Ontario and Quebec need to work closer together, we find that it is indeed distressing to our members in Ontario.

This brings us to Bill 8. When Minister Smitherman rose in the House and introduced the bill, he emphasized his government's support for medicare, the Canada Health Act, and for the prohibition of two-tier medicine, extra-billing and user fees. Our members applauded. Indeed, there was a collective sigh of relief the day the Liberals were elected. After years of downsizing through layoffs and attrition, we had hoped that the new government would respond to the wishes of the large majority of Ontarians.

However, when the bill was examined, it revealed several disturbing features. Specifically, I'd like to talk about part III of the bill. The bill spoke about accountability agreements and compliance directives. It gave the Minister of Health and Long-Term Care unprecedented powers. The minister could, in effect, order anybody in the health care system to do anything at any time. That's in section 22. The act gives the minister the power to order material changes to a person's terms of employment, including a reduction or variation in compensation and benefits, to deem that that change is mutually agreed to and remove any rights to payment or compensation. That's in section 27. It also applies, with necessary modification, to a contract or agreement for services: subsection 27(2). Where funding is reduced, varied or discontinued, which, incidentally is the rationale for most health care cuts and layoffs, it is deemed to be mutually agreed to and does not entitle any payment or compensation. That's included in section 28.

Another area of concern is the insulation of the government against any legal challenges or an obligation to provide compensation, as in section 30. All of these sections were interpreted by our legal opinion as having the power to open collective agreements, gut job security provisions and open the doors of Ontario hospitals to the same type of mass layoffs and privatization being suffered in British Columbia and that are planned in Quebec.

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Since the introduction of the bill, Minister Smitherman has been quick to deny that it is the intent of the government to use Bill 8 as a tool that would result in the same type of massive cuts and privatization inflicted in British Columbia. He has been very clear that unions and collective agreements are not to be party to accountability agreements or compliance directives, and that this would be made explicit in the amendments to the bill. In his address to this very committee, the minister said, "... labour unions may tell you that the accountability agreements will allow for opening collective agreements. This bill does not reduce or change any of the protections that currently exist in any of our labour laws. It does not allow anyone subject to an accountability agreement to reopen collective agreements. Unilateral wage rollbacks and unpaid days off might be the record of a previous government, but the suggestion by anyone that Bill 8 enables this is an act of partisan-inspired fiction." The minister has since tabled some potential changes to the bill; however, they won't be released until after this committee ceases public consultation.

Why are the unions and our members still upset? In his address to this committee, the minister said that the bill should not open current collective agreements. Given that all health care collective agreements, never mind what union you're in, are expiring this year, it is hardly the reassurance that we seek.

This government promised to eliminate P3 hospitals, yet delivered instead the same thing that was initiated by the previous government. The only change is that at the end of the lease, or mortgage period as the Liberals prefer to call it, the hospital is not owned by the contractor. Yet hundreds of unionized positions will be contracted out from these two hospitals being built.

This government is using the British model of P3 hospitals. These are hospitals that contain fewer beds and staff. The reason? It costs more to operate. Borrowing

costs for the private sector are higher than those of government, and those costs will be passed on to the taxpayer. With the two current P3 hospitals in Ontario, over $1 billion in Ontario tax dollars will be turned over to transnational corporations. Given that the required profit margin for these corporations can be up to 25% to 30%, are we going to be looking at $250 million to $300 million in Ontario tax dollars being taken by these corporations for profit? There are currently two P3 hospitals planned; however, we have been advised that there are potentially another seven in the works. We have also been advised that future hospitals will be built using the P3 model.

This government promised to eliminate for-profit MRI and CT clinics, yet these are conspicuously missing from Bill 8, a bill that purports to protect a single-tier health care system.

As a member of the Ontario Council of Hospital Unions bargaining team, which was successful in negotiating the first freely negotiated collective agreement in OCHU's 20-year history in 2001, I see Bill 8 as an impetus to the upcoming negotiations. Neither the Ontario Council of Hospital Unions nor the Ontario Hospital Association will be able to bargain freely if the government is lurking in the background, threatening accountability agreements and compliance directives.

Hospital workers have had a difficult time in the past decade. Boy, have we had a difficult time in the past decade. With each fiscal crisis, our numbers drop and our workloads increase. Despite these difficulties, our productivity has increased. We've had to learn to do more with less, yet we still put patient care first.

Our members are aging. They want nothing more than to finish their careers and enjoy their well-deserved retirement with dignity. The sad reality is that health care workers don't believe the reassurances of the minister. Reorganization within the health care system means that the services we are proud to provide are inevitably deemed too expensive. We are told that we provide hotel services and that the health care system can't afford us.

It was less than a year ago that health care workers in Toronto were acclaimed as heroes. It is our concern that Bill 8 is the first step to make us scapegoats for the inability of provincial and federal governments to adequately fund the system that Ontarians hold dear. Thank you.

The Chair: Thank you, sir. You've left us with about two minutes each for questions, starting with Ms Martel.

Ms Martel: Thank you for being here today, I want to focus on compliance directives. You quoted the minister, who said, "It does not allow anyone subject to an accountability agreement to reopen collective agreements." He didn't say anything about compliance directives.

I want to go to the same question that I was pursuing with Mr MacDonald. My concern is that the minister won't have to use a frontal assault through a collective agreement but will in fact use the compliance directives in order to effect change that could be negative for the people you represent. So if the minister says to a hospital, for example, as part of an accountability agreement, "We think you should amalgamate your housekeeping," or "You should contract out housekeeping," your members are going to be affected by that because if the service is contracted out and there are no successor rights—and frankly, even if there are—they may lose their jobs. What do you think about the fact that there is no reference to compliance directives in this, and that impact on trade unions? Are you concerned that in fact by a back door you may lose positions anyway?

Mr Vaillancourt: That is precisely our concern. For the minister to say, "We're not going to force unions to enter into compliance directives, agreements or anything like that," really doesn't mean a lot to us, because we're the ones who provide the front-line service in hospitals. Ultimately anything—a compliance directive that calls for a merger of services or, in the case of BC, calls for financial targets that need to be met, ie, 5% or 10% cutbacks—falls on the back of unionized workers. We are the ones who pay the price.

Just to go back, the minister said that current labour laws protect us, but if we look at what happened in BC and in Quebec, current labour laws can be changed very easily to remove successor rights. We have a majority government. The fact that we're not being directed by the minister directly doesn't mean that we're not going to be affected, because anything that affects health care ultimately trickles down and affects us directly.

Ms Martel: In the hospitals you represent, you would have seen examples already, I suspect, of amalgamations or contracting out of some of these services.

Mr Vaillancourt: Amalgamations, interdepartmental mergers, quality assurance projects. There have been all sorts of things. When we talk about the stress that we've been under—there is no job security in hospitals. We have a collective agreement that gives us, perhaps, five months' notice of a layoff, but if that's an impediment to anything being done, that could be easily removed.

Ms Smith: We heard this morning from Mr MacDonald, who I think works with you. He made some similar points. I had a couple of questions for you. With respect to BC's Bill 29, in what way do you see that as being a mirror image or in some way reflected in Bill 8?

Mr Vaillancourt: I'm not going to go to the point where we're saying Bill 8 and Bill 29 are in essence the same thing, because they're not. What we look to is that British Columbia started this process two years ago. We view Bill 8 as the beginning of the process. We have two of the three largest economies in Canada, coincidentally all with Liberal governments, which are either doing or are in the process of commencing major cutbacks to health care and public service. Our members are the ones who always bear the brunt. You don't hear CEOs saying, "We're going to take a $300,000 pay cut." No. What they do is lay off 10 housekeepers, who make $28,000 or $30,000 a year, in order to achieve those goals.

So the comparison is there not because the bills are similar; obviously they're not. Our concern is, that's the

road that we're heading down. BC is setting up the road map for this government.

Ms Smith: OK. In your presentation, you acknowledge the statement by the minister that Bill 8 does not apply to collective agreements or to trade unions, but you do say in your statement, "All of these sections were interpreted by our legal opinion as having the power to open collective agreements, gut job security provisions and open the doors of Ontario hospitals to the same type of mass layoffs" as BC. Are you referring to the Sack Goldblatt Mitchell legal opinion that Mr Hurley provided to me last week?

Mr Vaillancourt: I am.

Ms Smith: In that legal opinion, I don't see anywhere where it says anything like that. The only references I see are that Bill 8 could potentially extend "to the overriding of collective and other negotiated agreements," and at another point it says, "A trade union, for example, might well qualify under the broad definition of health resource provider, or in any event, could potentially be prescribed as a person or entity required to enter into such an accountability agreement."

Now that you've had these assurances from the minister that they don't apply, does that go some way to quell your fears from this legal opinion you received?

1140

Mr Vaillancourt: Respectfully, I would say the Liberal government told us that P3 hospitals no longer exist, and yet all they did was slightly tweak the agreement; P3 hospitals are in existence. The Liberal government told us that for-profit MRI and CT clinics would be taken out, and yet there's nothing in Bill 8 about that. There's a credibility issue here.

The Chair: Mrs Witmer.

Mrs Witmer: I think we've heard the same type of anxiety and concern from many others who work in the health sector. Health employees seem to be quite distressed about the possible implications, and I guess a lot of it is based on the fact that these changes did happen in BC, even though people were not expecting them and there was no indication. I think you have every reason to be concerned, because we have seen broken promises, and certainly, as you have acknowledged, anything is possible with a majority government.

I guess I would ask, what do you need to see in this bill that would give you the reassurance that this is not going to lead to massive layoffs? What protection do you need in here?

Mr Vaillancourt: It's a good question. I think what we need to see—our concern is that while unions are excluded from the bill—

Mrs Witmer: You are directly, but not indirectly.

Mr Vaillancourt: Directly excluded, but indirectly we bear the brunt of any downsizing, of any reorganization, of any re-engineering that occurs in health care.

Mrs Witmer: That's right.

Mr Vaillancourt: It's the trickle-down theory. It happens all the time. We've lived through it for 10 years. We're sitting here right now looking at a mass exodus of health care workers from the system at the end of 2005, because the pension plan is offering a temporary bridge that expires at the end of 2005. Our concern is that those positions will be lost through attrition. These people go out, and they don't get replaced.

The Chair: Mr Vaillancourt, your time has expired. Thank you for joining us here today. It was appreciated.

DONNA BUCK

The Chair: Our next delegate is Donna Buck. Would you like to come forward and make yourself comfortable?

Ms Donna Buck: I have a few issues I was going to discuss. I didn't realize it was going to be quite so formal.

The Chair: Well, we're not as formal as we might appear. You've got 20 minutes. You can use that 20 minutes any way you see fit. At the end of the formal part of your presentation, we will ask you some questions, and that time will be apportioned among the three parties. If I were you, I'd just relax and tell us what you came here to tell us. It's a quarter to 12, and your time will expire at five minutes after 12.

Ms Buck: Thank you.

The Chair: Thank you, and welcome.

Ms Buck: Government is the pillar of our society, and it creates the infrastructure. It must truly become the force that helps us to understand and regulate how we are cared for.

The things I wanted to discuss would be an increase in the use of holistic health, OHIP billings, more accountability by specialists for services rendered, caffeine's effect on society and control of air pollution. I'm not really certain whether these are under your—

The Chair: It's your 20 minutes, and you can pretty well talk about anything you like, as I understand the rules. But I would concentrate on areas that are directly related to the bill, if you could.

Ms Buck: Do you think any of those relate to the bill?

The Chair: Let's find out. Why don't you start talking, and I'll soon tell you if they don't.

Ms Buck: You can cut me off any time.

The Chair: I probably won't. It's your 20 minutes.

Ms Buck: I would like to suggest that invoices for OHIP billings be sent to every user so they can see the cost of these services, thus making medical costs more transparent. Sending out bills with a list of services rendered and amounts charged enables everyone to judge on a personal note whether the services rendered were worthy of the price charged. If I have no invoice, the service has no defined value, and I may not put a value on it. We'll appreciate the service more.

Also, we may demand more of it. If I went to a doctor's office and was given only five minutes, I may feel that's OK. But if I knew the monetary cost of that visit, I may feel I should have gotten more for the money paid. I would not go to a store and make a purchase without a clue as to the cost. That would be irresponsible.

If everyone knew the cost of their visits, they may feel more accountable in keeping the cost down and we may respect the doctor's advice.

In regard to health care and integrating holistic health into health care, conventional medicine is in a creative double bind, in that only if it feels it knows the cause and effect can it deal with a problem. The problem is, in some realms it is guessed that medicine knows only about 12% of all there is to know about the human body. In emergency situations or very critical situations, conventional medicine reigns supreme. But in less dramatic situations, traditional medicine may be more effective as preventive medicine and when the body needs help in healing itself.

Does conventional medicine feel threatened by the advances of traditional medicine? Two camps: traditional and conventional. Traditional had been in place for many years, then came conventional—for example, surgery, vaccines and pharmaceuticals—which gives much more immediate results. With conventional, everything is immediate. The diagnosis must be evident and the solution quick and visible. The problem is that if a cause-and-effect relationship is not evident, then the problem is a mystery, a diagnosis cannot be made, and nothing can be done.

Traditional is much slower acting, needs more attention paid to the patient and is less invasive. The patient is far more central to the cure. It is time-consuming but cost-effective. Solutions do not always fall into the cause-and-effect mode. Sometimes the solutions are just as mystifying as the workings of a computer.

Whereas conventional medicine may be likened to working with a typewriter, traditional medicine works more like a computer. Push Alt-Delete and something unexpected happens; put pressure under the shoulder blade and a neck muscle relaxes. Reactions happen without there being an evident connection.

A case in point is acupuncture. Meridian points were mapped by the Chinese thousands of years ago and have been found to be miraculous, allowing surgery to be performed without anaesthesia by inserting pins into the body. It wasn't until the 1990s that acupuncture was found to be scientifically plausible. Through intuition, trial and error and hard work, the Chinese were able to plot an electrical energy system of the body. At one time, electricity was seen as mystical, something to be feared, incomprehensible, energy travelling through wires. Now, even though we don't understand it, we don't care; we just know it works. Most of the alternative is unseen and incomprehensible, but it works. It relies on a visceral cause and effect, not a tangible cause and effect.

If traditional medicine can alleviate pain from a person who would otherwise continually suffer from excruciating pain all day long, shouldn't we try to employ it for the sake of those who are suffering? If chiropractic and acupuncture can alleviate the need for someone to undergo the dangers of having their body cut open and fiddled with, which always poses a risk, shouldn't we encourage these alternative solutions? Alternative medicine also advances more measures to help prevent diseases from entrenching themselves in the body.

The Ministry of Health should encourage the use of holistic medicine through offering OHIP coverage for its use, although if government funds it, then all therapies should have their own regulating bodies.

These are a little bit disjointed, but—

The Chair: I'm not finding it disjointed at all. I'm actually enjoying your presentation. Keep going.

1150

Ms Buck: Controlling our environment is very important. Could there be a special department set up that could effectively take down boundaries between ministries and levels of government so that issues such as air pollution, which affect everyone's health, could be fought and alleviated? This department could take measures to increase public transportation, lower car emissions, reduce industrial pollution etc. If one group had one task, maybe it could be achieved.

The next one is completely different: I feel that caffeine is as major a drug and social problem as smoking. I worked for 10 years to get caffeine out of the schools. The furthest I got was for the Toronto Board of Health to do a report on the effect of caffeine on children. Caffeine is now out of our elementary schools. Whereas we all know the effects of the drug caffeine, how could we have allowed it to be sold to our children in the most sacred of institutions, our schools? Nowadays, children are on antidepressants and are suicidal. Could the drug caffeine be part of the problem? Caffeine is known to cause anxiety, sleeplessness and, eventually, depression.

The problem now is that it's still in our high schools. If our kids knew the truth about what colas are doing to them, would they still drink them? We need to be the ones to explain the true effects of caffeine on their bodies now. In fact, do adults truly understand the effect of the drug caffeine?

Another one: I would like to see more accountability and responsibility taken by specialist physicians, just for that fact that if your problem does not register within the narrow confines of their specialty, then you have to go back to your GP and find a new route. This is where I think alternative medicine could be effective, in that it looks at the whole person and can find clues to the root problem of a malady, and then send them to the proper specialist.

That's it.

The Chair: Very good. You did a wonderful job. You've used up about eight minutes, which leaves each party four minutes. I'm going to start the questioning with the government side.

Ms Smith: Thank you, Ms Buck. We really appreciate your being here to provide us with your views on Bill 8 and on health care generally. As you know, we've taken the unusual step of going forward with this legislation to committee after first reading, which will allow for more input and for us to come back with a better piece of legislation, we hope, at the end of the day. We appreciate people like you coming in to provide us with your insights.

One of the things you touched on was a holistic approach to medicine and looking at a broader scope of

medicine. Perhaps you could just elaborate on that for us a bit and how you think we can incorporate that into our health policy.

Ms Buck: I think that in a lot of ways holistic medicine can diagnose and see the whole body, rather than having a specialist who sees one part of your body. But if there is no cause and effect and they can't diagnose it, then it's a mystery, whereas alternatives and holistic would look at the whole body. Sometimes something that's happening here may be caused back here. If somebody could just look at someone's body and say, "Yes, we think it's there, but in fact it's a referral; it's really a problem down here," they could make a decision as to where you have the problem and then go to a specialist, rather than, "You have a pain down here, but really it's part up here." If you go to see that specialist, then they won't be able to find it. If they could get a more holistic view of the body, you would save money, because you wouldn't have people going to one specialist and then another and another, and really the problem is not where they think it is but somewhere else.

Ms Smith: Sure.

I think one of my colleagues has a follow-up on that.

Ms Wynne: Thank you for your presentation. My experience of allopathic, or conventional, medicine is that it's very institutionally based and very reactive. Is that your experience? When you talk about cause and effect, unless we can find the cause, we don't know how to treat.

Ms Buck: It's very scientific. It's like going back to the 19th century. We're still back there with medicine, in that we see it as cause and effect. It's like locomotives: They run this way because we can see there's a cause and effect, therefore we can make them run.

Ms Wynne: And we think we can draw direct lines, right? We think we understand. Do you think that if we could move that institutional base into a more community-based model, the kinds of practices you're talking about would have a better chance of coming to the fore? What we're trying to do is move to a community-based model of health and away from a deeply entrenched institutional model.

Ms Buck: Possibly, yes. When you have a problem, somebody could actually treat a person as a person and find out exactly what the problem is, rather than just analyze them on cause and effect, which is a kind of science that's like a computer. You look at the computer and say, "How does it work?" That's like the body; we only know so much about the body and how it works. We only know so much about the computer and how it works. I think holistic goes more into it.

It's like trial and error. Following the meridians, if you do this—or like homeopathy. If you take one drug and it does something, then you know that's it. It's trial and error, but you don't really know, scientifically, it's right. What is the problem with trial and error? If you can get a solution by trial and error and you've got something that's good and it helps people, then shouldn't that be deemed as fine? We don't understand it.

The Chair: I know you are on a roll, and I hate to cut you off there, but we have to move to the other party. Ms Witmer?

Mrs Witmer: Thank you very much, Ms Buck, for coming and giving us your views on holistic medicine. I think there is certainly lots of information there that people need to continue to consider. I don't have any questions on Bill 8.

The Chair: Mr Arnott, you're fine? Ms Martel.

Ms Martel: I want to thank you for coming and giving us some of your perspectives with respect to health care, particularly your views about alternative and traditional medicine. I don't have any questions with respect to the presentation either, but thank you for taking the time to be here today.

The Chair: Thank you, Ms Buck, for coming today. We do appreciate it. You did wonderfully.

CANADIAN CENTRE FOR POLICY ALTERNATIVES

The Chair: At this point in time we were scheduled to hear from the Canadian Centre for Policy Alternatives. We're not exactly sure if the gentleman is in the room—you would be Armin?

Ms Armine Yalnizyan: I'm Armine, yes.

The Chair: Armine, I'm sorry.

Ms Yalnizyan: It's OK. It's an easy name to get wrong. You wouldn't believe what they do to my name.

The Chair: Well, I'm not even going to try; I'm going to let you introduce yourself for Hansard, if you would. You have 20 minutes, like every other presentation. You can use that any way you like. At the end, we'll apportion the time that is left over amongst the three parties. I've got about two minutes to 12 and the time is all yours.

Ms Yalnizyan: Thank you very much. My name is Armine Yalnizyan. I'm an economist based in Toronto. I'm a research associate with the Canadian Centre for Policy Alternatives, which is based in Ottawa. I am the surprised and honoured first recipient of the Atkinson foundation award for economic justice. I have been using that award to look at health policy reforms in the country.

First of all, I want to applaud the work this committee is trying to do to protect health care. Protecting health care in countries all over the world is the key policy issue right now, and it is a genuine challenge.

I'm not going to read from my text, which I will have distributed. I hope you're interested enough in our exchange to follow the argument and look at it later. I'm not going to vent or dwell overlong on the feelings of Bill 8 as I see them; undoubtedly that will emerge from part of our exchange. I'm going to focus only on the amendments that I think are key to move this bill in the direction that you say you want to go in, which is to protect the future of medicare and block two-tier care, or what I like to identify as the passive-aggressive commercialization of health care.

Yesterday's meeting of provincial premiers and territorial leaders was, how do you say, disheartening.

Premier Klein is still talking about opting out of the Canada Health Act, and the communiqué from all the premiers and territorial leaders announced that they gave medicare and the principles of the Canada Health Act a 10-year prognosis without more massive funds from the feds. This sabre-rattling is not productive, to say the least. It also invokes a feeling of déjà-moo: the feeling that you have heard this bull before.

The principles of medicare are under attack at the moment. You are trying to protect them through this bill. I do not believe this legislation is the key tool for that, but I am going to be focusing on the amendments to ensure progress in that direction. I'm going to point out for you, in very stark terms, why the stakes are so high that you do amend this bill and move in the right direction.

First, where is the pressure on medicare coming from? I believe the pressure is two-fold: first of all, the sustainability argument, where you have costs growing at roughly double the rates of revenue growth for the foreseeable future, and secondly, from waiting lists, that whole sentiment out there that is, "Let me jump to the head of the queue if I can afford to pay for it."

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All of you in this room probably know that in a few months' time at the Supreme Court of Canada, the Chaoulli case will be heard. That will be one of the major tests for whether queue-jumping will be viewed as possible under the Constitution and whether in fact people's right to be able to purchase care when waiting lists are too long is a constitutional violation.

This bill does not deal with the role government can play in containing those costs—the number one cause of the unsustainability—more effectively. It doesn't deal with this government's comparable advantage in the marketplace for health care due to its shear size and its ability to purchase: economies of scale from borrowing funds, necessary capital, investments; its ability to set prices and deals on prices and quantities in drug procurement, but also in quality, for example; and in providing the efficiencies of a single-payer model.

I'm going to focus primarily on part I of this bill, which refers to the health quality council, and part III of this bill, which refers to the accountability principle.

The function of the health quality council is absolutely key and can be amended to make it speak more dramatically to what this government can do to ensure better access to health care.

The monitoring function of the council at the moment includes the ability to collect, use and disclose patient information for reporting purposes. I'm going to suggest to you that you can amend the bill in this section to also include the ability to collect, use and disclose information about how public funds are used in all of our institutions in health care—in hospitals, long-term care, community health centres—to see very clearly how it is that best practices are offered and where the greatest cost-efficiencies are, not just in not-for-profit and for-profit modalities of providing care but who is doing what in the best possible way. When we see how public funds are being used to deliver care, we can then start talking to the public about what are the best modalities of care and where we can achieve real improvements in how we deliver care for the best value for money.

That sort of monitoring function can also show us the degree to which our taxpayer dollars are facilitating the shift toward investor-owned facilities. I think it's absolutely clear that taxpayers are very concerned about their value for money, and they don't want to be spending money on unnecessary things. If we are spending money on profits and shareholder dividends, we want to be able to know to what degree this is increasing or decreasing over time and whether, on net, we are getting better value for money because those facilities are able to give us either greater, faster, cheaper service or a higher quality of care. Right now we are being asked to do this as an article of faith, and I'm asking you to use the council's ability to collect, use and disclose information to help the public understand where we get better value for money.

I also believe that the council's reporting function should be the home of long-term planning on the key things that we can do to reduce waiting lists. There are three key things we can do to reduce waiting lists: We can have a better strategic plan on how we are investing capital; we can have a better strategic plan on how we are preparing for the health human resources shortages that are coming on stream in the next five to 10 years; and we can have a better plan for how we have information flows in the system. We all know that the need for electronic health records is very key, but we really have very poor information flows between different elements of the health care system as it's currently funded. This leads to blockages and unnecessary utilization of acute care, which is the system of last resort of care—our hospitals and emergency rooms. That's being used as our front-line use of care, which is of course the most expensive form of care. The way we are going to shorten waiting lists is by having plans on reducing waiting lists, not simply by declaring that two-tier health care should be blocked with this kind of legislation.

The stakes are incredibly high. There is a lot more money in the system than there was. When the previous government started managing the health care budget, it was spending about $18 billion a year. The previous government poured in new resources toward the end of its mandate. We now spend $28 billion a year, and rising. That's $10 billion more a year, yet waiting lists are more of a problem than ever and the sustainability of the system seems to be genuinely in jeopardy. In addition, we had a health accord between the provinces, territories and the federal government last February. That accord alone guarantees this province will receive $11.3 billion more by 2007-08. So we are talking about many billions more dollars coming to health care. I can tell you that the taxpayers and the general public are very concerned, as are many of the Premiers, that this money is going into a black hole. Why? We don't have a plan on how to use the new money to buy improvements in the system.

Yesterday, our Minister of Health and Long-Term Care, Minister Smitherman, gave the hospitals $385 million more to deal with the deficits in hospitals—with strings attached, he said. There are performance requirements. There is an acknowledgement that they need to reduce waiting times and hire more full-time nurses. I'm asking you, how does this money actually lever waiting times and more nurses? There are no plans on how those people will be hired and what the interim steps will be to reduce waiting times.

This situation leads me directly to the second set of amendments I would propose, which go to part III of the bill, accountability.

Again, what is the plan? Just more money will not do. You need medium- to long-term strategies on public financing of capital expansions, again, with the greatest value for money in mind. You need to improve information flows to minimize the supply blockages in the system; not just electronic health records but more posting of what's going on in the system, who is being moved where, which doctors, which specialists, which institutions have the longest waiting lists, which have the shortest ones, so we can move people more effectively into the appropriate levels of care and to the appropriate caregivers.

We need better training, upgrading, certification and utilization of our team of health care professionals. Right now you have no plan for how you are going to hire 8,000 more nurses, which is what you've said you want to do. This is a problem not just at the Ontario level, this is a national problem.

The real issue of course is not just capital and labour, but technology. That's true in every endeavour of providing a better service, and the technology I have in mind here is how we mix our capital and labour. That technology goes to the heart of primary care reform. We are not using the mix of people we have effectively. We are relying on the most cost-heavy institutions in our system and the most cost-heavy forms of labour, which are our doctors. Doctors are in a global labour shortage right now, as are nurses. Surely we can come up with more strategic ways of using our full-team complement of health human resources.

The system is indeed too expensive and will not be able to continue in the way it is. I guess when the Premiers and the territorial leaders talk about the lack of sustainability, it goes to the heart of how we are using that money. I'm hoping this government will seriously look at the way the public dollars for health care are used and seek to rebalance between the different ways we use health care in that public purse. More money is necessary but it's not the only answer.

I'm reminded of the Rolling Stones line, "You can't always get what you want, but if you try, sometimes you just may find you get what you need." I'm hoping this government will actually try; not just get the service providers to be more accountable and have performance requirements, not just get the federal government to try harder, but itself be more accountable to the public on how public dollars are spent.

The federal government, through the Romanow report, the Kirby report and a new political leadership, has already signalled its desire to work in a more co-operative manner with the provinces and territories, especially on the crucial issue of health care. I point to the national human resources strategy that is underway right now and the common drug review, which are national, not federal, initiatives but are spearheaded by the federal government. Ontario is impeccably poised to play a leadership role to make that co-operation happen in areas that would truly make a difference to the sustainability of public health care.

Let me close by saying that while I applaud this government's stated desire to protect public health care, which I believe is in all of our interests, this legislation falls very far short of that lofty goal. But with strategic planning embedded into this legislation, using the council more effectively and shouldering some of the duty to be accountable to the taxpayers of Ontario, with clear targets for improvement and standards for care, there is much that can be done to protect medicare provisions for today's citizens and for the citizens of tomorrow. Thank you very much.

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The Chair: We're going to start with the official opposition this time. You've got about two and a half minutes, Mrs Witmer.

Mrs Witmer: Thank you very much, Armine. This has been one of the most interesting submissions I have heard in the course of the discussion on Bill 8. I really appreciate the thoroughness of your presentation and also the recommendations you've provided. I found it interesting to hear you speak about the money we had invested in health care. It really was huge, but it was not something we usually heard. We usually heard from the opposition that we weren't spending enough. But I would agree with you that spending is not going to always improve the outcomes for individuals.

Having made this presentation today, what do you see should now happen with Bill 8? You're basically saying that although the government is well-intended and wants to do the right thing, this bill is not going to achieve it. So what should the government do? We have a bill with a preamble, accountability provisions. What to do?

Ms Yalnizyan: Again, I think the three sets of amendments that need to be made are in parts I and III: in part I, that the health quality council be given the explicit duty to collect, use and disclose information about how public money is used in all our facilities, both investor-owned as well as private not-for-profit, so we can see how the money is being used and ensure that the best value for money is taking place; and second, that it is included in here that the monitoring function of the annual reporting function of the council does include and embed long-term strategies for how we are going to finance the necessary expansions.

I think one of the great problems of the previous administration's pouring money into the system was that indeed a lot of money went into private for-profit care

with no indication that we got value for money for that extra expenditure. I would like to see this government take a look and make sure that extra expenditure is merited, in terms of the value for money we get.

I don't see any evidence of that. Romanow called for it. We didn't see any of it in the Romanow procedure. I think this is an opportunity to get the council to have some teeth to say, "Where's that money going? Is it good value for money? Do we revert to a not-for-profit modality, and what are the implications if we do?" and use that for strategic planning.

For example, in a previous presentation I made to the standing committee on finance and economic affairs during the pre-budget consultations, I indicated that if you could go to public financing rather than the P3 modality for funding the necessary capital requirements that the Ontario Hospital Association indicated are up and coming in the next three years, under the most conservative assumptions of what those deals look like, you could be saving the taxpayer money that could then go into training and upgrading nurses. In particular, the 8,000 nurses that you say you want could be achieved in the next eight- to 10-year horizon just from publicly rather than privately financing those initiatives. If we're going to be paying more anyway, why don't we pay to actually get more service, not just more payments to capital?

The Chair: Ms Martel.

Ms Martel: You're making my point; I love this.

Ms Smith: Such a nice segue for you, Shelley.

Ms Martel: Exactly. Here I go. I was going to talk about Romanow, because frankly, through that exercise the private sector did have the opportunity to come forward and provide specific evidence that for-profit health care is cheaper, more cost-effective and gives better health outcomes. I think Romanow was really clear there was no evidence from the private sector that any of that was happening. So I don't see why we would go any further down the road of private sector health care than we already have, which takes me to the bill.

Of course the bill talks in glowing terms about medicare. Who could refuse to deal with the sentiments that are outlined in the preamble? But if you've got a preamble that talks about saving medicare and you have a government that's going down the road of P3 hospitals, private for-profit CAT scan clinics and competitive bidding in home care, I don't see how we're saving taxpayers' dollars, and I don't see how we're using taxpayers' dollars in the best way we could.

Maybe you can comment again, certainly about P3s, because it's interesting that the government talks about public administration, public delivery, but they don't talk about public financing and how important that is. Also, maybe you can comment about competitive bidding in home care or the for-profit MRI and CAT scan clinics. Do you think we should, as the government promised, be moving that technology back into the publicly funded hospital system?

Ms Yalnizyan: I'm not trying to throw cold water on this, but I understand that the government, not just the opposition, is interested in looking at all options for saving health care, and I understand it is trying to make evidence-based decisions. So I would point to the submission I made to the finance and economic affairs committee. I'm happy to submit that to the clerk of the committee and circulate it to the members. It goes in more detail to what you are speaking to, Ms Martel. But I want to indicate that you cannot have a piece of legislation like Bill 8, where you say you want to protect health care and you want greater transparency and accountability, and yet you still keep these P3 deals under wraps. We still don't know what it means to be a mortgager rather than a lessee.

My greatest fear, now that we are mortgagers of these P3 hospitals and still don't know the terms of the agreement, is that we as taxpayers are now liable for repairs and maintenance, right? That's what a mortgager does. A lessee has the lessor do those repairs and maintenance. What's the nature of the deal? Can you please tell us what we've bought into? If those deals have not yet been confirmed, can we, as the public, please have the options you have considered for financing?

In a period where we've got a 45-year low in interest rates and where our public borrowing requirements by this government, thanks to the previous government, have been dropping for the last 10 years, there's no better time to invest publicly, save the taxpayer dollars in unnecessary costs and use those tax savings to actually hire more people, which is the real cause of waiting lists. It isn't just about where we're spending the money but how efficiently we're spending the money. My key concern, as an economist, is that we are getting value for money and that we are not wasting scarce government resources.

The Chair: Ms Smith.

Ms Smith: Thank you, Armine. That was just a fabulous presentation. We really appreciate your being here and bringing your expertise to bear. I want to congratulate you on your award, and we appreciate the Atkinson Foundation's providing us with your time and expertise on health care, which is fabulous.

You talked about the fact that you thought the council should monitor, collect, use and disclose information about how funds are used, and you talked about looking at best practices and finding ways to improve. I agree that's a great strategy. That's what I'm doing in my long-term-care reviews: actually going into the homes, looking at them and figuring out why, with the same funding, some are better run than others. What magic wand are they waving? So I do see your point of view on that.

I also noted your statement about the $10 billion that was added by the previous government with no discernible benefit, no improvement in waiting times. One of the things I did want to ask you about specifically was the accountability agreements in section 3. Do you agree that they will go some way to providing accountability to taxpayers on how our health dollars are spent and will go some way to ensure we have proper spending of our tax dollars, our investment, in health care?

Ms Yalnizyan: Excellent question. The $10 billion: It's easy to point and say, "Why didn't we get a better bang for our buck?" But the system is under huge cost drivers. We spend $2.5 billion in the Ontario drug benefit plan alone, and those costs are outstripping everything else in terms of cost inflation. We buy retail; we don't have a procurement strategy for ODB. There's the common drug review; we're not participating in that at the federal level. Why are we adding drugs? The previous government took a look at three-year price-quantity volume agreements. It was a great initiative; it's fallen in the water. You should re-seize that opportunity to get some kind of control over what you're spending for these drugs, but also make sure the new drugs that are coming on are cost-effective.

Similarly, in the situation of a global shortage of doctors and nurses, you are going to have cost-push. That's just the nature of the game. So are you using doctors and nurses in the most effective way possible, or are there other members of the health team whom you could be using more effectively?

As you pointed out, the same amount of money buys very different types of care in different types of institutions. Can we not look deep into these organizations and see what works best? There is no magic. It's not for-profit or not-for-profit that delivers high-quality health care; it's something about the way these labour and capital inputs provide a better outcome.

With respect to accountability, I believe you cannot force accountability out of your service providers unless you yourself as a government are willing to set standards below which you do not allow service provision to fall. For example, in long-term care we lost our standards on staff-to-patient ratios. We need standards. We need minimum expectations that the taxpayers, who are spending $28 billion a year and more, can rely on: This level of care will be guaranteed. I'm not talking about timeliness; I'm talking about quality of care and that you have clear and explicit goals toward which you want to move.

I don't believe the time issue in waiting lists is the critical issue. I think the issue is access and supply. We are heading toward real shortages in both capital and labour. You need plans on how you are going to address that, and those plans have to be made public: What is your capital financing plan, what is your health human resources financing plan, what is your plan on making the health care industry less of a cottage industry, as Senator Kirby would refer to it, and getting us information-connected in a way that works? There are no plans for any of these things. That's where the accountability comes from.

The Chair: Thank you, Ms Yalnizyan. Unfortunately, you're time has expired, but we did enjoy your presentation and appreciate it.

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YORK CENTRAL HOSPITAL

The Chair: Our next delegation this afternoon is from York Central Hospital. We have with us Jim Kirk, the board chair, and Bruce Harber, the CEO and president. Would you like to come forward and make yourselves comfortable.

Mr Jim Kirk: Thank you, Mr Chairman and members. My name is Jim Kirk, and this Jim Harber, the president and CEO of York Central Hospital.

The Chair: You have 20 minutes. You can use that any way you see fit. At the end of the 20 minutes, we will share the time remaining amongst the three parties to ask you any questions.

Mr Kirk: Thank you. I've had the opportunity to listen, read and, in fact, watch the parliamentary channel over the last couple of days. What I take from that is, what we want to tell you you've already heard several times. But let me tell you, as an overview, that we support the effort being made to find new ways to deliver health care. Yes, we support the health quality council. Yes, we embrace the five key principles of the Canada Health Act. In fact, we emphatically support the principle of accountability and accountability agreements, and perhaps it's no surprise that we support this on the basis of accountability being a two-way street. This is repetitious, but we want you to know this information from the perspective of a medium-sized community hospital in a very high-growth area.

Let me tell you a bit about York Central. It is a community hospital. There are 425 beds. It's in the town of Richmond Hill. The population is about 150,000, but our catchment area takes us well beyond Richmond Hill into parts of Markham, Thornhill, the city of Vaughan, King township and parts of Aurora. The catchment area itself exceeds 350,000 people, and all the concomitant industrial and commercial developments with it. The projections for growth over the next five, 10 and 15 years are similar to what we've experienced in the last 20 years; that is, anywhere from 5% to 8% to 10% growth every year. We see that happening for the foreseeable future. In fact, literally half a mile from our front door we see population growth of another 50,000 to 60,000 in the city of Vaughan.

Why do I bring this up? Well, we think we understand growth, and we think we understand the kind of pressures that are placed on the health care system from growth alone. We're living with it every day. We think we also understand the need, and we agree that we have to find new ways to deliver health care. You may also ask how we maintain composure in the face of this kind of pressure. We stay the course. We do have a mission, we have values, we have a vision, and we embrace it.

We have circulated a package, and you'll see there are three pieces in the document. The first is our formal submission, and you'll see on the first page the hospital's mission, vision and values. We're committed to these. They're shared by everyone at the hospital, and that includes the front-line staff, the administration, the physicians and the hospital board; this is a made-in-York-Central document. This is not boilerplate; it's the underpinning of what we think is our accountability framework. The challenge, of course, in a high-growth

environment is to maintain that mission, the vision and the values.

While you have the package open, I'll point out to you the second document—the documents are divided by blue pages. There's a piece called Bill 8 Background Analysis. This is something we'll be discussing tomorrow night at our board meeting, and will form the basis of our discussion and a subsequent formal response to the standing committee before the deadline.

The third document is an article, "Redefining Accountability in the Healthcare Sector." You'll see it was authored by Bruce Harber and Ted Ball. I think if you have the opportunity to read it, you'll find it, like I did, a very insightful essay on a new approach to accountability.

Also, to take you back to the background analysis, if you look at page 2, you can see in the table a suggestion of where we are today and where we'll be in the future if Bill 8 is implemented without amendment.

I think the unfortunate impact of Bill 8 could be that it could actually move us away from local accountability and away from the best practices and systems designs that are presently espoused by practitioners in that business.

Let me repeat: There's no question in our view that the health care system needs some fundamental change. You'll see on page 1 of this backgrounder, if you just flip back one page, some challenges that all of us are facing: fragmented services, decline in patient and staff satisfaction, serious quality-of-care issues, out-of-control spending, politicization of resource allocations. We believe this is where we need to collectively apply some urgent attention. Without being too dramatic, this is a direct assault on patient care and public interest.

If I can highlight some of the materials in our first document, we welcome and embrace the opportunity to build on the long-standing tradition of accountability, efficiency and innovation. York Central and other hospital organizations in this province have been participating for some time in a balanced-scorecard approach, which is a joint initiative of the OHA and the Ministry of Health and Long-Term Care.

At York Central we have had a tradition of community stewardship and accountability through our board of directors since 1961—in fact, that is before the hospital even existed—and similarly since 1961 with the volunteer association, and also since 1977 with a foundation board of directors who raised incredible sums of money from our community for our health care service. In fact, that organization, the foundation, has raised over $29 million in the last couple of years toward our major expansion and redevelopment project.

We do have some concerns with the Bill 8 provisions. We have generally three themes where we have concerns. One is that the hospital boards need to act in a governance role and not in an advisory capacity. Second, the expectation of boards is that they are independent. That's an essential part of the board's ability to fulfil its mandate of representing a community. Third, as I've said before, accountability needs to be a two-way proposition.

The minister has suggested that the accountability sections of the bill would result in some benefits to the health care system: clear performance targets, greater transparency and accountability, and greater collaboration and sharing of information. Yes, we think that's the intent, but we think there's a disconnect there between the intention and what is actually going to be delivered.

If I can move to our recommended amendments to Bill 8, there are five of them: One is that the hospital accountability agreements need to reflect best practices. There are perspectives that need to be included. That is more than the financing but is also the customer, the process, and the aspect of learning and growth. Accountability agreements should be designed to facilitate problem-solving. The assumption in some other jurisdictions where these agreements are in place is that there is a partnership between government and the service-delivery organizations. We believe that these agreements should be signed off only by the board chair, as the lead of the governors, and the Deputy Minister of Health, as the lead of the ministry.

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Second, we think that the services should be driven by a vision and a mission. As I've mentioned before, our hospital and, I'm sure, all others have that kind of mission and set of values. Accountability agreements should be based on those missions and visions as set out by the board of trustees. The bill, the way it is written, clearly has the potential to put the ministry in the role of system manager instead of system funder, which we fear would facilitate a great deal of control and micromanagement, potentially, through rules and regulations.

Third, local boards should have performance agreements with their CEO. This reflects the high-level accountability agreement the board would sign with the ministry, and in particular the outcomes that are required by the hospital organization.

Fourth, an appeal mechanism should be included in the bill so that, where the board is not satisfied that their case is being heard or understood by the ministry, there is an opportunity to take those concerns to the next level.

Fifth, Bill 8 must specifically include a reference to the minister's obligation to act in the public interest. As it is currently written, we think Bill 8 could enable the minister to issue compliance directives without necessarily considering the public interest. If not amended, this bill could undermine public confidence in the goodwill and responsiveness of government and the health system.

From our experience, communities in the past have taken ownership of their hospitals. The board of trustees is accountable to both the community and the province as the principle funding source. In governing the hospital, the board reflects the particular needs of the community. Without the ability to govern, as opposed to advise, trustees—volunteers—may well question their relevance in the system. Similarly, foundations and volunteer association boards, who raise incredible sums of money in their communities and have direct contacts back to their communities, may question their ability to continue

raising funds, knowing that the ministry or the minister can, at any time, change accountability expectations and services at the hospital.

Mr Minister, this is not a criticism of previous governments, but an observation that one of the refreshing aspects of a change in government is a renewed interest in getting on with the job at hand, being more collegial, more mutually respectful. We encourage the minister and his staff to follow the lead of our Premier and work to continue this collaboration and mutual respect.

I think you've been given this before, but I do find some comfort in an excerpt from the speech from the throne in November: "Your new government understands it can only hold others to a higher standard if it subjects itself to the same standard." I think that is heartening. The will is there. Certainly we want to be a participant in improving this bill.

Despite all of this whinging, we are grateful for the opportunity to participate in this initiative. We are grateful that the government is trying to do something about health care delivery. While we do take issue with parts of Bill 8, we are heartened by the efforts to date.

One last item: We do, of course, support all the recommendations and comments from the OHA. Those are my remarks.

The Chair: That's wonderful. Thank you, Mr Kirk. You've left about a minute for each of the parties to ask you one brief question.

Ms Martel: Thank you for being here today. Let me ask, if the bill with amendments still says that the minister can issue compliance directives, or orders, will that satisfy your concerns?

Mr Kirk: Sorry, I don't understand.

Ms Martel: The minister gave us some indication that he's going to be changing particularly the accountability agreements, so that they'll be negotiated, but in the framework that we've seen for changes it still says that the minister has to consider some representation etc before issuing compliance directives or orders. So if the minister still has that capacity to do that unilaterally, will your concerns as a board, particularly a voluntary board, be resolved, be addressed?

Mr Kirk: In fairness, I have to say changes on the fly are difficult to absorb and digest, to really come up with a reasoned response. I think it was Ms Witmer who suggested the other day that maybe this ought to have been a white paper so that there could have been more discussion and more dialogue. I share that view. It seems encouraging; the minister is prepared to make change. But I feel we all have to take a pause and consider these together and make sure that one proposal is not affecting another. I'm generally encouraged that the government is prepared to review this and make changes.

Ms Smith: Thank you, sir. I appreciate your presentation today, and the background information that you've provided is very helpful. You are aware that negotiations have been ongoing with the OHA for the past few months with respect to changes to this legislation, are you not?

Mr Kirk: Yes, I am.

Ms Smith: So you wouldn't actually suggest that the proposed amendments that we're talking about have been created on the fly, would you?

Mr Kirk: It has that appearance when we see it being presented through the press.

Ms Smith: But you do acknowledge that discussions have been ongoing for the past few months.

Mr Kirk: Oh, yes.

Ms Smith: And you're aware that the proposed amendments include the fact that the accountability agreements will be between the boards and the ministry, not the CEOs and the ministry.

Mr Kirk: Yes, I am. We don't know the details of those agreements, but—

Ms Smith: But you know that's the intention of the amendment.

Mr Kirk: Yes.

Ms Smith: And then the expectation would be, as you propose in your changes, that a performance agreement would be entered into between a CEO and the hospital board itself.

Mr Kirk: That's right.

Ms Smith: I take it you don't have any real concerns about accountability agreements in general between hospital boards and the Ministry of Health?

Mr Kirk: Not at all. In fact, Mr Harber's predecessor had a balanced-scorecard agreement with the board, and we are working on one with Mr Harber. It is a two-way proposition. We have expectations of the CEO to deliver, and similarly the CEO has expectations and commitments from the board to deliver so that the job can be done. If either party doesn't deliver, then the expectations change.

Ms Smith: Right. Given the proposed structure in the amendments, do you think that in any way jeopardizes your foundations or volunteer associations?

Mr Kirk: With the amendments?

Ms Smith: Yes.

Mr Kirk: As I say, I'd have to think about it. I don't think it does, no.

Mrs Witmer: Thank you very much for your presentation. Despite the last question about, "Would this jeopardize your board or your foundation?" there was the suggestion made yesterday by one of the presenters, I think Mr Watts, who said, "Perhaps this is a Trojan horse," and something to the effect that perhaps at the end of the day this is an attempt to change the governance structures and give the power to the minister and no longer the voluntary boards.

Until I see the amendments, I have to tell you, I am not reassured that this bill is not going to take away some of the power that the boards presently have. At the end of the day they may well become simply advisory boards. I don't know if you have any comment, but I am concerned.

Mr Kirk: As I said in my formal remarks, I appreciate the intent that the minister has explained. We're concerned that the document is not going to deliver on the

intent. Not only do we have a concern about accountability, but similarly clarity, to use the word, and everyone's looking for that. The more the government can incorporate into the bill, the better it is for everyone to understand.

Mrs Witmer: Thank you very much.

Again, Mr Chair, I would encourage the government to come forward as quickly as possible with actual amendments in order that we can give some reassurance to those who have been making representation to us.

The Chair: Thank you, Mr Kirk and Mr Harber, for coming forward today. We do appreciate it.

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SMITHSONIAN GROUP INC

The Chair: Our final group before the afternoon recess is the Smithsonian Group, Alan Smithson, the president. Have a seat and make yourself comfortable. You've got 20 minutes, the same as everybody else has here today, and you can use that any way you see fit. Any time remaining at the end of the presentation will be split amongst the three parties.

Mr Alan Smithson: Good afternoon to each and every one of you. My name is Alan Smithson. It's my privilege to serve as the president and CEO of Smithsonian Group Inc and represent the Canadian Pre-Paid Medical Plan on behalf of our clients, the physicians and patients of Ontario. I'm grateful for this opportunity to share some of our concerns regarding Bill 8, specifically section 16, the section on block fees.

I'm just going to branch away from my formal speech for one second because I realize that the OMA presented, I believe this morning, some information on block fees, as well as the Coalition of Family Physicians of Ontario, so I will just acknowledge that.

Before I get into this, I would like to tell you about Smithsonian Group and the Canadian Pre-Paid Medical Plan. Founded in 2003, Smithsonian Group Inc has created a service that provides a standardization of sorts to the uninsured side of medical care in Canada. Until now, physicians were given guidelines as to what they can and cannot charge for services that fall outside of the provincial formularies. Although the College of Physicians and Surgeons of Ontario does a great job ensuring proper ethical guidelines are in place, most physicians, in our experience, do not use these guidelines to create a fair and unbiased approach to billing patients for uninsured services. Many physicians simply lack written procedures and protocols to manage these extra services. This leads some physicians to reduce and eliminate many services provided to patients because there is no system in place to be compensated for such. It is important to note that the CPSO, or the college, has kept a very close eye on block fees, and thus far both patients and physicians are happy with the results.

With the shortage of primary care physicians in Ontario, it is important that three things happen: (1) that we keep the physicians we currently have, (2) that we create a reason for graduating physicians to choose the specialty of comprehensive family practice over other specialties and (3) that we maximize the efficiency of the physicians and their practices.

All of these objectives must be done while appealing to the patients that the system serves. We feel that through the practice of block fees or annual fee programs physicians are better able to maintain a high level of service while being compensated for such. Patients also benefit from this system because it ensures that the services they require will still be provided and allows them to budget for a once-per-year fee for any service that may be levied in their doctor's office. Block fees allow everyone involved to benefit, including the provincial insurance program.

This is our formal submission. Under section 16 of the first reading of Bill 8, November 27, 2003, the following rules have been tabled. I'm going to read them out for the benefit of the viewers.

"16(1) Except as provided for in the regulations, no person or entity shall charge a block or annual fee.

"(2) A physician, practitioner or hospital shall not refuse to render an insured service to an insured person or refuse to continue rendering insured services to an insured person for any reason relating to an insured person's choice not to pay a block or annual fee.

"(3) For the purposes of this section, the Lieutenant Governor in Council may make regulations governing block or annual fees, including the circumstances under which they may be charged and the information that must be provided to the person who is charged, but may not regulate the amount of such a fee."

Ladies and gentlemen, point three is the reason I'm standing before you today. My clients, both physicians and patients, feel that bestowing power to regulate the rules under which physicians practise block fees to the Lieutenant Governor in Council is unnecessary and unwarranted. Currently, OHIP compensates physicians for approximately 98% of all services provided to Ontario patients. The remaining 2% fall under the category of uninsured services. Examples of these services include sick and back-to-work notes, insurance and third-party form completion, cosmetic procedures and third-party physical examinations. All of these services have been deemed medically unnecessary.

Physicians may charge their patients for these services through two means: (1) they can charge for each service individually or (2) they can charge an annual or block fee.

Because OHIP does not reimburse physicians for these services, neither the Lieutenant Governor in Council nor any elected official should have the right to dictate how physicians collect payment for these services. It is the opinion of Smithsonian Group Inc, the Ontario Medical Association, the Coalition of Family Physicians of Ontario and our clients—both physicians and patients—that the system of regulating block fees shall remain within the power of the College of Physicians and Surgeons of Ontario and not with the Lieutenant Governor in Council.

Until now, the college has been the self-regulating body for the conduct of physicians and surgeons in Ontario with regard to matters of financial, ethical, legal and medical practices. History shows us that physicians have adhered to the codes conferred upon them from the college, with very few exceptions. This system has been successful thus far. What Bill 8 is proposing is to take the responsibility away from the physicians and give it to individuals who may not be as adept at making medically related decisions.

Subsection 16(2) of Bill 8 suggests that physicians may not give preferential treatment to one patient over another on the basis of the block fee. I believe all of you would agree with this: This cannot happen. In its current form of governing block fees, this problem is dealt with swiftly and effectively by the college. It would seem illogical to create a department in government to try to deal with patient and physician complaints and issues surrounding block fees when the college is doing an effective job now.

In summary, Smithsonian Group Inc, the Ontario Medical Association, the Coalition of Family Physicians of Ontario, Ontario physicians and patients whom we have contacted feel that the proposed legislation of Bill 8, section 16, is unnecessary, and that the current method of governing block or annual fees requires no change. By passing Bill 8 in its current form, it is felt that you may undermine the authority of the College of Physicians and Surgeons of Ontario and the relationship it has with the patients of Ontario.

This is the reason it was important for me to appear before you today to express the opinions of all our clients. I trust that an amendment to Bill 8 will reflect the best interests of all Ontario residents and the health care providers who service them. Thank you.

The Chair: Thank you, Mr Smithson. You've left each party just under five minutes each for questions, starting with Ms Smith.

Ms Smith: Thanks for your presentation today. I had a number of questions about exactly your role in the block fee structure. Approximately how many physicians do you have as clients?

Mr Smithson: We have 10 physicians right now.

Ms Smith: Approximately how many patient clients would you have?

Mr Smithson: It's about 10,000 patients that we service.

Ms Smith: OK. You talk about the fact that the physicians are governed by the College of Physicians and Surgeons of Ontario. I just wonder where you fit into that scheme. If the physician is responding directly to the college if there's a problem, where does your company fit in?

Mr Smithson: What we do is try to standardize each physician. I don't know if any of you have been to your physician recently to get uninsured services, but the rates for things are not carved in stone. There are no regulations of the rates that physicians can charge. The OMA does give guidelines, and they have a section that they hand out to the physicians based on what their recommended prices are. We do follow the OMA guidelines, thus standardizing what every physician charges.

I was recently in an office with three physicians. One of them was charging $40 for a driver's medical; the other was charging $140 in the same office. That kind of discrepancy leads Ontario patients to be wary of why they're being charged for these services and what they could be charged in the future. We act to standardize that.

To answer your question, we follow the college's guidelines to a T. We try to follow the most ethical way to do this. I have read reports of physicians saying that they're going to exclude a patient from the practice based on their decision not to go with the block fee. We find that this practice needs to be punished or dealt with by the college in maybe a little bit more effective manner. These complaints do go before the college's board. If we hear of physicians who are doing such, we make recommendations to them that they adhere to this. There are a number of physicians we've met with who aren't adhering to the college's guidelines, which we give them a copy of. They may just be unaware of such. The college's guidelines are under review right now.

Ms Smith: Right, but the agreement that you have with the patient is an agreement between yourself and the patient, is that correct?

Mr Smithson: It's not. It's actually an agreement between them and their physician. What we do is organize and standardize it for the physician. We send it out on behalf of the physician, but the agreement is with the physician and the patient.

Ms Smith: Who collects the block fee in that case?

Mr Smithson: We do. We have two options that the physician can do. We can do the block fee for them, in which case we collect the money for them. We deal with all the processing and payments so that they can focus on the practice at hand.

Ms Smith: How are you paid in that system?

Mr Smithson: We're paid a percentage of the block fee, and we're paid up front.

Ms Smith: "Paid up front" meaning—

Mr Smithson: The physicians pay us a certain amount up front to implement their block fee and organize their uninsured service side of things.

Ms Smith: What would an average block fee be for a family of four?

Mr Smithson: A family of four? Two hundred and fifty dollars.

Ms Smith: I take it, in your structure, they pay the $250 annually. It doesn't matter how many services they use in that year. If they use no services, there is no reimbursement of that $250.

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Mr Smithson: Absolutely correct. That's the whole idea of a block fee, that you're paying for services up front even if you don't use them. It's similar to an insurance program, only it's provided to you from your physician.

Ms Smith: Have you had any discussions with the College of Physicians and Surgeons of Ontario? Because if the agreement is between the physician and the patient but you're doing the collecting and doing the drafting, I would suspect that somehow in there the college would want to get involved if there's a problem.

Mr Smithson: You would think so. We have been in touch with the college and we have run all of our materials by them. The college acts on a complaint basis, so they will not give you information regarding what you've already done until there is a formal complaint, which we have not had yet.

Ms Smith: You did say at one point, "Patients also benefit from this system because it ensures that the services they require will still be provided," That would seem to somehow indicate to me that you think the services they are being provided may not be in the future if these kinds of block fee systems are not in place. On what basis do you make that statement?

Mr Smithson: How many of your family physicians here provide—and I'm going to pose this question to all of you—telephone prescription repeats or fax repeats by phone?

Ms Wynne: Mine does.

Mr Smithson: Yours does? There are a number of physicians who, in place of doing that, have said, "No, we're not going to provide these services any more. We're not going to take your telephone calls. We're not going to take messages. We're not going to return your calls. We're not going to do sick notes or passports." So by them not being compensated for such, they've said, "Instead of billing the patients, we'd rather just not provide the service." And that's what we're seeing all over Ontario.

Mr Arnott: Thank you very much, Mr Smithson. I found your presentation very interesting. I wasn't aware that there was a company like yours in existence providing this service for doctors. I think it's probably something that most of the committee members aren't aware of as well, so I think your presentation here today was very helpful. I would agree with you completely in the sense of your statement that we need to keep the physicians we have. Physician retention has to be a high priority. We need to create a reason for graduating doctors to choose the specialty of comprehensive family practice. Certainly that's something that I would agree with and we need to maximize the efficiencies of physicians in their practices.

I had a question which you answered in your presentation. I was wondering how much of the overall billings of doctors was covered by OHIP.

Mr Smithson: It is less than 2%.

Mr Arnott: About 2% is the uninsured services they provide. So that's an interesting juxtaposition of facts.

Mr Smithson: The other part of what we do is we help to educate the Ontario public—I would say the Ontario public, but the Canadian public in general—as to what is and what is not covered. Every patient we represent, that we send information to, gets a comprehensive patient information package which explains to them each service, why they're being charged for such and the prices for such according to the OMA guidelines.

Mr Arnott: You've said quite clearly that the College of Physicians and Surgeons is, in your opinion, doing quite a good job of regulating block fees.

Mr Smithson: For the most part.

Mr Arnott: Why do you suppose the government feels that it's necessary to take action in this respect with Bill 8?

Mr Smithson: I refer back to—give me two seconds here. The Ontario Health Coalition is opposed to block fee charges, and their only research has been articles that they've read in the Globe and Mail. That is probably why this has been tabled, because our media do have a lot to do with the policies we create.

Having said that, there are thousands of physicians in Ontario. Out of the thousands of family care physicians, two of them not abiding by the college's regulations do not represent a reason to strike down or to amend a current issue that's there. The reason the college is involved is that they are the regulating body behind the physicians. Whether it be services that are provided under the OHIP umbrella or outside of it, their conduct is representative from the college.

Mr Arnott: The Minister of Health, at the outset of these hearings, announced a statement of intent in terms of bringing forward amendments. Do any of those amendments—

Mr Smithson: I do have those amendments. Section 16 is not addressed in those amendments. What we would like to see ultimately is the section on block fees left exactly as it is, with the only change being: "the College of Physicians and Surgeons may make regulations governing," instead of, "the Lieutenant Governor in Council may make regulations governing," That's the only change we would make. Leave the structure of block fees within the college.

Ms Martel: Thank you for being here today. It wasn't only the Ontario Health Coalition who told us they had a problem with block fees. On Monday we had a presentation from the Medical Reform Group, who also represent primarily family physicians in Ontario, who in no uncertain terms said we should get rid of block fees.

Mr Smithson: What was their rationale, if you don't mind my asking?

Ms Martel: They felt that in a time of underservice, of a great lack of physicians in Ontario, most patients would feel that if they didn't pay the block fee, they weren't going to get any medical service; and secondly, that there is a discrepancy in what is being charged—you pointed out that, in the same practice, you went from a charge of $40 to $140 for the same service. There was one other that was a very good rationale in terms of why they, primarily as a group of family physicians also operating in Ontario, thought this should be done away with.

In that respect, I look at your own presentation, and here's one of your lines: "Although the College of Physicians and Surgeons of Ontario does a great job at

ensuring proper, ethical guidelines are in place, most physicians do not use these guidelines to create a fair and unbiased approach to billing patients for uninsured services." I'm not sure what you meant by that. I think I also heard you say the college needs to deal with these concerns in a more appropriate manner. So after I listen to you, I have some concerns about what seems to be a contradiction in your own presentation to us about physicians essentially having much different approaches to block fees and your concerns about that, and concerns about the college not responding in an appropriate manner to deal with that.

Mr Smithson: You put me on the spot here.

Ms Martel: I didn't mean to.

Mr Smithson: The college does have guidelines there. They have the means to enforce them, and they do enforce them to the best of their ability. Having said that, there are a number of instances I can point out where physicians are simply not following them, maybe because they don't know about them, maybe because there are not enough people watching it. If the Lieutenant Governor in Council is going to take control over how block fees are run, I think more specific rules and regulations as to what the Lieutenant Governor in Council will do with that need to be tabled. Either leave it in the hands of the college or at least make it clear. It says here: "the Lieutenant Governor in Council may make regulations governing block fees, including the circumstances under which they may be charged and the information that must be provided." That leaves the door open for them to do pretty much anything.

Ms Martel: When you say you have examples of physicians not following the guidelines, what do you mean? Do you mean they're charging over what the guidelines say?

Mr Smithson: There are no guidelines with regard to prices. Bill 8 does not discuss the price guidelines. It says right there: "may not regulate the amount of such a fee." So physicians can charge whatever they want for whatever service falls outside OHIP.

Ms Martel: OK. So what does the College of Physicians and Surgeons and the OMA give, then? We heard from the OMA this morning that they have guidelines too. What does that mean? Are they giving physicians a suggested price list for these services? Is that what it is?

Mr Smithson: The college, no, but the OMA does have a suggested price list for services outside OHIP, and physicians who are running block fees sometimes follow it and sometimes don't.

Ms Martel: In your experience, are they above?

Mr Smithson: No, usually below. It depends on the physician's office.

Ms Martel: How do you explain a gap of $40 to $140 in the same office for the same service?

Mr Smithson: I cannot explain that.

I don't want to say too much with regard to what the physicians are doing, but I know that some physicians are billing the government for physicals that are third-party or outside OHIP. So if somebody comes in for a third-party physical, rather than charge the patient, which they're not comfortable with, they bill it to OHIP and then charge the patient the difference for the form. That does contravene the OHIP guidelines. So those rules are all over the board; what the physicians are doing is all over the board.

Ms Martel: If I can just go back to your statement, when you made reference to the College of Physicians and Surgeons and talked about ethical guidelines, what kind of guidelines were you talking about? My assumption was that you were talking about pricing guidelines, but what is that?

Mr Smithson: The guidelines are actually in the OMA's report on page 31. It does have an example of their guidelines and their policy in place there. What it states is: "the patient must be advised of the amount of the ... charges," and they don't give an example of an amount. The patient must be given the option to pay individually or pay the block fee; it's not a comprehensive" You have to pay or leave." "The decision as to whether or not to elect this form of payment must be the patient's" and not the physician's, and the patient must be given a copy of the block fee rules, so the patient knows. These are all done through our program, but not necessarily done at the individual level of the physician.

The Chair: Thank you, Mr Smithson.

We're recessed until 2 o'clock.

Before we go, for those members of the committee who are going to be joining us in Niagara Falls tomorrow, the bus will leave from the south doors at 7:45 am, and we'll have a brief stop in Oakville.

The committee recessed from 1302 to 1403.

MARC SIMBROW

The Chair: We can call the committee back to order again. It's a few minutes after 2. Our next delegation is Mr Mark Simbrow. Would you like to come forward, sir, and make yourself comfortable, or as comfortable as you can be with that thing. You've got 20 minutes, and you can use that time any way you see fit. Any time left over after the presentation will be split among the three parties to ask you any questions they may have. The time is 2:04.

Mr Marc Simbrow: Thank you kindly. I would like to thank you for giving me the chance to speak to the standing committee on justice and social policy. It is an honour to participate in open government to express my views on Bill 8.

I agree that all Ontarians should be treated equally and that we must have equal access to health care. I have seen the nurses in Ontario under the last government. By cutting back in health care, both the nurses and doctors were hurting. Nurses play a very important part in health care. They work so hard and are very dedicated. Bill 8 is a positive step in health care. I have seen the nurses today. They are positive and happy, and believe that change is coming in the system for the betterment of this province. Honourable members, nurses are at the first forefront of health care.

Living in Toronto, we have good-quality health care. However, when you are in northern Ontario, like Moose Factory or other parts of this great province of ours, we must also encourage that there be nurse practitioners to assist doctors in remote areas. Midwives are also very important in the assistance of patients, and this acts as another access.

For patients in chronic care, we must assist families in every way possible.

For the future of health care, chiropractors should be covered by OHIP. Chiropractic care has helped with fewer hospitalizations and a highly significant reduction in chronic problems, as well as in levels and duration of disability. For the future of health care, not only should podiatrists, osteopaths and physiotherapists be included in OHIP but also ambulance drivers, with the new title of paramedics. We must seek alternatives to include them.

Access to publicly funded health care is a fundamental part of the Canadian social fabric. Ontario must not have a two-tier health care system. We need a health care system which is fair and just for every Ontarian.

Once again I would like to state that nurses are starting to believe in Ontario, and they are providing a vital service. Where would we be without them? We should hire more nurses and doctors, as well as nurse practitioners, all over the province of Ontario and not only in remote areas. By hiring more nurses, doctors and nurse practitioners, we will cut the wait in emergency rooms.

Also, for optometrists the system has not changed since 1990. If you are a senior citizen, you may have an appointment every year, while if you are aged zero to 60, you must wait every two years. This part of the bill should be amended so that every Ontarian is able to see their optometrist every year.

Let's look at naturopaths and let's look at other alternatives that will help to bring them into OHIP. Let Ontario be a shining example for the rest of Canada. Thank you kindly.

The Chair: You have used only about six minutes, which actually leaves us between four and five minutes per party to ask you some questions, if you don't mind answering them.

Mr Simbrow: I'm going to have some difficulties in pouring water.

The Chair: OK, maybe we can have someone help you. We're a full-service committee here. Let's start with Mr Arnott.

Mr Arnott: Thank you very much for your presentation this afternoon. When we do public hearings on bills, as a committee we certainly appreciate the input we receive. Quite often, the committee lineup is mostly interest groups and organizations that have a particular perspective they wish to offer, but I think it's always helpful when the average citizen takes advantage of the opportunity to come in and talk to a committee like this as well. Certainly you've articulated a lot of good suggestions for the government of Ontario, and I know it's appreciated by all of us, so thank you very much for coming today.

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Ms Martel: Thank you for coming today to make the presentation. You raise some concerns we have heard before, particularly with respect to regulated health professionals whose fees are not fully covered by OHIP, for example physiotherapists and chiropractors. Certainly the concern has been raised with the committee by representatives from those groups, but also by others who use their services, that it can be cost-prohibitive to use these health care professionals, depending on what the fee is in addition to the OHIP billing. If you're going to a chiropractor, for example, and you're paying $15 or $20 out of your own pocket, for many people that is cost-prohibitive.

That's a difficult issue in that if you go to full funding of those services through OHIP, how much would that cost the system? I suspect it would cost a fair bit, but I suspect that on the other end there would be some cost savings for people using those health care professionals who then might not have to have surgery or more costly intervention in the long run.

So you're concerned about having these services covered, I think primarily a concern due to cost, and how much it costs people to pay for that is a very valid concern. The committee will certainly consider if that's something that can possibly be done.

Mr Simbrow: Ms Martel, I'm sure you have the latest study of the Ontario Magna report.

Ms Martel: No, I don't.

Mr Simbrow: You don't? That's where this comes out for chiropractic care—very important.

Ms Martel: Thank you.

The Chair: Ms Smith isn't here. Ms Wynne?

Ms Wynne: Mr Simbrow, thank you very much for coming down today, and thank you for acknowledging the open process we're engaged in. Indeed, this bill is coming out to committee after first reading, which allows input at a very early stage. We appreciate your taking part in that, and there will be other opportunities for consultation.

I wanted to pick up on your comment about nurses and the need for more nurses in the system. I don't know if you were able to hear or get a copy of Minister Smitherman's comments yesterday about money that is going to flow into the health care system. Did you hear his speech?

Mr Simbrow: As a matter of fact, I did, and I'm very pleased by the honourable member.

Ms Wynne: Good. So you're supportive of this direction, where we would say, "This is our target. We want the money spent in this way, and we're going to hold the institutions accountable." You're supportive of that?

Mr Simbrow: For sure. Yesterday, when I was in the hospital, I could even hear the nurses, and they were really talking positively.

Ms Wynne: That is very good feedback. Thank you.

Mr Simbrow: Where before the nurses were saying, "I want to leave Ontario," today they're starting to really

feel positive. They feel they are in the system and that change is coming, and they believe. That's very important.

Ms Wynne: So they heard our message loud and clear that we were supportive of them.

Mr Simbrow: Yes, and they believe in it.

Ms Wynne: That's great. Thank you for that feedback, and thank you for coming today.

The Chair: Thank you, Mr Simbrow. Are there any further questions from the government side? There being none, I'd like to thank you for coming.

Mr Simbrow: Thank you kindly, Mr Chairman.

The Chair: No problem. It's still your 20 minutes. You can sit and drink your water if you'd like to.

Mr Simbrow: No, that'll be fine. Might I tell you, the hockey game was good. I got the guy, but I don't know if I'm good enough for the Toronto Maple Leafs.

The Chair: OK. Thank you.

SCARBOROUGH HOSPITAL

The Chair: If our next delegation could start to prepare to come forward, we're going to hear from Scarborough Hospital. It's Terry Brazill, the board chair, and Gary Johnson. Please be seated. Make yourself comfortable. You've got 20 minutes to use as you see fit. At the end of your presentation, if there's any time left over, we'll try and split it proportionally among the three parties to ask you any questions. I've got 2:15, and you've got the floor.

Mr Terry Brazill: Good afternoon, Mr Chair and members of the committee. My name is Terry Brazill. I'm the chair of the board of directors of the Scarborough Hospital. To my right is Gary Johnson. Gary's the vice-chair of the board.

We're pleased to have this opportunity to appear before the standing committee on justice and social policy as it considers Bill 8, the Commitment to the Future of Medicare Act.

For those members of the committee who are not familiar with the Scarborough Hospital, let me tell you a little bit about us. The Scarborough Hospital is one of the largest and busiest community hospitals in Ontario. The hospital was created in 1999 and continues the legacy of care of its two founding hospitals, Scarborough General Hospital and the Salvation Army Scarborough Grace Hospital. Today, the hospital serves the very real and evolving health and wellness needs of a very large, diverse and high-need community. The population in the hospital's primary catchment area, Scarborough and the southern part of York region, is close to one million people. It continues to grow at a significant rate. Our mission is to provide excellent patient care, promote health and improve the quality of life. We deliver a broad range of emergency, ambulatory and inpatient care, along with services that reach out to our community. We foster research and education that enhances health care delivery. At the Scarborough Hospital, care is provided to more than 300,000 people every year. Our emergency department is the busiest in the greater Toronto area, serving over 101,000 patients. If one of you were to get sick today, there's a one-in-three chance that you'd end up at our hospital.

We applaud the government's commitment to seek innovative solutions to delivering cost-effective, accessible and high-quality health care, and we firmly believe in the need to protect essential health care services, in particular by making that system sustainable financially. We recognize the importance that the people of Ontario and the members of our community place on accessible health care. We support the need to preserve the principle that Ontarians should have access to medically necessary health care services based on need, not on their ability to pay.

The minister has proposed, and we support, a number of amendments to Bill 8. We remain concerned, however, about the applicability of the accountability agreements contemplated in the bill, which we believe could undermine the government's intent with respect to this legislation.

In this regard, we echo and support the positions that have been put forward to the ministry and this committee by the Ontario Hospital Association. Bill 8 must support the role of independent voluntary boards and the voluntary governance structure at hospitals. This is the cornerstone of the public hospital system in Ontario. We agree and we accept our accountability for the prudent, efficient and transparent management of public funds. We take this seriously and we in Scarborough believe we do it well.

The minister has publicly acknowledged that boards have a tremendous responsibility and are entrusted with ensuring high-quality care for the people they serve. We wish to confirm our support for the proposed amendment to subsection 21(2), which would maintain the independence of the governance structure by requiring accountability agreements between the ministry and the hospital. However, accountability agreements must be custom-made and tailored to the unique needs of each hospital and the communities they serve. A cookie-cutter approach for the implementation of accountability agreements will simply not work. Not only would this not achieve enhanced accountability in the system, it could effectively silence the voice of the community in determining service outcomes and ensuring quality care. This will have an adverse impact on health services and patient care in our community and other communities across the province. Let me explain.

Our board of directors is comprised of dedicated, committed members of the community who volunteer thousands of hours annually to the hospital. We are the voice, the face, of the community we serve, a community that often struggles to be heard. A couple of examples will demonstrate how this works in practice.

First, our community has demonstrated tremendous support and gratitude for our work during SARS. We were there when we were needed most and at a time when many others were not. Our SARS experience high-

lighted the community's strong desire and need for local leaders to provide local decisions. Our board of directors played a critical role in providing support to management and in ensuring that the community's broader health care needs were not compromised.

Second, when our community told us they needed access to care for the uninsured, we listened. One of our physicians, Dr Paul Caulford, was recently recognized for establishing an urban outreach health clinic which provides access to care for people who don't have health insurance. Without our hospital, it is conceivable that these voices would not have been heard and access to these much-needed services would not have been possible.

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Our board members are passionate about ensuring that our hospital provides the best possible health care to our patients and their families. Just ask Gerry Phillips or Brad Duguid. Both Gerry and Brad have served with distinction on the board. In fact, Gerry was a past chair of the board. They are both well aware of the importance of being connected to the community.

Our community members live and make their living in Scarborough. We are in a position to know, understand and appreciate the needs of the community and the challenges and opportunities that our hospital faces. Our families and our neighbours utilize and depend on the services.

Board members not only reflect but represent the community that our hospital serves, a community that today comprises more than 25 ethnic groups and which the World Health Organization acknowledges as the most ethno-racially diverse community in the world. Our board also provides hospital management with leadership, support and guidance, drawing on members' individual and collective experience and multi-talented and multi-faceted skills.

Let me stress, our board is accountable, and we recognize and support the concept of accountability agreements. Practically, this could provide us with an opportunity to resolve the details of, and obtain the minister's approval for, our long-term master plan/master program that we have prepared and submitted to the ministry.

However, the bill should consider that if an agreement cannot be reached on an issue or series of issues between the ministry and the hospital, there must be a mechanism in place for dispute resolution, such as the appointment of an independent arbitrator.

We support the proposed amendments whereby the hospital CEO is no longer party to the accountability agreement. The CEO is accountable to the board for their performance and the board is responsible for the conditions of the CEO's employment through clearly outlined performance objectives and outcomes. Our board takes this role very seriously.

There is one final area that I want to touch on today. Later this year, we intend to publicly launch a capital campaign to support a much-needed emergency and critical care centre. We hope to raise substantial money from the local community with the understanding that the hospital board performs a role with respect to a certain scope of health care decisions—decisions that are often based on the community needs and desires.

The accountability agreement should take into consideration the endowment funds available to a hospital through its foundation. The reality is that Scarborough Hospital is below the radar screen when large foundations or corporations are considering donations to various organizations. This places the hospital and the community at a disadvantage.

Let me conclude my remarks by saying the Scarborough Hospital has distinguished itself as a front-line champion of the evolving needs of Canada's new urban communities. We are committed to ensuring that the people of Ontario and our local community continue to have access to the health and wellness services they deserve. We urge this committee to support amendments that strengthen medicare in Ontario.

At this point, we would be prepared to respond to any questions. I want to thank you very much for your time and attention.

The Chair: Thank you, Mr Brazill. I appreciate it. You've used about 11 minutes, leaving us with nine minutes.

Ms Martel: Thank you for coming today. I'm going to focus on page 15 on point 35 and point 37. You said that if there can't be an agreement reached on an issue between the board and the minister, then there should "be a mechanism in place for dispute resolution, such as ... an independent arbitrator."

I wonder, then, if you understand what the minister has proposed in terms of the accountability agreements, which is that, at the end of the day, if there isn't an agreement, the minister has the power to issue compliance directives or orders unilaterally. That is the proposal that he has made to this committee as of last Thursday. That's quite a bit different than the appointment of an independent arbitrator to deal with a dispute in question and to deal with the resolution.

What does your board think of the premise that the minister still has, at the end of the day, the unilateral ability to issue a compliance directive or order?

Mr Brazill: The board represents the community, and the community needs to be heard. If we were to look at arbitrarily doing a cookie-cutter approach to this, very likely—I'll give you a real-life example in terms of SARS. If the ministry had been able to do what they wanted to do, likely the Scarborough Grace Hospital would not be open today. So very realistically, the community needs to be heard.

Ms Martel: So you're not in favour or you are in favour of a situation where the minister has the final say? That is exactly what we're looking at right now.

Mr Brazill: No, we're not in favour.

Ms Martel: The other point was, your CEO is accountable to the board, and the board is responsible for the conditions of the CEO's employment. The other thing we were given last week in this regard was a framework

for the amendments where CEO compensation clawback is still at the discretion of and in the hands of the minister. So again, your role as board members is completely undermined because the minister at the end of the day can still do compensation clawback or other remedies with respect to your employee, who is the CEO. What does your board think about a situation where clearly the CEO is still going to be responsible in some way, shape or form back to the minister?

Mr Brazill: Our position, as I think we've laid out, is that the board feels that it should be the one that's responsible. That's where the accountability should be. The CEO needs to be the board's employee. It is now, and that facility needs to remain in place.

Ms Smith: I'm actually not going to be making very many comments. I just wanted to thank you for your presentation. Mr Duguid is going to speak, but I also wanted to thank you for acknowledging the work that has been done on coming up with proposed amendments. You actually acknowledged that they're happening and being discussed, and it's a lovely change.

Mr Duguid: I want to thank you as well for taking the time to join us today. You're part of a board that has some of the largest challenges in our system, with probably the busiest emergency in the country, a hospital that was at the epicentre of the SARS crisis, and a hospital that was recently amalgamated. You've got some very large administrative challenges there, and the board, I think, is probably stronger and more vibrant than it ever has been.

I want to tell you that I wouldn't be supporting this approach, this legislation, if I thought for one second that this legislation was going to usurp in any way the powers of the board. At the same time—and I think you probably agree—the minister made a speech yesterday talking about the need to really focus on outcomes and on our priorities—reducing waiting times, access to care and making Ontarians healthier being the three priorities. There is no way we could shift the system to get to the outcomes we want to get to if we don't have some ability to ensure that there's accountability in the system. I don't mean accountability in terms of just value for dollar; I mean accountability in terms of getting all the stakeholders in the entire system to be playing from the same playbook in terms of moving forward with the reforms.

I just want to make it clear that we're not looking at getting into the day-to-day operations of the boards. What we are looking at doing is making sure that for those few boards—and I know Scarborough would not be one of them—that just simply refuse to play ball, that simply refuse to come onside in reaching the priorities we were elected to bring forward, we have a mechanism to ensure that we are able to pull them onside.

Mr Brazill: As you know, Brad, from working with us—Brad was on the board up to his election—we want to provide every service we possibly can to the community. There is no question in terms of the board's commitment to medicare and the people of our community. If we were able to see funding over a period of time, where we understand what we have to deal with, instead of at the last minute so that we're running programs which we really don't know whether we can afford—that's been an ongoing process, as you're very much aware. I think the key is to hold the board accountable. You can pass legislation that says, "Don't run a deficit," and allow us to do our job.

1430

Mrs Witmer: Thank you very much for your presentation, Mr Brazill and Mr Johnson. You've expressed a concern here as it applies to the accountability agreement. We've heard the suggestion from some people within the hospital sector that what this is really going to do at the end of the day—it has the possibility of eliminating boards and the role of boards, the governance structure we have in place today. As you know, it's basically shifting power from the boards to the minister as he or she enters into accountability agreements which will not be negotiated and will give the minister the opportunity to issue directives. If no amendments are made, do you see this legislation reducing boards to simply having an advisory role, and if that were the case, what would happen to the people who presently serve on your board?

Mr Brazill: If I had given you this presentation yesterday, before we got the most recent thoughts on amendments, it would certainly be a lot different. As you're very aware, it would make the board ineffective. But I think the amendments that are being proposed at this point address most of those issues. Obviously we haven't seen them in specifics, so it's hard to comment on something vague, but I think we're going in the right direction. As long as we continue to realize the role of the board and not take away its accountability, make the board accountable, I don't think boards have any problem with that. I think we want to be. We're accountable to the community and we need to be accountable to the government as well.

Mrs Witmer: But you don't mind the fact that there is no accountability for the minister to the public or to the board? The way the accountability agreement reads right now, folks, it's a one-way street. Does that not concern you?

Mr Brazill: As it is today, but I'm confident that that will be addressed with the recent announcements on amendments.

Mrs Witmer: Then I would say you have more confidence than most of the boards that have come before us in the last two weeks. I hope you're right.

Mr Brazill: Maybe I'm a babe in the woods, but I feel we have to have confidence in the elected officials, and I really do feel you're going to do the right thing at the end of the day. That's why we're here. We would have some major concerns as it relates today, but I know you're going to do the right thing as far as the amendments.

Mrs Witmer: Well, you just keep saying it and maybe they will.

The Chair: Thank you, Mr Brazill, and thank you, Mr Johnson, for accompanying Mr Brazill today. We certainly appreciated your input.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair: Our next delegation is from the Ontario Public Service Employees Union, represented today by Leah Casselman, the president, and Patty Rout, the vice-president, local 348, and chair of the OPSEU health professionals. Please make yourselves comfortable.

Ms Leah Casselman: Thank you, I will. This chair is kind of nice.

The Chair: The same as everybody else who has appeared before us today, you have 20 minutes. You can use that any way you see fit. If there is any time left at the end of the presentation, we'll split that proportionally among the three parties.

Ms Casselman: Excellent. As you've just heard, I'm Leah Casselman, president of the Ontario Public Service Employees Union. This is Patty Rout, who chairs our health council, representing six health care divisions within OPSEU. OPSEU is grateful for the opportunity to participate in this public consultation.

Almost one quarter of all OPSEU's 100,000 members work in health care. They work as paramedics and dispatchers in our provincial ambulance services; they are service, office and clerical workers; hospital professionals and nurses in public general and psychiatric hospitals; and they work in long-term-care facilities and in the community home care sector. They work in public health and in mental health. We pretty much cover the waterfront here. They see first hand what has happened to health care in our province over the past eight years.

OPSEU echoes the concerns of the Ontario Federation of Labour and the Ontario Health Coalition. Our remarks will focus on the areas of most concern to our members.

Bill 8, the Commitment to the Future of Medicare Act, has a lofty title, but we have grave concerns that this bill will not fulfill those objectives. As it stands, the bill does nothing to further the principles of the Canada Health Act. It does not prohibit the further erosion of the scope of medicare. It does not deal with the increasing problems of privatization, profit-taking and the two-tiering of uninsured services. Further, it opens the possibility of extra-billing and allows block fees for physicians. We are particularly concerned that the bill gives the minister sweeping powers to order restructuring of the health care system without any democratic control, input or checks and balances.

The bill's preamble recognizes that our system of publicly funded health care services reflects fundamental Canadian values and that its preservation is essential to the health of Ontarians. It confirms the enduring commitment to the five principles of medicare: administration, comprehensiveness, universality, portability and accessibility, as currently codified in the Canada Health Act. This commitment should be broadened to provide for significant new initiatives with respect to these principles, including the absolute and unequivocal prohibition of two-tier medicine, extra-billing and user fees. The bill should also commit to not only publicly funded but also publicly administered and delivered health care services.

The government has indicated that this bill should strengthen and restore public confidence in the health care system. This confidence has been eroded over the last eight years, and no one knows that more than OPSEU members on the front line. Patty Rout will now describe further what front-line workers see for this bill.

Ms Patty Rout: I'm Patty Rout and I'm a lab technologist at Lakeridge Health, Oshawa. We have four hospitals and we have 21 work sites. I'd like to paint a picture for you of the problems in the health care system as my members and other health care workers in OPSEU's six divisions see them.

In long-term-care facilities, thanks to the previous government, we have no minimum standard of care. Staffing levels are among the lowest in Canada. Inspections are too infrequent and are announced to the companies beforehand. The majority of new nursing home beds have been handed to for-profit corporations. Resident user fees are up. The proportion of beds in long-term-care facilities held for those who can afford to pay a premium for a semi-private or private room has gone up to 60%, reducing the number of basic ward beds available. There is inadequate staffing in long-term-care facilities. This forces families to pay for their own caregivers, if they can afford to do so. Otherwise, residents go without even basic care as hours of care have been reduced while acuity has increased.

Home care: The privatized delivery of home care through the competitive bidding model has created tremendous instability. Six years after its inception, Ontario's home care system is rife with duplication, excess administration and profit-taking. This has had an impact on our workers as wages and working conditions are driven down. It has also harmed patient care. Not-for-profit organizations, such as VON, with long histories of providing quality care are being driven out of home care by this cutthroat competition. The second wave of divestments has fragmented services. It has caused instability and caused professionals to leave community care.

Precious health care dollars are being redirected out of patient care and into ballooning administrative costs, creating staff shortages and instability. Approximately $42 million per year of public money goes to profit the owners and shareholders of private companies. Homemaking and home support services have been virtually eliminated across the province, primarily affecting the frail elderly and disabled.

Tax dollars have been diverted from hospitals to finance tax cuts, leaving Ontario hospitals scrambling to provide essential medical service. Over the past eight years, the numbers of acute, critical and chronic care beds were cut by almost 9,000. The previous government closed 39 hospitals and cut 25,000 staff.

To finance rebuilding and redevelopment of our hospitals, the government's proposed solution is public-private partnership, despite promises made during the last election. The government argues that the William Osler

and Royal Ottawa hospitals are not public-private partnerships. However, the consensus is that the minor contractual changes announced in November 2003 do not substantively change the character of these P3 projects. There are also more P3 hospitals on the agenda in various stages of planning.

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The evidence that public-private partnership hospitals cost more is overwhelming. Following the same model as privatization in Britain, Ontario's P3 hospitals are already showing cost increases from initial projections. In Brampton, capital costs alone have increased from $300 million to over $350 million. In Ottawa, costs are up from an original cap at $100 million, to over $132 million. P3 deals are secretive. There is no public transparency on contracts. We do not know the extent of privatization; we are not told about timelines, commercial land deals and payments from hospital operating budgets.

For-profit operations in health care push dollars away from patient care to shareholders' pockets. Inevitably, either hospital services will cost more or services will be cut to keep shareholders happy. Both patients and the taxpayers suffer.

There is a severe shortage of health care professionals in hospitals. I'd like to say it's not just nurses; it's many health care professionals in this province. I can talk about that later. An older workforce is retiring. For hospitals and other health care providers, the ability to meet the needs of their patients depends on their ability to recruit and retain health care professionals.

Another staffing issue is the rate of part-time, casual and agency workers in our hospitals. This was illustrated very graphically during the SARS crisis last year. The expert panel on SARS said, "Existing rates of casual, part-time and agency employments are undermining efforts to ensure a stable and cohesive workplace."

We can't forget our shock last year when Health Minister Clement admitted he had no idea of the casualization of work in hospitals.

Laboratory services: The province's public health labs have been starved for resources, to the point that people working in key areas have been eliminated just when their work was most needed.

Lab restructuring is going on all across the province. The Ministry of Health seems intent upon increasing the role for the private sector in the provision of lab services. Private delivery of lab services has not contained costs. Indeed, new user fees have been introduced. Mobile unit pickup lab services that used to be provided at no charge are now subject to a user fee of $15 per pickup.

Public hospital laboratories operate at a disadvantage. Private laboratories bill OHIP on a fee-for-service basis, while hospital laboratories are funded out of hospitals' block funding. For-profit labs have taken the higher-volume and lower-cost tests while hospital labs must deal with more complicated, specialized, non-routine and less profitable tests.

The planning for laboratory restructuring involves the Ministry of Health, hospitals, community—including private—laboratories and physicians. Human resource planning is already underway, but OPSEU, which represents the vast majority of lab technologists and technicians in this province, has not had any involvement in this planning process—and it's not from lack of asking.

Private MRI and CT clinics: Private stand-alone clinics such as MRIs and CTs operate outside the public medicare system and drain money from the hospitals through third-party billings—WSIB and third-party insurance. This deprives our hospitals of revenue. Private clinics also poach our skilled staff from the public system.

A job in a private clinic can be very attractive to overworked, underpaid, stressed-out hospital health care professionals. This further undermines our public health care system. Private clinics also enable queue-jumping for so-called medically unnecessary services.

Ambulance: Downloading and other upheavals in Ontario's ambulance services have created severe imbalances in the system that must be addressed. The province has downloaded these services without proper funding. Some municipalities, like the city of London, have torpedoed fair deals for paramedics because of the cost factor. Others are still toying with the discredited fire-medic model; this despite the outcry in Owen Sound, where the past mayor was resoundingly defeated on this issue. The fire-medic experiment will not cut costs or improve service. Ambulance dispatch is in crisis. There are chronic staffing shortages at the 11 provincially operated central ambulance communications centres because pay rates are so low that the retention rate for new hires is only 30%. Ontarians are dying because the last government wouldn't address this crisis.

Mental health: The reckless Tory mental health agenda closed psychiatric hospitals and downloaded the costs of community programs. The divestment of seven provincial psych hospitals has resulted in massive bed closures and cuts to programs. Money promised to community programs never materialized. There has been no increase to base funding in 12 years. People with mental illness are on our streets and in our justice system. Patients are discharged with limited follow-up because of too few general practitioners and psychiatrists. The Tory record on bed closures is shameful.

OPSEU members are on the front line. We want to strengthen medicare. We want stability in the health care system. We want fair funding for the public services we deliver. We want to be paid fairly for the important work we do.

I'll turn the floor over to Leah now.

Ms Casselman: The Ontario Health Quality Council, as set out in part I of Bill 8, is intended to monitor and report to the public on access to publicly funded health care services, human resources in publicly funded health services, consumer and population health status and health services outcomes.

We would ask that the Ontario Health Quality Council also be required to report on the extent that the Ontario health care system complies with the CHA principles of public administration, comprehensiveness, universality

and portability and on issues relating to two-tier medicine, extra billing and user fees.

During the tenure of the previous government, we witnessed a serious erosion of democratic control over the health care system. We strongly recommend that the council should only be appointed by cabinet once assembled through an inclusive, representative process that does not include for-profit providers, given their obvious conflict of interest.

In addition to the requirement that the council deliver a report on the health care system each year to the public and to the minister, we would also give the council the power to make recommendations on the future course of actions to be undertaken.

We support the section in Bill 8, subsection 9(2), that extends the prohibition against extra-billing by physicians and other designated practitioners. However, another section of the bill, subsection 9(4), may well open up the possibility for the government itself, through regulation, to allow extra-billing and opting out.

We support a ban on extra billing and opting out and would request that the act be absolutely unequivocal in this regard. Both should be banned. Block fees should not be allowed, in regulations or anywhere else.

Queue-jumping: We commend the inclusion of section l5, the intent of which is to limit the ability of individuals to jump the queue. But the section must not be limited to insured services. As the list of medically insured services is restricted, this provision would not protect those seeking delisted or as yet unlisted services from queue-jumping. The major threat, however, is not the occasional queue-jumping abuse, but rather the systemic shift from public to private, for-profit health care services.

Accountability agreements and compliance directives: The original wording of the bill gives the Minister of Health broad powers without any form of democratic control. It allows the minister to order fundamental changes to our health care system with little or no public consultation, procedural safeguards, transparency or other checks and balances. It appeared to give the minister the authority to order individuals and organizations to comply with ministerial initiatives and to enforce compliance through regulations that are still unspecified. The original wording of the bill appeared to allow the province the ability to open and change collective agreements. In his remarks to this committee on February 16, Minister Smitherman said the bill was not intended to do so, although he acknowledged unions have widely interpreted Bill 8 to read that way.

We have reviewed the amendments provided by the minister on February 19. With the exception of the amendment excluding trade unions from the definition of health resource providers, agencies or entities, the draft amendments fail to address our many concerns about Bill 8. The bill should not grant arbitrary powers to restructure health care. It should promote transparency and democracy and not unilateral ministerial powers.

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We have recently received troubling signals from this government about the sanctity of free collective bargaining, and the entire accountability agreement section of Bill 8 heightens these concerns.

Further, according to section 20 of Bill 8, the minister, in exercising his or her powers, is to consider "fiscal responsibility, value for money and focus on outcomes." We want a high-quality health care system. We desire value for money and fiscal responsibility too. But in our experience, terms such as these are often code words for bringing in the for-profit sector. Our members are committed to public medicare and are opposed to any such language if it means bringing in more private sector involvement and profits.

While the motivation of the government is not entirely clear, part III of the bill can only be seen as an attempt to grant the minister unlimited power to dictate fundamental changes in the health care system without safeguards or democratic input. The powers and penalties in the bill are all stacked on one side. It is not on the side of those who want democratic representation and transparency in a medicare system supposedly designed for them. Accordingly, we call for a complete withdrawal or at least a rewrite of this section of the bill.

What would a true commitment to medicare include? It would include initiatives to rebuild comprehensiveness and to stop delisting, to protect and rebuild universality, and to restore accessibility to publicly funded services.

It would also be to improve public access to information, including financial information about health care institutions and sectors; to put in place public control, public governance and democratically elected boards; to restore full access to home care, including home nursing, homemaking and personal support; to improve access to primary health care; to improve access to drugs, treatments and assisted devices; to put a stop to creeping privatization and Americanization of health care, as promised in the election campaign; to create a democratic health council that reports on extra-billing, user fees and two-tier health care; to stop delisting of medically necessary services and to restore access to previously delisted services; to stop queue-jumping for so-called medically unnecessary services; to enact whistle-blowing protection for those employees who complain about poor practices; to stop P3 hospitals, private MRI and CT scanning clinics; to stop divestment of psychiatric hospitals, bed closures and program cuts pending a full review of the crisis we face today in our mental health system; to fully disclose OHIP delisting, physicians' out-of-pocket fee list and other charges; to invite input from health care workers, patients and clients of the health care system; and to commit to public health through provincial laboratories and public health units.

You've already heard from many OPSEU front-line health care workers in your hearings across this province. They have painted graphic pictures of the issues they face. We hope we've added to that picture here today with our remarks.

In closing, we would ask that this government hold fast to its campaign promise to restore our cherished health care system. You can show your leadership and

your commitment to change that works by empowering a health quality council that is truly accountable and can make recommendations for change, assembling the council through an inclusive, representative process, exclusive of for-profit providers, and banning all privatization initiatives, reversing the P3 deals already in the works and putting all private MRI and CT clinics back into the public sector.

To ensure that Bill 8 passes the tests of accountability, free collective bargaining and a commitment to the principles of the Canada Health Act, we believe the bill should be rewritten. We thank you very much for this opportunity to make our presentation.

The Chair: Thank you, Ms Casselman and Ms Rout. That was extremely well timed. You used up exactly 20 minutes and didn't leave us any time for questions, unfortunately.

Ms Casselman: We've done this before.

The Chair: We can tell. Thank you very much for coming today. Your input certainly was appreciated.

ST MICHAEL'S HOSPITAL

The Chair: Our next delegation this afternoon is from St Michael's Hospital. I call Jack Petch forward, with Jeffrey Lozon and Wendy Cecil. Make yourselves comfortable. Welcome. You have 20 minutes. You can use that any way you like. At the end of the presentation, if there's any time left, we're going to split it among the three parties for questioning.

Mr Jack Petch: We will save some time for questions, because I think it might be helpful to the committee to wonder about some of the things we talk about.

The Chair: Wonderful. It's 2:54.

Mr Petch: I'm Jack Petch, chair of the board. Next to me is Wendy Cecil, who's our vice-chair. Wendy's background is with the governing council at the University of Toronto, where she is the past chair and is currently involved in the U of T president's circle. Jeff Lozon is our CEO.

We're here on behalf of St Mike's, obviously. Just to give you a touch of history, but not much, our hospital was founded in 1892 by the Sisters of St Joseph to care for the sick and poor of Toronto's inner city. That is something we continue to carry on today.

We're going to tell you things I'm sure you've heard before from other people in different ways, but we're going to try and add some real-life part of it as to how we deal with some of the things we're going to address and some of the concerns you might have.

We also operate as a referral site for high-acuity services, such as heart disease and trauma. We share with Sunnybrook the trauma activities in and around the city of Toronto, as one of the two trauma hospitals. We have an annual budget of approximately $400 million. We have 600 in-patient beds and a staff of 4,700. We have 600 physicians, 1,500 students and 500 volunteers. We are also a teaching hospital affiliated with the University of Toronto and provide teaching and experience to a significant number of medical students who go through our hospital.

What we would like to do is to focus on just a few points in Bill 8, rather than on everything, but we will note that we adopt a lot of the position that the OHA has taken. We think there are a lot of very good ideas there.

We also note Minister Smitherman's comments of yesterday, in which he said there should be a sustainable financial footing for hospitals. We would interpret that as there being an ability on our part to do long-range planning with the government so we know, on a going-forward basis, what is expected of us and what we might expect from the government.

A culture of accountability and results is something we support 100%, and I'll touch base on that. The creation of strong community health care services: This too is important to us, because one of the costs we incur is keeping patients in our hospital longer than they need to be there because there is no place to send them. So those are things we're strongly supportive of.

We're going to touch on four key points, pointing out that today we are very accountable to the government, not only accountable under the Public Hospitals Act but, in our case—and Wendy will touch further on this—accountable as a matter of practice, that how we run the hospital, the undertakings we have, the responsibilities we see to the people of the province of Ontario are something we adopt and follow today.

The negotiation of accountability agreements: We see those too as something that should be negotiated, not imposed. We see it as something that would address the needs of the public, of the government and ourselves. I think a good, living example of that would be St Michael's undertaking of SARS 2 the summer last, where the province approached St Michael's Hospital to be the lead hospital in dealing with SARS 2. We had discussions, we expressed our needs, we expressed our concerns, and through that, we arrived at an understanding with the province as to how we would deal, as the lead hospital, with SARS 2. I think that's a very good example of how things could be dealt with, where rather than having something imposed on us, we have discussions that lead to better health care for everyone.

We would stress that the agreements that are entered into and to be entered into should be between the hospitals and the government, not between hospital executives and the government. That is something we feel very strongly about. It's we, the hospital boards, that are accountable, and those discussions and negotiations should take place at that level, obviously with the input and background of the CEO and the hospital executives. That, to us, is the proper procedure.

We also bear in mind and note that, as you heard yesterday, we are a part of the Catholic Health Corp of Ontario health care system. In that sense too we have another constituent that we work with.

Likewise, even in exceptional circumstances, directives should be addressed to hospital boards, not to executives. Again, looking at how we run our hospital,

we develop a budget in consultation with the medical staff, in consultation with the needs of our patients, in consultation with the province. The board sees that those are addressed and maintained. We see a dialogue in this case, and then if there are issues, they can be dealt with directly through the board.

1500

Jeff, as our CEO, develops on an annual basis his objectives; the board approves those. We see that Jeff is accountable to us, we see that he meets the commitments he makes to us, and we assess him on a regular basis. Likewise, we assess ourselves as directors: Are we doing a good job? Do we fully recognize and appreciate the responsibilities we have for public funds?

To give you a bit of a sense of that before I get into the more formal part, I look at our board, and our board is a group of people who work together, who have come from various backgrounds, who have various skills and interests. We have committees.

We have a business committee, and on that committee we have people who run public companies, who run private companies. They understand the business aspect of running a hospital.

We have an audit committee. The head of our audit committee is the former head of one of the national accounting firms. We think this is important, but what does that do in providing health care?

Well, we have a community advisory committee. We talk to our community, we understand their needs, and we ensure there are community representatives. We have a senior person from Regent Park on our board. We have the executive director of the YWCA on our board. So we don't lose touch with those to whom we provide our services.

We have a pension committee. Obviously, everybody suffered through the downfalls of the marketplace, so on that committee we have people who are in the investment business and can hopefully lead us in the right direction.

We have a research and academic committee, because, again, we are a teaching hospital, and that allows us to provide very high-level care in very acute circumstances.

So we recognize all the communities we deal with and we have representatives on our board. We have a very good board. We insist on attendance. As the chair, if somebody doesn't attend, I want to know why. If they're not willing to make the commitment and follow through, they're not welcome. We see accountability in real-life circumstances.

I talk about fiduciary and accountability and so on. It's something we stress on a consistent basis. One of the best examples I have of that is our doctors. In many cases, our doctors pool resources. We would have a group of anaesthetists. There might be—pick a number—six who provide service, but there's a seventh, and that seventh is supported by the six to do research. This is part of our accountability, our recognition of responsibilities, that we do have these broader responsibilities to the community.

I'm jumping around a little bit. I'm going to ask Wendy if she would touch on a couple of things, and then I'm going to come back to some of the other points we would like to make.

Ms Wendy Cecil: Thank you very much, Jack. Good afternoon, everyone. The first point I'll deal with is the transparent accountabilities that we believe already exist at St Michael's Hospital.

The board of St Michael's Hospital, like other hospital boards, takes our governance, fiduciary and legislative responsibilities very seriously. Our directors voluntarily demonstrate significant commitment, acting in full compliance with the terms of the Public Hospitals Act, hospital bylaws, related corporate governance legislation, and the recent legislation that affords the Provincial Auditor greater latitude in reviewing the financial performance of hospitals. All of these structures establish strong, transparent accountability to the government and to the public of Ontario.

At St Michael's, we are very proud of our long record of strong financial performance and demonstrated accountability to government and the public for the effective use of tax dollars. I'd like to give you two examples of our leadership in these areas.

First, St Michael's Hospital has had a decade of strong financial performance, demonstrating our longstanding commitment to fiscal responsibility and accountability for the resources provided by the province. St Michael's has recorded a balanced budget or better every year since 1991-92. Our performance is a direct result of the steadfast commitment of our executive team and voluntary board of directors, who work in a true partnership to ensure the transparent and just use of our resources in keeping with our governance and fiduciary responsibilities.

Second, the success of our merger with the Wellesley Central Hospital—which everyone affectionately referred to as the Wellesley—in the late 1990s is directly attributable to governance structures and processes that demonstrated our openness and transparency with all stakeholders throughout the transition process. When the Health Services Restructuring Commission directed us to take over operation of the Wellesley, the board of St Michael's Hospital quickly established an integrated governance model. Board members and senior medical leadership from the Wellesley were added to the St Michael's board of directors. Members of the St Michael's board stepped down in order to accommodate this. In addition, we expanded our board committee structure, specifically the membership and responsibilities of our community advisory panels that Jack mentioned a minute ago, to provide the external community with greater direct access to the board. These changes helped to build trust with our newly expanded community and demonstrated the value that our board places on being open, transparent and accountable to our internal and external communities.

In looking to the future, we support the intent of the government to continually improve the performance of the health care system. We welcome the introduction of a provincial health quality council. We believe that in order

to carry out its work effectively, the membership of the council should include representation from hospitals—both senior administrative and medical leadership. We were pleased to see this understanding reflected in the minister's draft framework for changes in the bill. We also encourage the government to expand the council's responsibilities to enable it to make substantive recommendations to the minister in respect of the operation of the health care system.

Next point: Accountability agreements must be negotiated and mutually agreed upon. The provisions of the draft bill require hospital boards to enter into accountability agreements and to adhere to government-prescribed performance goals, service quality and system outcomes. We support the concept of negotiated accountability agreements.

In the absence of a negotiated agreement, Bill 8 would transform the role of boards from that of a governing body into that of a government agency. Fundamental decisions about hospital services will be centralized in the hands of the Ministry of Health and Long-Term Care. The role of boards in the community would be rendered marginal. Communities will no longer have a voice in shaping the services available in their local hospital, such that Bill 8 risks disengaging communities from their relationships with hospitals. The environment will also severely threaten the capacity of hospital foundations to work with their communities to raise money for the provincially unfunded portion of capital necessary to maintain health care facilities.

In the minister's opening remarks to this committee, the minister stated clearly that accountability agreements will be negotiated and that the government and health care providers will work as partners to come to a mutual agreement on outcomes and performance targets. We support these statements. However, the minister's draft framework for changes is silent on these two issues. We note, however, that the OHA's amendments propose for a process of negotiating mutually acceptable agreements and dispute resolutions. We support the OHA's proposed changes and we would emphasize the importance of these processes being led by an independent third party.

One final note on this point: The bill is overtly silent on the notion of the mutual accountability shared by hospitals and government for the provision of health care services. In fact, there is no mention of the government's responsibility to provide appropriate and timely funding, and to work cooperatively with health providers to define service levels, the quality of care and the performance goals. In this regard, the bill fails to require the minister to act in the public interest in implementing performance agreements that will address the health needs of communities.

I will now ask Jack Petch to provide the remainder of our remarks.

Mr Petch: I'll begin by asking the Chair how much time we have left.

The Chair: You have about four minutes.

Mr Petch: You have our presentation here. I'm going to take one minute and save three for questions.

I've already mentioned that we feel strongly that the accountability agreements should be between the government and the board, not the CEO and the senior executives. Likewise we think that it's important that there be this kind of direct interaction between the board and the government. With that—you have our written presentation—let's take some questions.

The Chair: Thank you. You've left us about a minute each.

Ms Smith: Thank you so much for your presentation today. It's certainly well thought out and well drafted. I did note, however, in your opening that you failed to mention the fabulous research department that you have at the hospital.

Mr Petch: Thank you.

Ms Smith: Since I have a soft spot for the research department at St Mike's, I have to mention what a great job they do. I wanted to just raise the issue that you've seen the framework for amendments and you know that we're looking at accountability agreements being between the hospital board and the ministry. Moving along that line, you spoke a little bit about the fundraising and how it's impacted by the accountability agreements. Do you foresee any problems if there are accountability agreements between the board and the ministry?

1510

Mr Petch: Not if they're negotiated, I don't think. As you know, we don't get fully funded for capital, for equipment and so on, so we depend on our foundation to raise money. We just recently finished raising $50 million to do all of those kinds of things. If it's freely negotiated and there is that kind of dialogue, no, I don't see that as a problem.

Ms Smith: OK. My other point was, you made reference to fiscal responsibility, balanced budgets—your history of fiscal responsibility is impeccable. Generally speaking, do you have an objection to the notion of accountability agreements between the ministry and hospital boards?

Mr Petch: We think it's a very good idea, because in a sense we have that now in practice and I think formalizing it would be to everyone's benefit. For example—and Jeff knows this better than I—we do a lot of heart care, and we don't get fully paid by the province for the heart care we provide. Our costs are more than that, and everybody knows that. I think that's the kind of thing we could negotiate in an accountability agreement.

Mrs Witmer: Thank you very much, Mr Petch and Wendy. I would certainly concur with Ms Smith that your hospital does a wonderful job of providing high-level, quality, compassionate care to the people in the immediate community and beyond, and we really appreciate the leadership that you have exhibited in responding to those needs.

We hear from your presentation and others that we know the government wants to get it right, there is a commitment to medicare, but there's a lot that remains to be done, particularly in the area of the accountability agreements and the whole issue of accountability. My

question to you is pretty simple: Before this would go back to the Legislature, once the amendments come forward from the government, would you like another opportunity to be able to come to a committee such as this to give your input one more time as to how you think the legislation could be further improved in order to meet that genuine commitment I know the government has to medicare?

Mr Petch: I think it would be helpful if we could see what it is one would see in an accountability agreement, what kind of things would go into it, with some suggestions. Then we could be more direct in our response and the kind of commitments we can make as a hospital.

Ms Martel: Thank you for being here today. You told the committee that you have seen the minister's draft framework for changes, so you will know that in section 22 the minister still retains the right to issue compliance directives or orders, which hardly sounds like negotiation to me. Second, in section 23, the minister retains the right to claw back CEO compensation or to apply other financial remedies to a CEO who is an employee of your board, not an employee of the minister. Given what is in the draft framework as we speak, can you tell me if that resolves the concerns that your board has with respect to negotiation versus imposition, or having to be in a position where the minister still has control over your CEO?

Mr Petch: I think it's important that the minister have some element of control over the hospital board. For example, if we make a commitment in our agreement and we're not complying with it, then clearly he should have the ability to issue a directive to the board to comply. I think that's important. But I think it's then up to our board to deal with the CEO. I don't think there should be a relationship between the CEO and the minister. I think the relationship is CEO-board, board-government. I think that's the appropriate way to go.

The Chair: Thank you for coming today. We really did appreciate your input.

GREY-BRUCE HEALTH SERVICES

The Chair: Our next delegation today is from Grey-Bruce Health Services, Brian Renken, board chair, and Pat Campbell, the CEO. If you'd like to come forward and make yourselves comfortable. Same as everybody else we've had before us today, you get 20 minutes. You can use that any way you see fit. At the end of your presentation, we'll apportion the time that's remaining amongst the three parties for any questions they may have. You've got the floor.

Mr Brian Renken: Thank you, Mr Chairman. I want to thank the committee for allowing us to make this presentation. My name is Brian Renken; I'm chair of Grey-Bruce Health Services. On my left is Pat Campbell, CEO for the corporation.

You have our written presentation before you. I'll try to skim through that, and I'd like to allow more time for questions if that's the committee's pleasure.

First of all, let me give you some background about Grey and Bruce counties. It's a relatively sparsely populated area. We have the highest senior population in Ontario, second-highest in Canada. So we have some serious concerns in terms of the elderly.

We also have a higher incidence of heart disease and stroke in our area, compared to the provincial average. We certainly have a challenge in terms of obtaining tertiary care for our clientele. As you know from the Romanow report, there's a clear distinction between rural Ontarians and urban Ontarians in terms of the type of health care that they are able to access. Obviously, the recruitment and retention of health professionals is a serious concern for us.

Let me just elaborate on how Grey-Bruce Health Services was formed. That was a volunteer amalgamation back in the mid-1990s as a result of the HSRC directives that were going on at that point in time. We've been able to amalgamate five hospital boards, and we presently operate six hospitals involving primary and secondary care, a medical clinic and a withdrawal management program, all under one governance structure.

Our main concern is to provide primary care that is integrated in the delivery of the health care system. We also work in partnership with the Grey-Bruce health network to create access to quality patient care and develop joint clinical pathways and health information systems for our constituents.

We feel, as was evident in the previous presentation, that there is a certain accountability that we have at the present point. We also participate in the hospital report series and have done so since the inception. We spend an inordinate number of hours trying to collect that data and then try to improve on the results from each survey that's done. We also have formal licensing and inspection through clinical areas in the laboratory, diagnostic, food services and pharmacy areas. We are accredited through the Canadian health council on health services. We've also participated in the third party review. We've asked for results. To date, we have not received that. We're presently open to the media at all of our board meetings and, as St Mike's indicated before us, we also have community advisory committees that are active in providing local input to what our hospital needs.

We have serious concerns about the impact that Bill 8 will have on our local accountability. We are concerned about what the board might be faced with if there are executive directives issued by the minister and what that would do to our local community. We feel that local community input is important and we're a little concerned that some of those directives may be coming from Toronto, as opposed to what the rural constituents really need. Grey-Bruce Health Services certainly has no difficulty with accountability agreements. We want them to be negotiated and agreed to well in advance. We don't want to be told what we should be doing.

Second, we have a concern about how they might affect our situation with our CEO. We want to have control over the CEO, and we're quite satisfied with the

way that is in place at the present time. We really consider that there will be significant resignations if this bill is allowed to proceed. We will have difficulty, in my opinion, accessing quality board members both to our board and to our foundations. We're concerned that if there's no public notification process prior to the minister unilaterally making changes, it could affect our overall health care system in our rural area. That's obviously a concern.

It's our submission that the minister should consider what's happened with the CCACs. Mr Watts spoke to that yesterday, and I think he was quite clear on what that has done.

We're concerned about the rate of care to delivery in low-density populations.

I'm the foundation representative on the board, and as such, I'm concerned about what this might do to the fundraising capability of the foundations. We have five foundations at the present time that are related to our corporation, hoping to raise approximately $27 million over the next five years. We feel that the five foundations need to maintain a local community investment in health care, and it's our submission that the community's commitment to its foundations will be based on trust. If they don't have any faith in the fact that local decisions are being made for our local hospitals, then our capital fundraising campaigns are certainly going to suffer. We would ask the committee to consider what's happened in other provinces. I am told that there's been a serious and dramatic failure when something like what Bill 8 is proposing is put into effect.

1520

In terms of the current performance agreements, we don't really have a major issue with performance agreements, provided that they're negotiated fairly and reasonably. We are already starting to work at some types of performance agreements through the planning and human resources area. We would ask the committee that any type of performance agreement would have to incorporate multi-year funding. There has to be a mutual agreement with joint accountability both by the government and by the hospital sector itself. Those agreements should be incorporated, as you've heard previously, with the board directly, as opposed to the CEO.

Suggested amendments that are referred to there: The preamble, in our submission, should include accountability by the government and, by necessity, should incorporate a good faith element. The principles should include negotiated performance agreements. You should be rewarding good governance; you should be incorporating community involvement in the health care system so the stakeholders have a say; and you should, with respect, make decisions—or the minister should make decisions—based on public interest, as you've heard from the previous presentation.

One suggestion is that the arbitration mechanism of the agreement should allow for some kind of resolution if the two parties cannot come to terms on an agreement. The term should be three years, as was referred to in the written submission. We have great concerns with sections 25 through 32 and the consequences, and amendments should be put in place that deal with those non-compliance issues.

We've suggested that there may be some substantial implications for the province in a couple of areas. As the government seeks to reduce the escalation in spending, the resulting health care deficit will land firmly at their feet, in our submission. We firmly believe that directors will abandon their roles and contribute to other volunteer activities as opposed to being merely an advisory committee for the minister. Communities certainly would lose their influence over how services are delivered to them and how the local hospitals are managed. We believe that the opportunities to build on local hospital network initiatives to create an integrated system of care would be lost—in effect the silos will be intensified. That's something I understand the minister wants to try to avoid.

Lastly, when it comes to leadership, the constraints and personal penalties associated with the performance agreements will, in our view, drive CEOs from the industry. We need exceptional leaders who are innovative and creative and are interested in furthering the health care of our constituents. Obviously, recruitment of physicians to medical leadership positions in the board, which is a difficult task at the best of times, will certainly become impossible if this bill is imposed.

Our final recommendation is that there be a provision for the public to respond to any proposed amendments and to re-open the hearings for input at that point in time. We'd ask you to consider learning from the experience of other jurisdictions, such as British Columbia. We want you to be alert to the inconsistency that the government appears to be following at this point when it relates to school boards compared to the health care industry.

I want it clearly understood that Grey Bruce Health Services is 100% in support of performance agreements between the hospital board and the ministry, but we would ask you to pay critical attention to how the performance agreements are drafted, perceived and implemented.

Thank you for the opportunity of speaking.

The Chair: Thank you, Mr Renken. You used up about 11 minutes, which leaves us with nine.

Mr Arnott:. I have a question. First of all, I want to compliment you for coming in today. We certainly appreciate the views that you've outlined. I'm sure you are aware I represent a riding just to the south of you, in Waterloo-Wellington, and 75% of my riding is small town and countryside, so many of the issues that you face are similar to ones we face in Waterloo-Wellington in our small hospitals.

I received a letter from Gil Deverell, who is the chair of the North Wellington Health Care Corp, which is the amalgamated board of the Palmerston District Hospital and the Louise Marshall Hospital in Mount Forest. Gil is somebody I've known for a long time. He talked about this bill: "While some ... aspects of the bill are laud-

able.... " But he went on to say, "However, from my viewpoint as an active participant in hospital governance in rural Ontario for some 25 years, Bill 8 is a serious threat to the successful continuation of public hospital governance by local boards made up of volunteers from the community."

He goes on to say, "The bill explains that the accountability provisions in part III allow the minister to 'require the entering into of accountability agreements and to issue compliance directives' and 'to reward' compliance or 'deal with' lack of compliance." I think he sees that as, maybe not threatening language, but certainly ominous language.

He continues on, "If the Ontario Legislature no longer has confidence in the ability of our hospitals to be governed by local volunteer boards who are responsible to the public served by the hospitals, then that declaration should be made openly and should be the subject of public input and debate."

Do you agree with these statements?

Mr Renken: Absolutely. I'll let Pat speak to it but, very briefly, I think Mr Watts yesterday referred to the Trojan horse issue in terms of taking away the volunteer boards. That's an extreme concern for me personally, and I think it's the wrong way to go.

Ms Pat Campbell: I guess the comment I would offer is I've been in Grey-Bruce three years now, and the realities of providing health care in a geographically broad area are very different than in the high-density populations in the urban areas. Those realities are not well understood for people who have not tried to operate in those environments. Decisions get taken based on looking at the numbers, as opposed to looking at the realities of trying to maintain a system of care at some level that's available to the public.

Speaking for Grey-Bruce in particular, we have tremendous weather concerns and the reality of level 1 paramedics, which make the need to have close access to emergency care quite significant, as opposed to having advance-care paramedics. Those issues are very real for our population, and not, to my understanding, well understood for people who are dealing with the broad health care system in total.

Ms Martel: Thank you for being here today. You said you participated fully in the third-party review process and the results have never been shared. You're not the first person to tell us that, and I hope the parliamentary assistant can get those reports out the door to these people who work so hard—this and in Ottawa. Just a suggestion.

Near the back, under "Implications for the Province," you said, and you were quite direct, "Directors will abandon their roles and contribute their volunteerism to other causes where their efforts will make a difference because they will only be advisory if the ministry is directing the CEO."

If you have seen the revised framework that the minister is now operating from, where new amendments will come from, it still says in section 23, "CEO compensation clawback or any other financial remedies to be applied to a CEO," by the minister, "as a last resort only after all due process," but he's still the minister at the end of day and has that power.

Does that qualify for you as the minister directing the CEO, if the minister at the end of the day has control over compensation and can apply financial penalties?

Mr Renken: I'll take the question. Very few times has our board become politically motivated, but when they saw this provision and the provision in Bill 8, they wanted us to make a presentation. So we're fundamentally opposed to that being allowed.

Ms Martel: So you haven't been convinced that in the direction the minister now wants to go, which was released to us last Thursday, there has been any change there that would give you any comfort.

Mr Renken: In our submission, it's not good enough.

Ms Martel: In the same way, in the same document, just the section above, in section 22, it does say that after due process provisions and after the minister has heard representation, there has been an exchange of documents and information etc, the minister will still have the ability to issue compliance directives or orders. That's a far cry from, for example, a dispute resolution mechanism, which the OHA has put forward, I gather.

What concerns, if any, does that still give your board, that at the end of the day you might have notification, you might have some time to make your representation, but the minister still has the authority, then, which is unilateral, to impose compliance directives or orders?

Mr Renken: Once again, that's going to cause problems with our board. We want to be able to make those decisions. We don't feel that the minister should be able to do that directly with the CEO. It's something I think they're fairly adamant on, and they're not prepared to accept that. I think that's why we will lose some board members.

1530

Ms Martel: So what you've seen to date, both in terms of the original bill and then the proposed changes, is not giving you the comfort you need to say to your board, "Stay on. Things are going to be OK"?

Mr Renken: It has not.

The Chair: Ms Smith.

Ms Smith: Thank you for coming in today and providing us with this presentation. I want to follow up on something Ms Martel just said. First of all, I'd like to thank Ms Martel for her advice; it's always nice to have. I also want to ask: You are of the understanding that in the framework that's been provided, the accountability agreements will be between the board and the ministry? That's what we foresee in the amendments that should be presented.

Mr Renken: I've seen that.

Ms Smith: That still raises concerns for you about your board membership?

Mr Renken: It's still the same. We're still convinced that may not be an appropriate process.

Ms Smith: That having an accountability agreement between the board and the ministry would still cause your board concern?

Mr Renken: No, that's fine. We're quite prepared to have an accountability agreement. As long as it's between the board and the minister, that's fine.

Ms Smith: That won't impact on the membership?

Mr Renken: As long as it's negotiated and everybody has reasonable notice.

Ms Smith: That's great. That's what I was trying to get at.

You did make reference to the rural setting. Also, on page 6 in your presentation you say, "Service planning may not reflect care delivery required in low-density populations." We haven't had a lot of presentations from non-urban health care providers; we've had a few. I was just wondering if you could expand a bit on what concerns you might have that accountability agreements might not reflect the specific needs of a rural setting.

Ms Campbell: Accountability agreements are likely to make assumptions about how care is to be delivered that may not reflect our reality. I'll give you a specific example. The stroke strategy that's rolling out across the province identifies a particular mechanism to use in looking at the handicap to stroke patients around swallowing. That mechanism, to be blunt, did not work in rural Ontario. It implied there would be a team that would be trained and able to carry out this service on behalf of all parts of the hospital that would have need for stroke care. In reality, we have 11 hospitals in the province, and a team is not going to be able to perform that function. That reality had to be taken into consideration, in terms of our planning and our service design, and had to be quite significantly changed to allow that to be carried out. That would be a specific example, out of the stroke strategy, where there is an assumption that the care delivery model that works in an urban centre can be applied to a rural centre.

Other similar issues come up around the availability of health human resources: an assumption that you would have ready access to all kinds of health human resources that frankly my population doesn't have access to. Those would be a couple of specific examples.

The Chair: Thank you for coming today. We certainly appreciate your input.

SOUTHLAKE REGIONAL HEALTH CENTRE

The Chair: It had been our intent at this time to hear from Ms Olga Kremko, who is not with us, but I understand that our delegation from Southlake Regional Health Centre is here and is prepared to go ahead a few minutes early. Is that correct?

Mr Stephen Quinlan: Yes.

The Chair: Come on down then, if you would. Welcome. As you make yourselves comfortable, I'll explain the rules a little bit. You have 20 minutes. Use that any way you see fit. If there is any time left at the end of the presentation, we'll split it proportionately among the three parties. If you would introduce yourselves for Hansard, it would be appreciated. The floor is yours.

Mr Quinlan: Thank you, Mr Chair and members of the panel. We will each introduce ourselves as we present. My name is Steve Quinlan. I'm a member of the executive committee of the board of Southlake Regional Health Centre. By way of introduction, I'm also the past president and chief executive officer of Seneca College in Toronto. I volunteer my services not only to this board but also to the province of Ontario through the board of Ontario Exports Inc, which you know is the arm of the Ministry of Industry and Trade designed to assist Ontario manufacturers in exporting their goods and services. I also volunteer as a board member of the Canadian Education Centre Network out of Vancouver, British Columbia, which is designed to bring international students into Canada. I serve on the board of D'Youville College in the United States, which provides Ontario with 800 to 900 students every year who fit into our elementary and secondary schools as qualified teachers. I also provide educational consulting services around the world as a volunteer, and recently worked in South America, the Far East and the Middle East.

I use this by way of introduction, because I feel that my qualifications and experience may even be very pale in comparison to the sense of community spirit and giving that we currently enjoy on the board of Southlake Regional Health Centre. It truly is a focus on our society and our community that has transformed Southlake from a rural community hospital in northern York region into a regional tertiary health centre whose programs serve a population base of 1.3 million, which has grown over 400% in the last 30 years and represents one of the most diverse populations in Canada, with over 50 different languages spoken on our streets daily.

At the outset, I must say that this vision of transformation, which I referred to earlier, initiated some 10 years ago, would not have materialized had it been left exclusively to the Ministry of Health. The obvious concern of the ministry in the last decade has been cost containment, despite an overwhelming increase in population within the 905 area and a complementary increase in the aged population. Indeed, we live in and serve the fastest-growing community in Canada. We don't dispute for a moment the ministry's intention or focus, and we would go so as far as to say we understand it, given the economic reality of the last decade. But having said that, government cannot and should not deny a growing population the health care it needs. Indeed, I would be remiss if I didn't suggest to you that government has a moral and ethical obligation to respond to those needs.

Our progress as an organization was premised on an evidence-based approach to decentralization of tertiary services closer to home. It is a long commute from our community into Toronto. Those improvements came through extensive ongoing negotiations with the governments of the day in a very sincere and genuine attempt to address the increasing needs of a rapidly growing and, as I referenced, increasingly diverse community.

Yes, we did prevail in having an agenda of growth in tertiary programming adopted by the Ministry of Health. This accomplishment was accommodated successfully because of the many checks and balances that were implemented throughout an ongoing process of justification and planning. This due process was not an enjoyable element of the progression I have noted over the last 10 years; however, in hindsight, our dogged determination and the ministry's cautious and systemic approach were forces that were required to ensure these complicated and comprehensive programs would be planned appropriately.

Bill 8, specifically sections 22 to 28, will ensure that this type of innovation and what we refer to as visionary leadership by a board and its administrative staff will never occur again. Is this really what each of you wants in one of the fastest-growing electorates in Canada? Instead, we suggest that a sincere and genuine commitment to enhance the quality of life of our communities and increase the scope of services in a rapidly growing and aging region will be penalized severely, without due concern for the public interest. In addition, I ask you to reflect for a moment: What competent and committed CEO would risk his or her career pursuing a growth-and-quality agenda when exposed to a law containing sections 27 and 28 of the current Bill 8? Those who would remain would be followers, not leaders; bureaucrats, not CEOs. Their focus would essentially be one of "Yes, Minister," not one that would inspire and motivate our medical staff. Community needs and concerns would be fleeting considerations, and it would not be long before it would take four months to get a doctor's appointment, just as it now takes four months to get a plastic birth certificate.

1540

This is not supposition; it is a fact that any reasonable, objective and informed constituent would conclude in reading Bill 8, based on its tone and its unprecedented attack on community boards of hospitals and their CEOs. It is intended, in our view, to quell the visionaries in health care and punish in an unconstitutional fashion those who would challenge the fiscally driven intentions of the province as they relate to health care.

Should we strive for greater accountability in health care? Of course we should, and we must. How can we do that? We refer you to page 2 of our submission, where we have identified 13 key performance indicators. We could well identify a further 13, and we believe this is something that should be seriously considered.

Can we demand efficiency and effectiveness in the delivery of health care? Yes, no question about it. We, as a board, have an obligation to do exactly that.

Should we encourage a responsible and innovative provincial focus as it relates to quality in health care? Yes. It is overdue and is anticipated eagerly by all providers and volunteers who respond to any element of our health care services. But should we accomplish this increased accountability through a bill that threatens and punishes the very providers and volunteers who have delivered unselfishly in the past? I think not.

To treat so shabbily and disrespectfully our health care providers and volunteers, without whose help we could not run our hospitals, would imply that the Ontario health care system, our hospitals and our providers are failures and have acted irresponsibly in shaping the current system. The evidence to the contrary is indisputable. Ontario remains the most efficient and effective province relative to hospitals in all Canada, and this accomplishment was realized despite the lowest per capita allocations and the lowest per capita acute care bed complements in a province characterized as the economic engine of Canada.

On a very personal note, my first read of Bill 8 left me feeling ashamed and culpable for something I must have been party to that was wrong or irresponsible, but in my heart I know that not to be the case. Surely, to have a government feel compelled to wield this type of power localized under any one individual and to have his or her sights levelled toward hospital boards and CEOs left me feeling ill, to say the least. As a trustee of a busy 905 hospital, I said to myself, "Was I party to some irresponsible, misguided plan, which had as its intent the bankruptcy of the health care system, with no consideration for patient care or fiduciary responsibilities?" I know that was not the case. Neither I nor my fellow board members felt that way.

All of our board are responsible people: active and retired chief executive officers, senior executives of major provincial institutions or corporations, or professional people who have been held accountable all their lives to shareholders, investors, customers, regulatory bodies or the like. We know what accountability is, and we know what accountability is not. Let me assure you that accountability is not bureaucratic control. Let me repeat that: Accountability is not bureaucratic control. What is it, then? It is leadership, vision and fiduciary responsibility, all of which we practise on a daily basis.

I wish to suggest that accountability is a two-way street. Members of the Legislature have responsibility and accountability to the people of Ontario. Accountability goes both ways.

In December, we opened a cardiac care centre at Southlake Regional Health Centre. It's been operating for three months. Every day of the week, we operate on patients. Our wards are filled with those patients. To date, we have not received five cents in grants from the government for this service. We're financing it entirely ourselves.

In three months' time, we opened approximately 100 new beds. We have no equipment, and we have no furnishings. We are still awaiting approval on our capital budget for that facility. Indeed, it may be done and it won't open for use by the public. So I ask the question: Is that accountability? I phrase that in the context of accountability being a two-way street.

I feel proud to serve as a volunteer trustee on a board that represents my community hospital. I welcome increased accountability and any development that will benchmark quality initiatives so all elements of our system will benefit. Appropriately structured and nego-

tiated accountability agreements are perhaps timely and required additions to the complement of checks and balances we utilize on an ongoing basis to maximize our efficiency and our effectiveness in the delivery of health care in this province. Nevertheless, we firmly believe that all the aforementioned developments can be achieved without sections 22 to 28 of Bill 8.

I would ask the panel to seriously consider the Southlake submission, which highlights our objections to Bill 8 and also emphasizes the positive elements of increased accountability in health care when done right. We are not asking you to do this alone. We would welcome the opportunity to work with you to achieve mutually beneficial outcomes.

The official submission, endorsed through signatures of the entire board, will no doubt provide a less personal analysis of this bill. Yet the conclusion remains the same: Bill 8, even in its recently revised form, is inappropriate and will lead to the elimination of community boards throughout the province. I conclude by asking this panel: Is that what you really want?

Thank you for the opportunity to make this submission. I'll turn it over to my colleague Nancy.

Dr Nancy Merrow: Thank you for the opportunity to address the committee today. My name is Nancy Merrow. I'm a family physician with a sub-specialty in palliative medicine. I speak to you today as the acting president of the medical staff of Southlake Regional Health Centre, representing physicians practising at our centre.

By strange coincidence, I happened to be under the weather yesterday and had the opportunity to watch the committee on TV. I'm very impressed with the process here and how organized you are and how fair it's been—very timely. I was looking forward to coming down today.

It's clear from the tone of all the presentations I was able to watch and from the little I've heard today that we share the same struggle: How can we meet the needs, wants and expectations of Ontarians and their families—who are an increasingly health-savvy, aging population—within available resources?

I've submitted a letter to the committee, and my remarks will not repeat that but only reflect some of the main points.

I have three points to make, and the first is regarding availability of physician services under Bill 8. Bill 8 eliminates direct payments to physicians for insured services. This affects our hospitalists, pathologists and physicians providing mental health services in hospital programs. Long-standing inequities in the OHIP fee schedule have made these kinds of alternative payments necessary. Please don't destroy one if you can't fix the other.

The second point is that the physician human resource pool is a fragile one. The bill sends yet another message to providers that somehow we are part of the problem and that if we could just be more accountable, the system's problems could be fixed. In this time of physician human resource crisis, this is the wrong message, that somehow we aren't doing enough to control costs. Providers need to hear that the minister is joining the effort to meet the needs of Ontarians and their families, not abdicating his accountability to already overburdened providers.

1550

The third point is that my presence here today with my colleagues from the hospital board and foundation reflects how our organization responds to a perceived threat to our ability to care for our patients. Physician leaders, board members, foundation and administration work together effectively and locally to act on behalf of the community we serve. Bill 8 directly dilutes and diminishes the responsiveness of our board and CEO to the needs of our community. I do not want to see this advocacy ability eroded.

I would appeal to the committee and, through Ms Wynne, to the minister for a more collaborative approach to getting a handle on matching needs and expectations with resources. To devolve accountability when resources are centrally controlled is a recipe for disaster. Bill 8 alienates the volunteers and professionals on whose goodwill and dedication the system survives. I urge you to make the amendments necessary to present to your provider partners the spirit of shared responsibility needed to move ahead with meaningful reform.

Ms Carol Oliver: I'm Carol Oliver and I thank you for giving me the opportunity to be here today. I am the president of the Southlake foundation. I've been in the fundraising business for 24 years, 11 of those years at North York General, seven when it was York County and now Southlake. Over this time I've raised well over $100 million, with the help of many affluent, influential volunteers. I'm also the past chair of the international board of the Association for Health Care Philanthropy. So I've had the opportunity, as Steve has, to get around the world a little and look at health care philanthropy.

You have a letter signed by the chairman of the foundation board and myself, so I'm not going to read that. I simply have three quick, but I think important, points I'd like to make.

The first point is, I believe there is a very real risk of significantly fewer charitable dollars coming to hospitals as a result of Bill 8. At Southlake we're now raising the final $1 million of a $16.5-million campaign. We're funding a new emergency, a new regional cardiac, as well as new cancer facilities. We've received over 8,000 donations for the campaign to date. Why did those 8,000 people give so generously? Because they love the quality of care and they respect the leadership of the board and the management of Southlake. Southlake will be launching yet another, larger capital campaign in the very near future to fund the new regional cancer centre, and I feel that this incredible power of community participation will be at risk. People are not motivated to write a cheque to the government. We have 42,000 donors in our database and they're all ready to help Southlake. I believe there are many campaigns in Ontario that will be compromised.

My second point is, I believe there will be increased fundraising costs due to the added expenses of foundations just trying to convince donors that there is some local ownership. As a fundraising professional, my performance is based not on the dollars I raise but on the cost per dollar raised. I want the money going to the hospital, not to PR firms that are developing messages that try to convince people we do have some local autonomy.

The third and last point, but I think it's the most important one, is the risk of affecting the motivation of influential volunteers. The whole key to raising large sums of money is dependent on having an army of influential and, hopefully, affluent volunteers. These people are leaders. They are CEOs who are willing to work incredibly hard. You just put a goal in front of them and they want to reach it. But they also want the power to influence the gifts, to be absolutely sure that those gifts are meeting the primary needs of their community.

The power of these volunteers is really awesome. I had lunch today with the CEO of a firm that has $1 billion a year in business. At lunch today he agreed to make nine calls. We discussed the range that should be asked for each of them. The lowest one was $100,000 and the highest was $1 million. We don't want to turn people like this off, or we'd be looking to the Ministry of Health for significantly more money to replace the millions that these dedicated volunteers would be raising.

The Chair: That was just about 20 minutes right on. Unfortunately, there is no time for any questions, but we certainly appreciate you appearing before us today.

OLGA KREMKO

The Chair: I understand the person who had previously been scheduled for 3:40 has since arrived. Olga Kremko, would you like to come forward. Make yourself comfortable. You have 20 minutes to make your presentation. If you would introduce yourself for Hansard, that would be appreciated. At the conclusion of your presentation, if there is any time left over, we will ask you some questions amongst the three parties.

Ms Olga Kremko: My name is Olga Kremko. I have been a citizen of Toronto all my life. I have participated in the Toronto Health Coalition and the Ontario Health Coalition, as well as other health-oriented things.

First of all, the preamble to Bill 8, the Commitment to the Future of Medicare Act, incorporates the principles of the Canada Health Act and the values of the Romanow commission. It does not mention that health care belongs to all Ontarians, as well as Canadians, because it is paid through our taxes. It does not include the negative aspects of the state of health care here in Ontario that have been introduced since 1995. These cuts were due to the federal budget of that year and made worse by the Conservative Party, which cut taxes to corporations and the wealthy. The preamble does not include concrete initiatives which show exactly how the present government would make certain we go back to the health care we enjoyed before 1995.

It does not mention the serious erosion of our public health system and to the universality, comprehensiveness and accessibility of our OHIP. This includes $100 million of services that have been delisted from OHIP. Some 9,000 Ontarians have no access to a family doctor—this is what the Ontario Health Coalition has said—and 25% of the physicians in practice are on the verge of retirement.

Due to the restructuring of our hospitals, we have fewer hospital beds and staff. Many have died waiting for beds or operations and others are still suffering, waiting for operations. Many elderly and disabled, although they previously would be in hospitals, have been forced to go into nursing homes and homes for the aged. The workers in these homes do not have the expertise to look after these people. In addition, the proportion of beds that is held specifically for those who can afford to pay a premium for a semi-private or private room has risen to 60%. These people go without even basic care due to cuts, and staff have been reduced. Only those whose families can afford to pay for their own caregivers are well looked after.

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Budgets for food in these facilities are less than for people who are incarcerated in penitentiaries in Ontario. The meat is tough and sometimes food is tasteless. There are fewer fresh vegetables and fruits available. Some families try to compensate by bringing in home-cooked meals.

The public facilities have been forced to compete with the private facilities, which the previous government supported. The consequence is that they are now as bad as the private ones.

Homemakers and home support services have almost disappeared so that caseloads from 2002 to 2003 have approximately 115,000 people, including frail elderly, who are left at home to look after themselves.

Drug costs are high and inaccessible for a growing number of people. The hospitals or whoever is managing the drugs do not examine the drugs because the new drugs are just repeats of the old ones. The finance committee wanted the elderly to pay more for their drugs. Before 1995, seniors did not pay anything for their drugs. Seniors have paid taxes for most of their lives and are still paying them. They deserve to have their drugs free.

The bill supports the prohibition of two-tier medicine, extra-billing and user fees. However, there are no specifics as to how they are going to do this. Fundamental to the universality of the public health system is the prohibition of two-tier medicine and extra-billing. In addition to the two-tier system mentioned above, there is two-tier health care, which is privatization. For-profit health corporations make a profit with user fees, service charges and two-tier access, the deleting of services and procedures for profit. Private laboratories charge fees now for pick-up and delivery and they affect long-term-care facilities as well as home care patients. Private MRI and CT scan clinics; people who pay out of pocket; medically unnecessary scans—those with the least medical need can jump the queue.

Service charges and fees for a whole range of services: Access to publicly funded physiotherapy, rehabilitation therapy and speech pathology is severely eroded. At some point within the next few months I have to go for physiotherapy, and from what I understand, I have to pay for it. Also, my mother had macular degeneration. There's a new drug that's out that can prevent macular degeneration. I am worried that I will get macular degeneration, and how will I be able to afford to pay for this drug? Apparently it cuts off at the halfway point.

Inadequate home care budgets led to massive cuts to home nursing, homemaking and personal support service. Those who can't pay go without and end up with preventable injuries and illnesses. To get on a doctor's list, doctors charge block fees to patients.

The health quality council is necessary to report on compliance with the principles of the Canada Health Act. The health quality council does not ensure reporting on to what extent the health system conforms with the principles and it's not required to make a report on issues such as two-tier medicine, extra-billing and user fees.

No person with financial interests in a for-profit health care corporation should be allowed to sit on the council. This arm's-length council should be composed of a democratically selected group appointed by all parties that represent patients, advocates and workers, as well as the so-called experts. They should include representatives from diverse groups, from geographically remote areas and from equality-seeking groups.

The purpose is to investigate how the health system conforms with the Canada Health Act principles of comprehensiveness, universality and accessibility and to report on two-tier access, user fees, service charges and extra-billing. It should have the power to make recommendations and to operate in a completely transparent manner. It should also report where the money goes.

You must stop the block fees and charges that create a barrier to access. It's a good thing that you're thinking of prohibiting physicians and other practitioners from opting out of OHIP, but the wording in the regulations allows the protection to be reversed. The government should not allow physicians to extra-bill by regulations. The college of physicians requires that the physicians allow patients to make the decision about whether or not they will pay block fees and cannot refuse a patient who will not pay in this manner.

It's good that you have the block fees under the control of the government. It allows the regulations of the bill to determine whether and how block fees are charged. Bill 8 needs to ban the practice. It violates the principles of the Canada Health Act. It is a barrier to accessibility. Physicians can charge on an item-by-item basis for the uninsured services. Severe shortages of doctors; abused patients; patients with few choices to leave a physician since they cannot find another one—they can't leave the physician they have even if he does ask for the extra fees.

The bill should address the transition to the team-based, salaried, reform primary care model used in community health care. Section 27 allows the minister to order fundamental changes in the health system with little if any public consultation, procedural safeguards, transparency or other checks and balances.

The system should be accountable to the people of the province and not to the minister—after all, we pay the taxes—and not publicly accountable in a top-down fashion.

There is no democratic control, no diverse representation on boards and governing bodies, no public accessibility to financial information about the health system. There's no whistle-blowing protection for health workers, no public consultation and meaningful input to changes in the health system, no democratic consultation prior to cuts, and no democracy and transparency.

Defunding and delisting: The important change is accountability to the people of the province. As I said before, they pay taxes for our health system.

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We have to stop privatization and ensure democratic, public, non-profit delivery of service. The P3 hospitals put millions of dollars of public funds into the hands of profit-seeking corporations for whom a veil of commercial secrecy obscures public scrutiny, over-profit taking and the misuse of public funds.

Higher borrowing costs, consultant fees, inevitable legal fees, outrageous executive salaries, fraud and profit-taking drive up the health care costs, making competing claims on scarce resources. In their endless search for profits, corporations seek new sources of revenues, imposing fees and service charges wherever they can. The motivation: the means for an increasing two-tiered health care system are increased. The result is the scope of services offered under the public system are refused. Beds and staff are cut, patients face a barrage of new fees, and two-tiering increases. Public accountability and access to information is reduced. Democratic control is reduced. Advertising, consulting and legal costs go up. Fraud goes up. Executive remuneration goes up. More and more of the health system is governed by a bottom line of profit margins and the rate of return for investors—which I understand is something like 25%.

We can provide masses of evidence from around the globe to substantiate these claims. Some of these are from England and Australia, where they end up paying two or three times what they would have normally paid if they had been done things the way they were before 1995, which is the federal and provincial governments, as well as the community, putting in money to bring in a hospital.

The creation of for-profit clinics to deliver hospital service poses serious threats to the sustainability of medicare. Access to good diagnostics is limited by the supply of equipment and trained personnel, that is, radiologists and technologists. While private clinics provide machines for which we ultimately pay, they do not increase the number of health professionals. The private clinics find their staff by poaching them out of public hospitals, leading to staff shortages in the public facilities.

In addition, they seek new revenue streams, including out-of-pocket payment for so-called medically unnecessary scans, a trick to get around the Canada Health Act. A person who pays for a medically unnecessary scan, as I mentioned before, jumps ahead of the queue, using up scarce resources for no reason and pushing back those with medical need in the waiting list. In addition, private clinics take the less risky and less costly scans, leaving the heavier-burden scans to the public system which has been deprived of personnel. They also take the third-party billing patients and those in WSIB, depriving hospitals of this revenue. These clinics make profits at the expense of the public health care system.

Also, I want all of you to realize that under the free trade agreements, once you privatize a system, you can't make it public. When you get the world trade agreements into it, you'll have thousands of corporations trying to get into the act. In the States, the HMOs are having really big problems. Some of ours, like Power Corp, are into the HMOs. They want to move into Canada because Canada is great big profit area for them. If you have something like cancer, the HMOs in the States won't even let you know, because it costs too much.

These P3 hospitals frighten me. I would be terrified of going into them, whether it's the one in Brampton or the one in Ottawa. I would be frightened because of their secrecy. You don't know what the heck is going on there. Also, there have been studies to show that people who go to private hospitals die a lot faster.

The Chair: You have about a minute left.

Ms Kremko: The main thing for our health care is that not only does the province have $5.6 billion of debt, but all our municipalities have it. Not just all our municipalities but also our hospitals and so on have large deficits. I feel that what we should do, for the time being, is have taxes go up 2% to 3%. You can do this. The other government did whatever they felt like doing. This government can do the same.

The Chair: On that note—

Ms Kremko: Also, there is the Bank of Canada. It takes more to borrow from a bank, because they have to make a profit. But we have the Bank of Canada, where we can get money at a very low rate.

The Chair: Thank you, Ms Kremko. That would be a great note to close on. We're more than out of time. I did extend your time a little bit, because I knew you were in mid-sentence. We do appreciate your input today. Unfortunately, there's no time for questions. We do thank you for coming.

Ms Kremko: I will try to hand everything in by Friday.

The Chair: Wonderful. If you would, we'd appreciate that.

HEADWATERS HEALTH CARE CENTRE

The Chair: Our next delegation is from Headwaters Health Care Centre. Bob Baynham, the CEO, Brian Shannon, chair of the board, and Glenna Carr, trustee, are with us today. Would you come forward and make yourselves comfortable. You probably have heard the rules by now, but I'll repeat them for you anyway. You get 20 minutes to use any way you like. At the end of your presentation, we'll apportion among the three parties any time that is left. If you'd introduce yourselves for Hansard, that would be wonderful.

Mr Brian Shannon: Mr Chairman, thank you for the opportunity of presenting some brief remarks to you and your colleagues regarding this important piece of legislation. My name is Brian Shannon, and I have the privilege of chairing the Headwaters Health Care board of directors. With me today are Ms Glenna Carr, one of the directors of the corporation, and Mr Bob Baynham, our chief executive officer.

Our hospitals are a source of pride in the communities we serve, which have been supported us on each and every occasion we have sought their support. I am convinced that we are well governed, well managed, have excellent and caring medical staff, and deliver health care very effectively.

We serve the county of Dufferin and the town of Caledon, which has a population of roughly 110,000 people. We're the result of a voluntary merger in 1993. We operate a 108-bed acute care facility in Orangeville and a 36-bed complex continuing care facility in Shelburne. Our budget is about $35 million, and I have the pleasure of stating that this year our budget will be balanced, as it was last year. We received our full accreditation last fall, and every time we have applied for accreditation, we have received it.

We're not without our challenges. We are short about 13 family practitioners in our catchment area, which, as you can appreciate, is a major problem for us, and we really would like to enhance our mental health services.

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As I said, we're the result of excellent community partnerships, and our community has a great deal of pride, not just in our facility but in the care we give. We have received continuously exceptional financial support and have the privilege of being the first hospital in North America to have digital imaging.

I'd like to make it very clear that we do support the establishment of a health quality council and the principle of ensuring accessibility, and we're very pleased with the principle requiring accountability. However, I find it very difficult to envision a scenario where a minister of the crown would find it necessary to circumvent our board and ignore our history of excellence and effectiveness in the manner outlined in this bill.

Ms Carr will now make some specific comments regarding the legislation. If I may, I'd like to make some closing remarks.

Ms Glenna Carr: Thanks very much, and good afternoon. It's a pleasure to have the opportunity to meet with you at this late time in the day.

I would like to speak directly to the areas where the objectives of accessibility and accountability can be strengthened and improved by changing Bill 8. I have

three points to make. You have our presentation, so I'll speak to some of the recommendations and add to what you have in front of you.

Community hospitals are not just a public asset. They are a matter of civic pride and of community confidence that quality care will be there for us when we need it. They are often the emblem or the symbol of how Canadians define or distinguish themselves and their values. The strong connection between our community and the hospital is, in our view, put at risk by the new relationship proposed by Bill 8 that will put the minister between the local hospital board and the hospital staff.

Our board does feel accountable to our community, as well as to the government, for public funds. We believe that strong and effective hospital boards with decision-making powers and accountability for their decisions are essential to maintain strong community commitment and relationships between the communities and health care providers. You have heard from very eloquent speakers this afternoon on this issue.

In our view, Bill 8 blurs the responsibility by creating a dual accountability for the hospital CEO to a minister rather than simply and straightforwardly to the hospital board. The board should be accountable to the community and to the ministry, based on a mutually negotiated agreement. Therefore, we recommend that Bill 8 preserve the role of local boards to be responsible to govern and to enter into accountability agreements with the provincial government.

My second point, the power of the minister and boards: The minister already has draconian powers, some might say, under the Public Health Act. He can put hospitals under supervision, and there is an array of other sanctions available.

In our view, the Ministry of Health should focus on results and resources required, not on detailed implementation. It is local boards that should provide the governance oversight and set local priorities.

We recommend that section 27 be removed to prevent an override by the minister of the existing relationship, the employment contract or performance agreements that already exist between a board and its executive.

The next point is on how to have effective accountability agreements. We embrace the need for accountability agreements. In fact, our chief executive officer, Mr Bob Baynham, has been already working with the joint committee to develop agreements for hospitals that are realistic in setting targets and defining measures that respect the need for mutual co-operation and commitment by both hospital boards and the Ministry of Health.

We're acutely aware that one size does not fit all and that there is a variety of ways and means to obtain the desired results. We will all benefit from embedding in the legislation the principle of having mutually agreed and negotiated accountability agreements between boards and the ministry, but it will be much more effective and sustainable over time if the specific nature and content of the agreements can evolve and improve in policy and in practice, rather than in inflexible, detailed legislative fiat. For example, to address health care as a system in the future, we may need to develop agreements that are multilateral and include community care and home care as well as hospitals. But let's learn to walk first and demonstrate that agreements between hospital boards and the government can in fact produce effective health care.

My last point is on mutual accountability and access. We believe that Bill 8 will be improved by recognizing that the minister also has accountability obligations, as well as hospital boards, to ensure that policy and resources are provided that will enable the achievement of medicare principles.

We believe that each hospital and community has access issues that must be addressed by the province as well as by local providers. In part, a multi-year funding commitment will help. However, we do have specific access issues that may differ from others. We do not all start at the same level playing field. It's not just a row of hospitals down University Avenue that we have in Shelburne and Orangeville. For example, we currently have no provision or resources for mental health and barely any for geriatric care. We have one geriatric psychiatrist who comes once a month. It doesn't seem to be enough.

We're also aware of unintended consequences that can arise. The Ministry of Health negotiates and signs agreements with the OMA. We live with the results. For example, recently an agreement was changed from a fee-for-service agreement to an alternative funding arrangement. This is a fixed price. It has impacted seriously on our wait times for emergency services. It was not the intention to do that; it was an unintended consequence. But that's something we're trying to improve. It was not our doing; we are trying to play catch-up with the result.

Therefore we think it's important that Bill 8 reflect the mutual accountability of both government and boards to ensure that the principles embodied in the legislation are not just lofty sentiments or good intentions.

Mr Shannon: I recommend that the members be very cautious in taking in any action that so clearly undermines hospital governance in this province. No one is well served by so cavalierly circumventing the relationship between a board and its chief executive officer.

I've been a hospital trustee for six years, and I sincerely believe that hospitals in Ontario are a source of pride, not a source of concern, as envisioned in this legislation. I suspect and am convinced that there are very few boards or hospital administrators who need external assistance in governing or managing these facilities. Delivering effective health care in this province is common practice. It's a result of the partnerships existing in and among our communities. The key to an effective provincial system is the continued support of the ministry, working in consultation with its partners, the community-based hospitals.

In closing, we agree with the principle of public and, more importantly, personal accountability and are content that the minister has the capacity to implement this now without this bill and specifically sections 22 to 28.

Performance expectations of both partners need to be clear, agreed to and committed to by boards and the minister. Accountability agreements need to be sensitized to local needs, programs and services and fiscal realities. The minister must commit to setting realistic expectations, establishing meaningful performance indicators, providing realistic and equitable funding and recognizing the systemic role and requirements of our partners, such as community care access centres, health councils and other community-based health service providers.

We'll entertain your questions, if you have any.

The Acting Chair (Mr Brad Duguid): Thank you very much. There are about nine minutes left for questions, so three minutes a side, beginning with Ms Smith.

Ms Smith: Thank you, Mr Duguid. It's nice to see you in the chair.

Thank you, all three of you, for coming. It's nice to see you again, Ms Carr. I'm very appreciative of your input. You are aware that there have been discussions ongoing with the OHA over a number of months with respect to this particular bill. We brought this bill forward for public consultation after first reading, knowing full well that we would need adjustments, and the minister in his statement last Monday did state that there would be adjustments.

Have you seen the framework for the amendments we are proposing?

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Mr Shannon: Yes.

Ms Smith: So you are aware that the accountability agreements we're talking about in this legislation would be between the board and the ministry, not the CEO. You did discuss a concern that there would be interference between the relationship of the CEO and the board. You are aware that the proposed amendments would include agreements between the board and the ministry, not the CEO; is that correct?

Mr Shannon: That's clear, but I think it's important to highlight that that can be done now. You don't need a piece of legislation to do that. I can't think of one board in this province that wouldn't co-operate with the minister in developing a performance agreement.

Ms Smith: Are you saying you don't see the need for accountability agreements at all?

Mr Shannon: No; they're a good idea, I believe. I'm very comfortable with the principle and the practice of them. It doesn't necessarily follow from that that it needs to be in legislation.

Ms Smith: As they're described in section 19, "an agreement establishing any one or more of, (a) performance goals and objectives respecting roles and responsibilities, service quality, accessibility of services, related health human resources," and on and on: Are those the kinds of things you would expect to see in an accountability agreement?

Mr Shannon: I think so, but as I said, you have to be very realistic. There are 100-odd hospitals and you're going to have to be very sensitive to the realities of each individual hospital, whether they're community-based, the programs there, the services that are appropriate there. This is not a simple task. I think it's quite a dramatic task. It's a worthwhile task but you have to be very realistic in terms of how they're developed and how sensitive you are to the needs. The needs of our community are far different than any other community around. So it's a challenging thing to do but it's not a statutory thing.

Ms Smith: Absolutely. We have heard from a number of presenters over the last several days about the need not to have a cookie-cutter approach but an approach that would address the needs of the very different facilities and how you provide health care in your community the best way possible. So we have heard that, we've had a number of presentations on that and we appreciate very much your input today.

The Acting Chair: On to the Conservative Party.

Mrs Witmer: You mentioned digital imaging. I can remember having the pleasure of visiting the hospital when that was new and, you're right; you were first. Congratulations to Headwaters Health Centre. You've done an excellent job over the number of years that I've been familiar with the hospital as to the service you've provided to meet the local needs. We wish you continued success.

The one thing that's really impressed me as I've attended these hearings and read the submissions is the passion and the sincere commitment that board members on hospital boards in this province have to the hospitals they serve. I think it would be extremely unfortunate if, at the end of the day, the government did anything to eliminate the governance structure as it presently is and shifted power to the minister. I hope the minister and his staff and members of government have seen how well served the people in this province are by people such as yourself.

If you take a look at the fact that the entire part III, the accountability agreement, is the one that seems to be giving hospital boards the greatest concern—it has been suggested that it needs a total rewrite. The government has indicated that perhaps they are willing to step back and make some changes to the bill. If that's to be the case, would you support that those amendments would come back to a committee like this and you would have one more opportunity to give your input in order to ensure that the needs of your community would continue to be well served by the new legislation?

Mr Shannon: We'd look forward to that. I don't mean to be political, but I was quite surprised at the alacrity with which this piece of legislation hit the street. I think everybody should be more sensitized to each other before we present something of that nature to the assembly. There are lots of other ways to achieve what the minister appears to be wanting to achieve rather than through this bill. I really would recommend that we take our time. That's why I said to be very cautious. You don't need to be told about the number of activities that go on municipally and in communities that are volunteer-based. To cavalierly intervene there is fraught with risk, I

think. There is pride in every hospital in this province for good reason. Those communities built them. We provide a provincial service, but our communities built them and love them and care for them. So just be very careful.

I'm very concerned why anyone would intervene between our board and Mr Baynham. He has respect for us and we have respect for him. Why would you so quickly insult him and me and our colleagues on the board by intervening in that relationship? There needs to be some sensitivity here.

I'd recommend that you just slow down a bit and maybe rethink if there are ways to achieve what you want other than putting through a bill which—I'm an effectiveness nut, and I can't see the effectiveness dimension in the bill.

Mrs Witmer: Right. I think you said there is a need for more consultation.

The Acting Chair: That's it for your time. Ms Martel.

Ms Martel: Thank you for being here today. Ms Carr, it's good to see you in a different capacity. Welcome.

Let me start with something the parliamentary assistant said—because she said it to you and she has said it to others today: that there have been discussions and consultations etc going on about this for months. If that's the case, I can't understand why the government, through the minister, came back last week with a set of proposed amendments that don't resolve the concerns of hospital boards. They just don't.

Let me use the example you ended on, which was the government getting between the relationship between yourself as a board and your CEO. It's very clear in what we got last Thursday that section 27 continues to prevail. It says it would only apply to CEOs, but it still prevails. The minister can come in at any point and do a compensation clawback on your employee, without your input and without your approval. If there were consultations, how come that is still in this bill, in the proposed changes the government wants to make? Do you still have concerns?

Mr Shannon: I have concerns. I'm not sure if your question should be directed to me.

Ms Martel: Let me ask you another one. I've heard them say a couple of times now that there have been consultations on this for months. First of all, the bill wasn't introduced until about November 27, so it's hard to say it has gone on for months. Second, you would think if the government had heard the concerns, we would not have been presented with a two-page document last week that doesn't resolve the concerns.

The second area has to do with the power of the minister with respect to compliance directives and orders. The minister was in this committee two weeks ago and said that these things are going to be negotiated, but he comes back to us with a proposal that, at the end of the day, still says that he and he alone has the unilateral right to issue compliance directives and orders. I fail to see where the negotiation exists in that. It certainly is beyond the power he has in the Public Hospitals Act right now, which is, as Ms Carr said, pretty substantial now. If your concerns had been listened to, don't you think that section would have been changed to reflect that we're going to get to this position but only after negotiations, and if we can't agree, maybe we'd have binding arbitration instead of unilateral orders by the minister?

Mr Shannon: I wouldn't even be comfortable with binding arbitration. I wouldn't be comfortable with any relationship where the government intervenes between the board and its CEO. It's just not appropriate in human resources practice, in law, in any way. It's just not a good activity. So, no way is that a palatable thing for anybody to be doing in terms of intervening between the board and the CEO.

Ms Martel: But this goes even beyond the CEO, because the minister, under that provision, could certainly issue an order or a compliance directive directly to the hospital board. This is over and above what he can do to your CEO. The minister has some powers under the Public Hospitals Act. If there's a rogue board, he can get it under control using the current mechanisms. Can you give us any reason why you think the minister might have been provoked to take the step he's taking in this particular piece of legislation?

Mr Shannon: I don't think it's appropriate for me to speak for the minister.

The Acting Chair: That's a good answer, because your time has just run out. Thank you very much for your deputation. We really appreciate your taking the time to come down here.

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GTA/905 HEALTHCARE ALLIANCE

The Acting Chair: The next presenter is the GTA/905 Healthcare Alliance; Jane Watson, chair. Welcome, Ms Watson. You have 20 minutes to use however you wish.

Ms Jane Watson: Good afternoon. My name is Jane Watson, and I am the chair of the GTA/905 Healthcare Alliance. The alliance is an amalgamation of all of the 11 hospitals in the GTA/905 area. In other words, we represent 22 sites from Oshawa to Burlington and north past Newmarket. We have been in existence for eight years, and our membership consists of the chairs and 11 CEOs of our hospitals. We meet regularly to discuss how we can work with the government to ensure the residents of our communities receive quality health care closer to home.

None of our hospitals disputes the principle of accountability. Although we're unsure of precisely why the bill was written and the specific problem it was set up to rectify or who provoked it, we certainly cannot argue with the sentiments in the preamble—no one who values the Ontario health care system could.

However, despite the good start, the original bill, particularly part III, seems to deteriorate into a series of heavy-handed demands and rigorous threats. Therefore, we were pleased to note that in his comments of February 16, the minister has admitted he believes the tone is not right in some areas, and that boards and CEOs do hold

positions of great honour and responsibility. He also promised to introduce amendments clarifying the process for entering into accountability agreements.

However, not all of the amendments or the regulations are yet available, and I must be accountable to my board, to the hospitals they represent and to the communities they serve. Hence my presence here today.

I am aware that you've already heard from numerous delegations, and you're probably tired of hearing the same message, but I beg your indulgence while I reiterate the concerns of the GTA/905 Healthcare Alliance with Bill 8 and offer some of our recommendations.

The alliance hospitals endorse the concept of a health quality council. The public and the government deserve to receive third-party information on our services and outcomes. We are confident these reports will substantiate our need for additional funding and hopefully will lead to the development of some long-term plans for meeting Ontario's health goals and commitments.

However, we do have one recommendation in this area. Section 5 should read that, "The council shall in each year deliver a report on the state of the health system in Ontario to the public and to the Legislature." In other words, the council should report to the Legislature—not the minister, as the bill currently reads. This would make the process more transparent and increase its chances of success, as it would truly be reflective of the needs and concerns of the citizens of Ontario.

With regard to health services accessibility, accessibility to health care services is one of the cornerstones of the Canada Health Act. The GTA/905 Healthcare Alliance supports efforts to ensure accessibility in the system on behalf of the 2.6 million residents in the regions of Durham, Halton, Peel and York. In reviewing the proposed legislation, the alliance has identified two key areas for consideration to ensure appropriate access to health care services.

First, although the bill has an accessibility component, we believe equitable and enhanced access to health care services requires a mechanism to ensure timely access. Patient wait times need to be appropriately measured, and patients should not be adversely affected by inherent problems in the health care system.

Second, alliance hospitals are concerned that provisions in the legislation banning payment of hospital physicians will contribute to the growing problem of recruitment and retention of key hospital positions. In a perfect world, hospitals should never have to pay directly for a doctor's services. However, in the real world there is a severe shortage of physicians. In high-growth areas such as ours, paying doctors to serve as hospitalists has been a creative solution to ensure accessibility to hospital services for people who do not have a family doctor.

Our recommendation here is that the proposed legislation needs to more closely examine measures dealing with accessibility to clearly state the government's commitment to reduce wait times and to ensure that patients receive equitable access to service, when and where they need it. In addition, in subsection 9(2) the ban to prohibit physician payments should be eliminated.

With regard to accountability, the GTA/905 Healthcare Alliance hospitals support government efforts for increased accountability and the development of performance agreements for both hospitals and other health care providers, but we have serious concerns with how accountability measures are presented within the proposed legislation.

First, for accountability measures to be effective, they must apply to both hospitals and the government. Mutual accountability establishes a pro-active, partner-oriented system and is based on respect and recognition. We need this to establish a sustainable, effective health care system that will respond to the needs of our citizens.

Second, hospital performance agreements need to be negotiated between the government and hospitals to enable hospital boards to make the best health choices for their organizations and communities.

Third, negotiated performance agreements also encourage a collaborative relationship between the Ministry of Health and Long-Term Care and hospitals by establishing expectations, standards, performance benchmarks and the implementation of best practices, and preventing the micromanagement of the hospital system.

We believe, therefore, that the proposed legislation needs to incorporate a collaborative approach between government and health resource providers through a process of mutually negotiated hospital performance agreements, where accountability measures apply to both parties in a balanced and equitable approach. I understand that the minister has now promised that the accountability agreements will be negotiated. However, we believe this should be clearly stated in the bill, along with who exactly makes the decisions and when the decisions are to be made.

In addition, the GTA/905 Healthcare Alliance firmly supports the OHA's suggested reworking of sections 21 and 22, including its proposal for a due process for negotiation and renegotiation of accountability agreements. I know you got that information on Monday.

Just as an aside, though, I do want to caution the government that for negotiated performance agreements to succeed, the government needs to bring hospital per capita funding to appropriate and more consistent levels across the province.

I have four comments under governance.

First, the minister's enhanced role under the new proposed legislation provides sweeping powers without clarifying the minister's accountability role to both hospitals and the communities they serve. In our opinion, the existing bill will make hospitals agencies of the government and not their communities. This seems to completely contradict the goal of the current government.

Second, the minister's proposed right to direct hospital boards to sign accountability agreements without negotiations, to issue compliance directives to hospital executives and to terminate agreements essentially and fundamentally undermines the role of the hospital board.

I served as a board member of Credit Valley Hospital for 11 years, two years as chair, before I took on my current role. I joined the board because I thought I could make a difference to my community hospital on behalf of my family, friends and neighbours. I would have had no interest in joining a board that existed merely to rubber-stamp dictates from a third party.

Most board members feel the same way. During my volunteer tenure at the hospital, I interviewed numerous candidates for positions on the board. They all came with one thought in mind: to bring their expertise to help the hospital and support their community. I was often asked, "Is this a working board?" Fortunately, I could always answer, "Yes." I am not sure I could give the same answer if this bill, as it currently exists, is implemented.

Third, the existing bill also allows the minister to unilaterally alter terms of employment with hospital executives. As a person who has sat on numerous committees to select the right CEO for the hospital and the community and to choose a senior person with the right skill set to help us achieve our goals, I am personally insulted.

My work with hospitals is non-paying. In fact, it is often expensive as it can take me away from my for-pay responsibilities. Therefore, it has always been in my best interests and in the best interests of my community to choose a person who I believe can get the job done right and get it done correctly.

If I ever made the mistake of hiring someone who was inappropriate or who was unwilling to follow mutually negotiated agreements, it would be up to me to terminate their employment. I can assure you that I would not hesitate to do so. After all, their incompetence would be impacting my community. Through the alliance, I work with 10 chairs on a regular basis. My sentiments are not unique.

In addition, the bill increases the chances for the CEO to be placed in conflicting circumstances. His salary comes from one group, but tenure is impacted by another agency. Will a CEO's time then be spent walking a tightrope trying to keep both parties happy?

Another fallout from the current bill is that hospital foundation boards may have difficulty in executing fundraising initiatives under the shadow of the proposed legislation and the uncertainty of whether agreements may be terminated and hospital projects carried out. I think this was amply demonstrated a little earlier with the group from Southlake. In addition, local communities may be reluctant to support hospital fundraising efforts if the Ministry of Health has the power to override hospital board and executive decisions.

We also recommend that sections 23, 24 and 27 be deleted as they are unnecessary.

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Furthermore, there are a number of initiatives currently in development by the OHA and its member hospitals to provide governance and administrative support to hospitals that experience challenges in carrying out their duties. Therefore, some of the amendments I just mentioned are unnecessary.

In summary, the accountability and transparency sentiments embedded in this bill are fundamental to the quality of health care that the residents of Ontario deserve. However, sections of this act must be clarified to make it a workable document. We realize there will be amendments and regulations. We would appreciate the opportunity to come before you again to provide input in these areas.

Together, the Ontario government and its hospitals can build a health care system that would serve as a model for the rest of the world, but we have to work together.

Thank you. I'd be pleased to answer any questions you have.

The Acting Chair: Thank you, Ms Watson. There's just under nine minutes to be shared, starting with the official opposition.

Mrs Witmer: Thank you very much, Ms Watson, for your presentation. In the last point you focused on—well, I guess not quite the last—you mentioned the fundraising. We've heard from a couple of other hospital boards that certainly if we were to take away the power, the governance structure that we presently have in place, it could have a very negative impact. We saw that recently in Cambridge, when a supervisor was imposed and there was no board. It actually did have quite a negative impact. The community wasn't quite so keen to get involved in the fundraising, and they're now hoping that will change. So I think that's a really important point and I'm glad you brought that forward, and others as well.

You've said here that you believe sections 23, 24 and 27 should be totally deleted. Could you just reiterate why you feel those should go in their entirety?

Ms Watson: Section 23 refers to the continuation of the agreement, and it brings into play people. When somebody signs on behalf of the corporation, it's the corporation that is in charge of the contract, not the person. So that part is redundant; we don't need that at all.

Section 24 is the termination clause. Again, that shouldn't come into play. It's the CEO who's responsible for the termination.

Section 27 again relates to the terms of employment of an individual. If a performance agreement is not met, the contract is with the corporation, not with the individual.

Mrs Witmer: I appreciate that. The one question I've been asking is, would you like to come back and have an opportunity to comment on the amendments to the bill, which I think at the end of the day are going to be quite overwhelming? I guess you've already indicated here that you would very much appreciate that opportunity before it goes back into the House for further debate and discussion.

Ms Watson: Definitely. The alliance hospitals want to stay within the whole process. We're in the beginning, and we want to continue right on.

Ms Martel: Thank you for being here today. Have you seen the revised framework for amendments that the minister made available to the committee?

Ms Watson: I saw it briefly when I came in the door today.

Ms Martel: That was the first time?

Ms Watson: Yes. The OHA did send out something similar, with the amendments. Again, your earlier comments in relation to the board do not seem to be addressed here. I really want to make that clear, that the CEO reports to the board and should not report to the minister.

Ms Martel: So any efforts by the minister to do a clawback on compensation or apply financial penalties or remedies as a result of non-compliance would be inappropriate for you, in your past capacity as board chair and a different capacity now?

Ms Watson: Definitely inappropriate, and I would not see why someone would want to come to a hospital and be the CEO with the idea that the minister could throw them out and take away their compensation package.

Ms Martel: Or even just trying to serve two masters, because in essence that's the position they would be put in.

Ms Watson: Definitely.

Ms Martel: You'd want to grab a copy of the document before you leave, because you would also want to take a look at some of the other sections. You reference section 27, which still says it would apply to CEOs. I think you reference sections 22 and 23. I apologize if I have that wrong. There are some suggested changes. I don't think you're going to get a whole lot of comfort once you read those. So I suggest you take that back and your boards can share that, and then you can see where we end up after March 9, when we will actually start dealing with clause-by-clause on this. I suspect this will have to come back for public hearings again, because there are so many changes that have to be made.

One question I had for you had to do with your recommendation under accessibility. You stated that the legislation needs to more closely examine measures dealing with accessibility to clearly state the government's commitment to reduced wait times. This is on your page 3. Can you give the committee some idea of what your specific suggestions are with respect to that? What is it that you would like to see in the bill around accessibility that would give you some sense that the government has some accountability back to the system and to patients as well?

Ms Watson: This is something interesting, and I'm not sure whether it would go into the act itself or more into the regulations. What I was concerned about was that in the preamble, it talks about access based on assessed need. To me, everybody in Ontario has access to the hospital system, but it may not be immediate. It could be a week, three weeks, four weeks, perhaps several hours. The preamble, which is wonderful, doesn't address the fact that it should be timely access. What we mean by timely, I don't know, but there has to be some way of figuring out how long we're prepared to let somebody wait before they have access to a doctor or to a particular procedure.

Ms Martel: Or access to cancer care treatment etc.

Ms Watson: Exactly.

Ms Wynne: Thank you for coming today. Thanks for your presentation. You said we're tired of hearing the same recommendations, but you know what? It's always interesting to get people's perspective and there's always something unique about the presentations.

I just wanted to go through some of the comments you made, and then I've got one question, OK?

Ms Watson: Certainly.

Ms Wynne: You're generally happy with the idea of a health quality council?

Ms Watson: Generally, yes.

Ms Wynne: On your issue around section 9—I know you haven't had a chance to look at the document that Ms Sourial just gave you—the proposed amendment there would amend that section to permit payments by public hospitals and mental health facilities for insured services rendered in those facilities: hospitals and laboratory physicians. I think that's what you were concerned about, and that's the direction we're going.

Ms Watson: Good.

Ms Wynne: There you go. One down.

Your concerns about sections 21 and 22: I just want to clarify that it is going to be laid out more clearly that the accountability relationship is between the minister and the board and that there will then be a performance agreement between the board and the CEO. That's certainly something that a number of hospitals have supported.

I understand that at the end of the day the concern is about the reaching over the board and dealing with the CEO—I want to come back to that—but the fundamental structure that's in place is from the ministry to the board, and then the board holds the CEO accountable.

I'm just a little worried about some of the language around the loss of authority of the local boards, because that's certainly not the intention of this bill. Right now, the minister can send a supervisor into a hospital board. That clause already exists in the Public Hospitals Act. Do you want to comment on that?

Ms Watson: There seems to be a conflict here, because the bill directly says the minister will establish an agreement with the CEO.

Ms Wynne: What I'm saying is the amendment is going to clarify that. The agreement is going to be between the board and ministry, and then there will be a performance agreement. Part of it is that we're talking about performance agreements and accountability agreements, but the accountability agreement that's envisioned in this bill is between the minister and the board. That's going to be very clearly articulated. Then what's also going to be clearly articulated—and it's referenced in our note about the amendments from Mr Smitherman—is that due process and notice and all those provisions that will be in place before the minister can take any action around the CEO are going to be laid out.

Again, there are some boards that have taken heart from that. We had a presentation today from Scarborough

Hospital, and that seemed to be moving in the direction they wanted. I'll leave that with you, but due process is part of it.

The Acting Chair: That's it for time. Ms Watson, thank you very much for joining us today.

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ONTARIO LONG TERM CARE ASSOCIATION

The Acting Chair: The next presenter is the Ontario Long Term Care Association, Karen Sullivan, executive director, and Nancy Cooper, director of policy and professional development. You have 20 minutes, to be used however you wish.

Ms Karen Sullivan: Good afternoon. I'm Karen Sullivan. I'm the executive director of the Ontario Long Term Care Association. With me today is Nancy Cooper, our director of policy and professional development. I'd like to thank the committee for agreeing to hear our views on Bill 8.

We're here today on behalf of our members, who operate over 400 long-term-care homes and provide care and services to over 45,000 residents throughout Ontario. Our members are a mix of private, not-for-profit, charitable and municipal organizations, in most cases with decades of hands-on experience. They have the wisdom that comes from having advocated for and adapted to significant changes in their legislative, governance and accountability frameworks.

For most of the past decade they've been attempting to meet a combination of increasing resident care needs and growing public awareness and expectations. This experience provides the context for our comments today. We hope it will help foster an understanding of our concerns and provide a learning experience.

I'd like to start by saying OLTCA supports the minister's intent to move the legislative and policy framework of our health system forward in concert with a changing environment. In so doing, however, it's important to recognize that the starting point for sectors within the health care system is different and that the legislation's impact will vary. This also means there may be lessons for all sectors in the unique experience of some, most notably long-term care.

OLTCA views this as important, in particular with respect to some of Bill 8's accountability provisions. Our association fully supports enhanced health care system accountability. OLTCA believes that not only should health care providers be accountable to the government and to those we serve but that all of these players must be accountable to each other. This fundamental principle must extend beyond simply auditing resource utilization to support a system that equally fosters effective service delivery and public confidence.

Extensive accountability frameworks are not new to the long-term-care sector. In fact, for the past decade our sector has been operating within arguably the most comprehensive accountability framework in our health care system. Some of its elements are similar to those proposed in Bill 8.

Currently, each long-term-care provider delivers care and services under the terms of an annually renewable service agreement with the Ministry of Health and Long-Term Care. Care and service delivery standards are detailed in a program standards manual. A compliance program assesses and regulates individual home performance against these standards on an annual or more frequent basis, as deemed necessary. All compliance reports are public documents and, along with annual review reports, are required to be publicly posted.

The government has a mix of available remedies for non-compliance, ranging from graduated sanctions, such as freezing admissions, to provincial prosecutions, including licence revocation.

Long-term care is the only part of the health care system with an envelope structure for operating funding. Funding is allocated within one of three envelopes. Permitted expenditures are defined for each envelope and annually reconciled in over 100 lines of detail. The annual financial report is required to be publicly posted. If there are surpluses in care and program funding, these must be returned to the government. Also, if there are deficits, they must be made up by the provider.

All sources of funding available to providers are subject to government regulations and are capped, with the exception of charitable donations or, in the case of municipally operated homes, municipal tax subsidies.

Despite this level of comprehensiveness, this accountability framework does not meet expectations, and as an association, we have been advocating for enhancements for some time. Two of the reasons it doesn't meet expectations are relevant to the provisions of Bill 8. They can be summed up as ambiguity and inconsistency.

Let me give two brief examples that will illustrate the operational impact of accountability ambiguity and inconsistency. Our existing compliance framework includes an enforcement sanction. However, nowhere is it clearly articulated, let alone understood, what the specific conditions are that would put a home into enforcement, what the home would have to do to address the situation, how long they would have to do so, the penalties and when these penalties would apply. There is nowhere to access information on any homes in enforcement, and even if you could, it would be difficult to know what the information meant.

Similarly, providers can regale you with the uncertainty and confusion that is created by compliance standards being interpreted differently from region to region and, at times, seemingly influenced by the public issues of the day.

The lesson to be learned is that the effectiveness of compliance, enforcement and sanctions as accountability tools is related to the extent to which they are defined to create clearly understood expectations, rules and consequences, and to the extent to which they are mutually supportive. We have learned these lessons and they drive our concerns with respect to sections 19, 21, 22 and 26 of Bill 8.

While long-term care's existing service agreements strongly resemble the accountability agreement outlined in Bill 8, we are not fundamentally opposed to the basic concept of the accountability agreement as an additional accountability framework tool. We believe, however, its current broad definition creates significant risk for applications of this tool with respect to setting goals, objectives, time frames and requirements that are either inconsistent or conflict with the existing service agreements and the program standards manual.

The potential risk for these inconsistencies and conflicts is exacerbated with Bill 8's use of directive wording with respect to providers signing accountability agreements. This prescription is in contravention of the fundamental tenet of contract law, which stipulates that parties must enter into a contract freely. This tenet applies to the existing service agreements. Further, since this legislation does not place any accountability on government to fund the system appropriately, the current wording would leave an open door for government to create arbitrary and unachievable expectations and goals.

We strongly urge this committee to amend the legislation to ensure that the scope and application of accountability agreements is specifically defined and consistent with existing long-term care service agreements and other accountability instruments and that accountability agreements are negotiated, not directed.

Section 22 gives the minister very broad power to issue directives "compelling a heath resource provider ... to take ... action specified in the directive or to comply with one or more of the prescribed compliance measures." This gives us cause for concern at two levels, given that providers can only do what the government is willing to fund and that funding will always be limited.

Our first concern relates to the fact that providers are required to deliver the program that is encompassed by the governing legislation, the service agreement, the program standards manual and the funding provided by the Ministry of Health and Long-Term Care. There is nothing in this current wording of Bill 8, however, to prevent the minister from arbitrarily directing compliance outside these defined and funded program parameters. In such instances, providers would be left with the option to either not comply with the minister's directive or to potentially violate the existing service agreement. This would likely have a further negative impact by directing scarce care resources away from where they are already sorely needed.

Our second concern is that a resulting compliance directive might be seen to be within existing program and funding parameters when in fact it is not. For example, ministry compliance advisers have already been recommending one-to-one programming for the growing number of residents affected by dementia. I don't know of an operator, an administrator, a director of care or any other staff member who would disagree with this recommendation. This level of care, however, cannot be provided within current funding levels. A minister's directive would leave two choices: to not comply or to take the care resources from one person to another. Neither is appropriate, palatable or defensible.

In view of this, we urge this committee to amend the wording of section 22 so that it confers powers consistent with the mandated scope and available resources of the long-term-care program. The fundamental principle should be that providers are accountable for delivering the defined and funded long-term-care program. The minister's powers to direct should be clearly specified and understood to operate consistent with this principle.

For the same reasons, we make a similar recommendation for section 26, which sets out "consequences of failure." The minister's scope for action should be specifically defined, understood and consistent with the provisions of the service agreement and other existing accountability instruments.

Based on the day-to-day experiences of our members, OLTCA believes that without measures to clarify these ambiguities and remove the risk for inconsistency in application, Bill 8 will not support resolving the current accountability issues in long-term care. It will also increase the risks that these same issues will appear elsewhere in other sectors of the health care system.

Before leaving accountability, I wish to note for the committee three other areas of concern to our association.

The first is the non-liability clause in section 30. Typically, the non-liability clause in a bill would provide that no action can be taken if the minister has executed the authority provided under the legislation in good faith. This good-faith principle is not specified in the non-liability clause in Bill 8. In view of the fact that Bill 8, as it is currently written, conveys broad powers to the minister and the fact that all health care providers and those the system serves have the right to expect that the minister does indeed act in good faith, we believe the good-faith principle should be specified.

Our second concern deals with the penalty provisions set out in section 31. We agree with others who have pointed out that these are unduly harsh and unnecessarily punitive.

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Our third concern is that Bill 8 is silent on its application to our municipal homes for the aged and our charitable homes. As members of this committee may or may not be aware, municipal homes for the aged are operated by municipalities and, as such, are subject to municipal legislation. Similarly, charitable homes are operated by volunteer community-based organizations and boards. We would request that the relationship of Bill 8 to these types of governance structures be further clarified.

We now turn our remarks briefly to part I of Bill 8, dealing with the Ontario Health Quality Council.

OLTCA fully supports measures to enhance service quality, and we believe this council has some potential to do this. However, we recommend the following changes to Bill 8 to increase the likelihood for this potential to materialize for long-term care.

First, it is essential, given the increasing importance of long-term-care services to Ontarians, that long-term-care

resident issues be recognized and valued in the appointment of council members. Currently there is reference to choosing "experts in ... areas of patient and consumer issues," but no reference to residents. We strongly urge this committee to correct this oversight.

Secondly, we urge that the term "health system organization" be expressly defined as it relates to those who are prohibited from sitting as members of the council. We assume this prohibition is meant to avoid a perception of bias in the council's conduct of its business. If we are correct, then the definition of "organization" must be sufficiently broad to encompass the full range of organizations that inhabit the health care field: providers, professionals and consumers alike.

Thirdly, we believe that an effective focus on quality, which by definition requires long-term stability, will only be accomplished if the "specific powers and duties of the council and its members" are set out clearly in the legislation and are not left to the uncertainties of cabinet regulation.

Finally, we are concerned that it is not clear how this new council would interact with the other individuals and agencies that are currently authorized to inspect or audit long-term-care homes. Our concern is not with the concept of audit or inspection. We are left to wonder, however, about the additional management and administrative resources that might be required when homes are already strapped for resources to deliver an increasingly higher level of care.

In closing, I want to again thank the committee for giving us the opportunity to share our experiences and our concerns. Bill 8 is an important piece of legislation that will impact the lives of Ontarians in a significant way. It is important that its provisions be drafted so its goals can be achieved within the reality of where health care is provided and received.

The Acting Chair: There are about six minutes left to be divided evenly. Ms Martel.

Ms Martel: Thank you for your presentation today. May I ask what discussions on this bill you might be involved in with the ministry right now? Any?

Ms Sullivan: Not on this specific bill, except for coming here.

Ms Martel: Can I ask when you first saw the bill? Was it at the time it was introduced, November 27 or so?

Ms Sullivan: Yes.

Ms Martel: The reason I ask that is that it's very clear that long-term-care facilities are to be the subject of the accountability agreements. We have certainly heard there have been ongoing discussions between OHA, OMA and other providers, but it's interesting that there's no discussion going on directly with you right now, because you represent a significant number of facilities that are going to be directly affected. Essentially, your first presentation about your concerns is to this committee right now.

Ms Sullivan: That is correct.

Ms Martel: I'm sure the ministry is going to take that into account and start to have some discussions with you directly, because there are a number of very specific concerns you raise that clearly show that how you operate now under the service agreements would not be compatible with accountability agreements per se. It's also not clear to me whether the government can achieve what it wants through the current service agreement structure or whether an additional layer of bureaucracy is going to be added over and above the agreements.

Ms Sullivan: That's the main part of our concern. We, unlike other parts of the health care system, have had service agreements and different forms of accountability than others. We accept that. We look after the frailest people in our society, and we get government dollars to do that, and so we think it's really important that we're accountable. There's just some confusion around how those will work with this. Certainly, the entire issue of accountability in long-term care is being looked at, so we want to make sure it all meshes and works and doesn't make more ambiguity or inconsistency, which is part of the issue around the current pieces of accountability we have.

The Acting Chair: Ms Smith.

Ms Smith: It's good to see you again. I appreciate your taking the time to come out and provide us with your input on this. I think I'm more familiar with the workings of long-term care than some members on this committee, or I'm becoming more familiar. So I appreciate a lot of what you've put together today.

One question I have for you is a very specific question on the service agreements that are annually renewed. What are the provisions in place if you don't come to an agreement with the ministry on a service agreement?

Ms Sullivan: We have an evergreen clause, because they don't always arrive for us to sign within the time frame they apply to. They don't automatically expire; there is an evergreen clause until we get the next one.

Certainly since 1993 there has been full compliance. In the early days, when the service agreement was first developed, it took some time for the sector to understand what it meant, and there was some back and forth on the development of the agreement. But I don't think—and I don't know this for sure—you'd find a home that doesn't have a signed service agreement.

Ms Smith: You spoke about your concerns about ambiguity and inconsistency, and one of the things you raised was enforcement sanctions in the long-term-care framework. The minister presented to this committee last week a framework for the amendments we see coming out in the next short while with respect to this legislation. Did you have a chance to see those?

Ms Sullivan: I looked at them but very briefly. Actually, I saw them today for the first time.

Ms Smith: One of the things we're looking at, with respect to accountability agreements and compliance directives, is to "Include notice and other due process provisions, including time frames for notice, to address development of accountability agreements, issuance of compliance directives and orders (eg, discussion process, meetings, exchange of documents/information, represen-

tations that the minister has to consider before issuing a compliance directive or an order.)"

Would those kinds of mechanisms go some way to easing your concerns about ambiguity in the process?

Ms Sullivan: Yes, they would help.

The Acting Chair: Mrs Witmer.

Mrs Witmer: Thank you very much, Ms Sullivan. I'm glad we have finally heard from the long-term-care sector, because obviously you do come under the jurisdiction of this bill. I would hope, having heard that you haven't had any consultation with the Ministry of Health until now, that there would be an opportunity for you to engage in some discussions, because I think there are some unique issues you have with this bill that others may not.

I'm also glad that you took the time to remind this committee, because I think there are some people who maybe forget, that there are already accountability frameworks in place. It's not something new. It's certainly something that has been ongoing. You've also pointed out some of the drawbacks of those accountability agreements. I think that's important, because if there are problems such as ambiguity and inconsistency now, it really does speak to the fact that the government needs to consult with stakeholders to ensure that some of the problems you've experienced are going to be dealt with before any future accountability agreements are put in place.

I think you make a very good point about the fact that in section 22, with the minister having broad powers to issue directives compelling a health resource provider to take action, there is cause for concern, because obviously, at the end of the day, you can only do what you're able to do based on the funding you receive. I think it's important, and maybe is being forgotten, that obviously our health providers try to do the best job they possibly can. But there are scarce resources, and you can't be found at fault if you don't have the resources to do your job.

Do you think this whole issue of funding could have some serious implications as the government moves forward with these accountability agreements?

Ms Sullivan: The whole notion of accountability for our sector is about a partnership around that accountability. We want to deliver the best possible care to people's parents and grandparents, and we want to be able to demonstrate that we're doing that. If we're not, we think there should be things you can do to remedy that, because it's a serious issue.

But a part of it certainly is that we have to do that within the framework that exists. The framework is accountability and it's funding. Our funding comes from two sources. It comes from the government and it comes from the resident, but both portions are defined by the government.

So that was our statement around accountability being all the partners. It has to be that kind of relationship.

The Acting Chair: Thank you very much. We really appreciate you coming here, making a deputation and taking the time.

The committee now stands adjourned until tomorrow morning in Niagara Falls.

The committee adjourned at 1721.

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