ISSN 1488-9080

Legislative Assembly
of Ontario

First Session, 38th Parliament

Assemblée législative
de l'Ontario

Première session, 38e législature

Official Report of Debates (Hansard)

Tuesday 17 February 2004

Journal des débats (Hansard)

Mardi 17 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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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
3330 Édifice Whitney ; 99, rue Wellesley ouest
Toronto ON M7A 1A2
Téléphone, 416-325-7400 ; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

Tuesday 17 February 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE ET DES AFFAIRES SOCIALES

Mardi 17 février 2004

The committee met at 0833 in the Howard Johnson Plaza Hotel, Sudbury.

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.

The Chair (Mr Kevin Daniel Flynn): If you would take your seats, we can call the committee to order for the morning. I'm sure some of the members will be joining us in progress.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 659

The Chair: Our first delegation this morning is from the Ontario Public Service Employees Union, Local 659, Sudbury Regional Hospital, Yves Shank and Jan O'Leary. You have 30 minutes for your presentation. Any unused time from the presentation will be used by members of the three parties to ask you questions or perhaps for any clarifications. The floor is yours.

Ms Jan O'Leary: We'd like to thank you this morning for this opportunity to speak to you about some of our concerns with Bill 8 in the format introduced by the newly elected Liberal government last November. My name is Jan O'Leary, and this is Yves Shank. We appreciate the ability to discuss this matter in a public forum in the hopes of contributing ideas that will help redefine this bill into a commitment for the future of medicare that we can all support and believe.

We represent approximately 314 hospital professionals in the Sudbury Regional Hospital system. We also represent OPSEU hospital professionals working in our hospitals in our capacity as executive members of the hospital professionals division. We are both laboratory technologists. I have proudly worked in the hospital system for over 29 years, and Yves has done the same for 13 years. We have been active proponents supporting public health care for the length of our careers. I have vigorously fought against the privatization of laboratories, supported by strong evidence that private labs cost more.

Today we would like to address two sections of the proposed bill. We have narrowed our discussion to these items because they could potentially dramatically affect our professions, our workplace, our livelihood and, most importantly, our patients. I would like to point out that most hospital professionals do not refer to patients as clients or customers. This commercial terminology should be restricted to stores and salesmen.

Part I: The Ontario Health Quality Council implies a group of people who would oversee the health system in Ontario to ensure quality health service to the people of Ontario. However, Bill 8 enshrines a committee with limited abilities to report on health care in this province. It cannot judge the extent to which the health care system conforms to the principles of the Canada Health Act. It does not have the ability to report on two-tiered health care, extra-billing or user fees. By all appearances, it will be a funnel for Ministry of Health directives—a statistical reporting group with stats provided by the minister.

What happened to democracy? How will the appointments to the council be open and transparent? Will people who could gain financially from the privatization of health systems be excluded? The terms and conditions stated in Bill 8 are vague and without substance. They offer no solace to the reader. If the government is serious about forming a council that would benefit the people of Ontario and their health care system, they must allow this council to be representative of the patients, the patient advocates, front-line workers and professionals, and they must allow this council to do more than just spew statistics. This council should be empowered to make recommendations that will benefit the patients and the taxpayers. The members of this council must not be able to benefit financially from their participation on this council.

Part III: Part III of the bill was a difficult section to read due to its shocking content. Our initial impression of

this section could not be limited to one word. The terms "vague," "non-specific," "equivocal," "dubious," "ill-defined" and "obscure" all came to mind.

The most glaring issue is the lack of triggers that would determine when the minister should direct a person, an agency or an entity into any of these accountability agreements. Only the list of matters to be considered provides a hint of the governing principles.

If we look at section 20, we see statements like "value for money" and "reliance on evidence." Do we assume that the evidence showing value for money will be provided solely by the Ministry of Health?

Section 24 virtually states that all such agreements are at the whim and whimsy of the minister—one person with all this power. How does this benefit our health care system? What controls would be in place to assure fair delivery of such a broad-reaching power? The agreements could change from day to day, adding to the already chaotic health care system.

Mr Yves Shank: Section 27 flies in the face of trust, as listed in "matters to be considered." Front-line workers in our hospitals or the people of Ontario will not trust a government that considers eroding hard-earned benefits and imposes this insult by stating it is mutually agreed upon. This section of Bill 8 implies a direct threat to collective bargaining and democracy. Is this government intent on creating labour unrest and instability in our health care system?

Most hospitals in this province are still reeling from the horrible effects of the Tory agenda. In Sudbury, we dismantled a three-hospital system in forced compliance to the Tory directive. We aligned our services to meet the one-site model, and here we sit, five years later, no closer to the final goal of the glorified one-site superhospital. Although many of the programs have merged on to individual sites, each site must maintain a full complement of professional groups to answer the needs of each of the programs. This means we still require, for example, the services of the laboratory, diagnostic imaging, respiratory, pharmacy and dieticians at each site to support the individual programs. Many of the professional groups must run between sites in any given day and work in substandard conditions. For instance, at one site, we work in a lab set up in patient rooms, without adequate ventilation, lighting, proper ergonomics, storage or space.

We are facing a dangerous Canada-wide shortage of laboratory technologists. We are so short of staff in Sudbury that as of this week we have again downsized the lab at one site to cope. We cover the night shift by sending technologists when needed by cab from site to site to perform work. Our staff is wearing down and our sick-time hours are a testament to our weariness.

0840

In 1993, Canadian medical laboratory technologist training programs, excluding Quebec, enrolled 752 students in 21 programs. By 1998, the number of programs in Canada, excluding Quebec, was reduced to eight, with a total enrolment of 164. The program closures were made in response to the impact of technical advances, health care reform initiatives, budget cutbacks and laboratory consolidations, which resulted in a significant reduction of employment opportunities for graduates. A few programs have reopened; however, the anticipated rate of retirement in the baby boom technologist workforce is creating a significant shortage. The health care system is bracing for a mass exodus of seasoned employees in 2005, when the offer of the transitional benefit available to members of the hospitals of Ontario pension plan, HOOPP, expires. This substantial monetary incentive will motivate hospital workers to access the early retirement options available.

In order to keep these seasoned employees within the hospital system and to attract students into our training programs, our local opted into a central negotiating process to achieve a contract that would meet this goal. The process was a difficult two-year, unprecedented struggle. The arbitrated outcome, although not optimal, will potentially help to slow the exodus and produce graduates. Bill 8 has the potential to negate all advances made. A reduction in compensation or an erosion of any of our benefits will force the seasoned to leave and the students to choose programs that allow fair compensation for the dangerous work we perform.

Without adequate staffing, programs will be cut. Patients will be affected by reduced access to our diagnostic and therapeutic services. Our health care system will be negatively impacted.

The workers in the Sudbury hospital system have had to adapt to decision changes imposed by administrators and ministry appointees. It is the front-line workers who continue to provide quality care to the best of their ability in spite of dramatic day-to-day modifications and reductions. We have maintained a professional, caring attitude while government promises have fallen short of the community's expectations. Bill 8 implies that front-line workers are somehow responsible for the crisis and must pay up.

We are considered the invisible workers in the hospital system. We are the diagnostic, therapeutic and rehabilitation workers. Our members took an unprecedented stand last year when the OHA attempted to arbitrarily change the rules of bargaining. We believe our members will view Bill 8 as an intrusive, undemocratic attack.

Our ability to achieve substantial improvements in compensation and working conditions is greatly inhibited by the legislation governing hospitals. The realities of our working conditions came to fruition during the SARS crisis, where we were asked to protect the health of our patients in extreme conditions, risking our own health. If this government truly believes that we are the heroes they professed in the media, then we ask that the government treat hospital workers with the respect we deserve.

Ms O'Leary: Our members want stability in the health care system. Our members want fair funding, public funds used in public institutions. Our members want safe workplaces. Our members want fair compensation for fair workload. Part III of Bill 8 must be removed in its entirety if we are to succeed in retaining

and recruiting health care professionals of the calibre we have come to expect in Ontario.

The public wants universal, portable health care. There is a collection of our seniors' memoirs of life before public health insurance called Life Before Medicare—Canadian Experiences. It depicts the hardships faced by Canadians before the advent of medicare. This book is a reality check for all those who wish to erode medicare. We ask that this government carefully consider all actions that could negatively impact the provision of health care benefits in Ontario. We ask that this government uphold its promise to stop the privatization of our health care system. We ask that this government carefully consider the full implications of this bill.

Thank you for the opportunity to address your committee.

The Chair: Thank you, Jan, and thank you, Yves. Thank you for your brevity as well. We're at 8:45. We started at 8:34, so you only used up 11 minutes, which leaves us with about 19 minutes for questions. We're going to start with the official opposition, we'll move to the NDP and then we'll move to the Liberal side to ask you questions. By my count, we've got about six or seven minutes.

Mr Frank Klees (Oak Ridges): Thank you very much for your presentation. We, too, share many concerns with you regarding this bill.

We had the opportunity to hear the Minister of Health yesterday effectively apologize for the state of this legislation. He was clearly embarrassed at the ambiguity of this bill. He was clearly embarrassed that this is the first major piece of health legislation that this government is coming forward with, and it's not a very good representation of, first of all, the principles that the preamble speaks to and what the government is suggesting that they want to do, because it leaves not only people like you, but I can tell you, stakeholders right across a spectrum of health care with many, many concerns.

Now, he did say, to his credit, that there would be wholesale amendments to this bill. He, in his statement, made reference to meetings that he has had with stakeholders, saying that he recognizes their concerns and that they are already in the process of drafting many amendments.

The concern I have is that this government doesn't exactly have a reputation of keeping its promises. In fact, there is such a huge credibility deficit that's being generated by this government in such a short period of time that, as much as I want to believe the Minister of Health when he states what he says about not intending the bill to say what it says, I have a hard time believing that when we finally see the amendments, they in fact will do what he commits them to do. I don't know about you and what sense of confidence you feel that this bill will be revised to the point where it actually does give you the kinds of protections that it speaks to or that you've asked for.

I noted one comment that the minister made in his remarks yesterday. He said accountability is a two-way street. He's referring, of course, to the objective that he sees in this bill of bringing accountability into the health care system. I don't believe there's one stakeholder—I don't believe you would speak against accountability and health care. Very important. I think we all agree with that. The problem as we analyze this legislation is that it's far from a two-way street in this legislation. In fact, it's a one-way freeway for the minister to do whatever he chooses to do.

To the point that I think you were referring to as well in part III, section 27, some of the most draconian wording that I've ever seen glares at us from this legislation. Clause (a): "The change"—and he's referring to material changes in employment agreements—"shall be deemed to have been mutually agreed upon...."

I think one of the fundamental principles of contract law is that there is negotiation between two parties who freely enter into an agreement. In this particular case, this government is willing to set aside that freedom of the other party to enter into an agreement and simply say, "No, I, as minister, determine this is what it's going to be, and we are going to deem under law that you've actually agreed to it." I don't know about you, but to me this doesn't smack of a two-way street. It really smacks of an overpowering minister who is going to take hold of health care and is going to do whatever he chooses to do—a dangerous precedent, I believe.

I'm not confident at all that we will see the kinds of amendments that will do what we need to have done.

0850

What I would ask you to do, because you've made some good recommendations—I think it's going to be important that we get specific recommended amendments to this legislation. Coming from you as stakeholders, because I don't want to trust the government to incorporate the wording into this —

The Chair: Could you summarize, please, Mr Klees?

Mr Klees: I'm going to be looking to you, if you would, to provide us with some specific amendment wording that will safeguard these principles that we believe are so important.

The Chair: Ms Martel.

Ms Shelley Martel (Nickel Belt): Let me just deal with some questions in the order that they appear in the brief. The first has to do with Ontario Health Quality Council. Yesterday, when we had a briefing with the minister, I focused on the issue of the council because I, like you, am very worried that we might have a group of people who are very much concerned with health care but have no power to influence any change with respect to Ontario's health care system. I like your term "statistical reporting group," because I'm afraid that's exactly what this group is going to be.

If you look in the bill, with respect to the functions, they are quite narrowly defined and essentially focus on monitoring health information. The minister talked yesterday about statistics regarding obesity, diabetes etc. They have absolutely no power to make recommendations other than what they should report on, which is a

fairly limited scope and leads me to think that the minister tells them what they're going to report on and they go from there.

What are you concerned about with respect to this particular group? Do you think they're essentially just going to be there giving statistics in the way that ICES could, or do you see that they should really have some more significant, important role in actually making recommendations to the minister on health policy, on changes to health policy, on changes to health legislation, on funding? What would your vision be of a group that's supposed to be in place looking out for medicare?

Ms O'Leary: I guess in our minds, we've already seen what happens with some of these councils or the reporting-type groups. That happened with the laboratories, where they brought on board the private laboratory stakeholders to determine the state of our laboratory system in this province. When I have a look at the legislation in Bill 8 that talks about a council—we see a quality council, in my mind and in OPSEU's mind, as being a body that would have the ability to say to Canadians, "We're doing really well in this particular area of the province in our health care system and we're doing very badly in this area." It has to be put forward in an unbiased manner. It cannot be, as we've stated in our report, anybody that would have a financial stake in the outcome. We must have Canadians on a council who are interested in an end result that would provide top-notch, quality health care in this province at the best price and the best delivery system.

Ms Martel: Should they be making recommendations to the minister about funding? We need more money for public health. Obesity statistics show that that's an area we have to focus on. Should they have the ability to say to the minister, "I'm sorry, the government's just not spending enough on public health and if you want to deal with obesity rates, you've got to up the ante in terms of what you're doing at the local level through the public health units." Is that an additional function that they should be allowed to perform, given the very limited mandate they have right now?

Ms O'Leary: I think their scope should be broadened to the point that the Minister of Health would be an overseer of general projects, determining how much money might be allocated to the council to study particular issues. But the council should have a very broad mandate, and the mandate should be accountability to the public, not to the minister. It should be accountable in a way that, at the end of the year when they present their report and their recommendations for changes, the report and the recommendations should have some teeth. It can't be a recommendation for funding etc if it has no ability to go anywhere. So if they present a report, there should be some follow-through, there should be a method of monitoring what happens at the end of that process.

So if they've recommended that in this year these particular items are the most glaringly difficult or troublesome areas of our health care system, at the end of one year, their next report should also review what has been done, what action was taken, how much money was funnelled into that particular project, so that the recommendations and any funding recommendations are made public. Any reports, good or bad, should be made public and they should be unfettered by the minister or the minister's groups.

Ms Martel: You've suggested very strongly that all of part III should just be taken out of the bill. You may know that the minister yesterday said there would be a number of changes coming in this particular section, for obvious reasons. The legal opinion provided was very clear that it was very broad and gave far too much power to the minister. We hope that we will see what he has in mind before the end of this week, but we weren't party to that yesterday in terms of receiving any information in terms of proposed wording changes. So from OPSEU's perspective, the best thing to do with all of part III is essentially to take it out at this point. Is that your recommendation?

Ms O'Leary: Yes, definitely.

Ms Martel: Let me just move on to the final point you made with respect to privatization. You said, "We ask that this government uphold its promise to stop the privatization of our health care system." I asked the minister yesterday where in the bill were the provisions to ban the for-profit MRI-CAT scan clinics, and of course there aren't any provisions in the bill to do that, just like there aren't any provisions in the bill to stop the P3 hospitals, despite the very clear election promise made by the Liberals to do both.

This is a bill that purports to want to protect medicare but says nothing about the ongoing privatization of the health care system under this government. What are your concerns in that regard?

Ms O'Leary: I guess I'd have to preface that by saying that we've already been under such tight restraint in our hospital system, and we feel that we've been backed against the wall in Sudbury. Our hospital system has been completely dismantled. We had a job line in place. They told us to perform certain tasks, make things happen. Everything was destroyed completely and put back together in a system that was supposedly going to land up on one site.

When I have a look at where we are now, which is nowhere, five years later, we're working in abhorrent conditions and our patients are not getting the quality care that they did in Sudbury. We previously had a system that was very comparable to any system in Ontario. I look at where we are now and all I see is a system that's been backed so far against the wall that now the only thing that can be said is, "Oh, well. I guess we're going to have to dump it to the private sector." I see that as the most horrible thing that could happen to our system. This would fly in the face of everything my grandparents fought for; it would certainly fly in the face of everything we need.

I have studied and worked hard on avoiding the privatization of laboratories in this province. I've watched and seen the figures. We have investigated this to the best of

our abilities. We have attempted to obtain records to prove our case. Ultimately, we know that private laboratories are going to cost more in this province. We know it. We want to stop it. I don't want to see anything else in our hospital system privatized. Any time public money goes to obtain health care in a private manner, where somebody is pocketing money, the quality goes down and the accountability is not there like we have in the hospital system. I just see privatization as the worst thing that could ever happen to our system.

The Chair: We'll go to the Liberal side now.

Ms Monique Smith (Nipissing): Thank you very much for joining us this morning. I'm very familiar with the Sudbury hospital situation, being from Nipissing right down the road, so I sympathize with you and I recognize that it's been a struggle for a long time. I also noted in the Sudbury Star over the last couple of days that, again, there's talk of the minister coming. The minister has already come to visit the hospital and he's coming back to do a summit to see how we can move forward from this log-jam position that you've been in for so long. I think that's progress and that shows a commitment on the part of our government to try and make this work and move forward with your project. So I hope to see movement there, on all our behalf, in northeastern Ontario very soon.

I wanted to address some of the concerns that you raised. I don't think you were privy to the address that the minister gave yesterday at the beginning of these hearings, so I'll make sure you get a copy of it today. I think it'll dispel some of your fears about this legislation. He spoke of some of the changes to the legislation that we're looking at.

0900

First off, he addressed the CUPE concerns, which I think are similar to your concerns about Bill 8 and its effect on collective agreements. He was clear that Bill 8 cannot open collective agreements. Unions have never been subject to accountability agreements, nor will they be subject to accountability agreements under this legislation. It will be clear in the legislation that that is not affected. So your concerns around sections 26 and 27: where those sections were specifically targeting CEOs who may have been entering accountability agreements, were never intended to have any impact on collective agreements or the workers in the hospitals—just so you know that. I'll come back to that again in a minute.

You were concerned about the structure of the councils. In the legislation, we do speak about the "desirability of appointing ... experts in the health system in the areas of patient and consumer issues and health service provision." I understand that you don't like the word "consumer," and I actually agree with you on that. Certainly we do talk about patient issues and patient concerns as being one of the voices at the table. We also talk about "governance, accountability and public finance," and "persons from the community with a demonstrated interest or experience...."

The minister spoke yesterday about keeping interest groups away from this organization, so that the stakeholder groups that are advocates on behalf of various groups would not have a place at this table. The council would be broader than that and would actually preclude those stakeholder groups from being part of that. Does that, in some way, address some of your concerns?

Ms O'Leary: I think it would, as long as the advocates are there for the patient groups.

Ms Smith: I'm sure there will be representation from user groups: people who have used the system. The purpose is to have a broad group, so that all the voices are heard at the table, and to have people who have not just one but many views or who come to the table wearing many different hats. If they've been patients and also a nurse or something, they will come to the table with different views so you can have as many voices as possible there. I think that's the intention.

"The council's mandate would be to measure the effectiveness of the system and to report on its performance in priority areas....

"The council would report to the people of Ontario about wait times for important procedures, for example cardiac care, and hip ... replacements. The council would monitor and test the effectiveness of the system through broader measures like population health status and the prevalence of serious and preventable diseases...."

I think those are some of the things you were talking about: wanting to have reports about wait times and wanting to have reports about wellness and health statistics. I understand your concern about it not being just a statistical reporting system, but I think there is a value, there being so many reports done in the system now, to having one place where they're brought together and made public. Certainly the minister has made a commitment that all reports of the council will be public. Does that address some of your concerns on the council's work?

Ms O'Leary: I think it still leaves the council as a reporting mechanism. You could possibly hire somebody from the Ministry of Health to be a reporter for such statistics. A health council, in our minds, should be a committee that could come together and make recommendations, not just report.

Ms Smith: OK.

I just wanted to go back to your concerns about the accountability agreements. The minister stated:

"Bill 8 is a big step toward greater accountability in the system. It creates a framework that allows the minister to establish negotiated accountability agreements with publicly funded health resource providers. The health care providers we intend to designate in the bill are hospitals, CCACs, long-term-care facilities and independent health facilities.

"The bill does not apply to solo physicians or group practices or labour unions, and we will offer amendments that make that abundantly clear....

"The ministry would establish accountability agreements with the board of directors. And the board is then

required to establish a similar performance agreement with the CEO."

So the ministry would be doing the agreement with the hospital board, and then the board would have a performance agreement with its CEO. The accountability would be very much between the hospital and the ministry, and collective agreements would not be touched by this. I just wanted you to have that information as you go forward, and I'll make sure you have a copy of this statement that was made yesterday.

Ms O'Leary: Could I ask a question?

The Chair: Very briefly.

Ms O'Leary: The definition of an accountability agreement is also lacking in the bill. It leaves the term so broad. In the hospital system, we've already gone into an accountability agreement where we had a ministry appointee come in and tell us how to fix our hospital, which ended up being cut, cut, cut. We've lost programs; we've lost services. I would like to see the bill define what an accountability agreement is going to do as its end product and in its format.

The Chair: Very good. I think the point was taken. Thank you very much for coming today.

We move now to a little bit of housekeeping for the members. We have to be out of our rooms for 12 o'clock. So at some point between now and 12 o'clock, would you make your way up to your rooms and bring your suitcases down to this room.

SUDBURY AND DISTRICT MEDICAL SOCIETY

The Chair: We move on now to the Sudbury and District Medical Society. Dr Pierre Bonin is the president, and Dr Rayudu Koka is the past president. Please be seated. Would you identify yourself for Hansard when you make your presentation? You've got 30 minutes to make your presentation. You can use that 30 minutes as you see fit. Any time left over at the end of the presentation will be shared fairly among the three parties. This time we'll be starting the questioning with the NDP. The floor is yours.

Dr Pierre Bonin: Good morning, Mr Chairman and committee members. I'm Dr Pierre Bonin, president of the Sudbury and District Medical Society. Joining me today is Dr Koka, past president of our medical society and a psychiatrist in Sudbury. After my presentation, I look forward to answering any questions the committee may have.

I've been in practice in Sudbury as a family physician since 1997, and have been actively involved in the medical community in Sudbury for many years as well. This has given me the opportunity to gain valuable insight into many of the issues confronting our health care system at many levels.

Let me start by saying that my colleagues and I in the Sudbury and District Medical Society believe in a strong, publicly funded health care system that preserves the spirit of the Canada Health Act. As physicians, we see each and every day the value our system has in the lives of our patients. However, we also see what chronic underfunding and a lack of physicians are doing to our patients, your constituents. It's clear that our system, which is based on the Canada Health Act, is not adequately meeting health care needs. From my perspective as a doctor in the north, accessibility and portability, two tenets of the CHA, are areas that are failing the test. The CHA has not been amended since its creation in 1984. It needs to be modernized or supplemented with supportive legislation. If Bill 8 is an attempt to reinforce or strengthen the CHA in Ontario, it does little to do that. While I strongly agree with the preamble of this legislation, I'm sad to say the content of the bill does not support the strong values outlined in the preamble.

One area I had hoped to be addressed in this legislation was sustainability, which is key to the establishment of a secure health care future. We need predictable funding to implement much-needed long-term planning. This will eliminate the fluctuations in funding that cause us to struggle from crisis to crisis and prevent us from retaining and recruiting the valuable physician services your constituents need. Also, vital issues such as quality and balanced accountability are not truly addressed in Bill 8.

Ensuring Canadians have timely access to the care they need speaks directly to the issue of quality. We need to set benchmarks that will give clear direction around such issues as waiting times and access to diagnosis and treatment. Two years ago, the Ontario Medical Association conducted a survey in which 90% of doctors in Ontario cited waiting lists as having a negative impact on patients' outcomes. Since then, waiting times have only become worse.

On the issue of accountability, physicians believe we all share this responsibility. The inclusion of balanced accountability in Bill 8 would ensure that all participants, including government, fulfill their obligations. Much work and significant amendments are needed to make Bill 8 anything other than, at best, a feel-good statement by this government that does not deliver real change or, at worst, that makes health care delivery more complicated and bureaucratic and in turn more harmful to my patients.

0910

In preparing my remarks for today, I had the opportunity to enlist the support of the excellent health policy department of the Ontario Medical Association. In reviewing the bill with them, I found out that it wasn't just my colleagues in Sudbury who have grave concerns about the first draft of this legislation. In fact, physicians from across Ontario were deeply troubled about the content of the bill. Subsequent to that, I have been told that only a couple of days after the legislation was introduced on November 27, the OMA raised concerns with the minister directly and ongoing discussions have been taking place among various stakeholders, the minister and the ministry to work toward making Bill 8 legislation that does not make Ontario a worse place to receive

medical care. The reason all these discussions were required is that when physicians first read Bill 8, as presented, it was clear the minister was above the law and denied due process to us in the health care system.

It is clear from Minister Smitherman's remarks before this committee yesterday that he has recognized the need for significant change in the bill. The minister recognized there were major changes needed to the tone and language of the bill. As written, Bill 8 is seen by my colleagues as an attack on the profession. The accountability section of this legislation is another area where the minister indicated he was prepared to make some change as well.

I commend the minister for being open-minded and working with stakeholders to address our real concerns over the past couple of months. This has been a good start; however, the minister and the members of this committee must make further amendments to the legislation if Bill 8 is to live up to the lofty goals set out in its introduction.

While there are several areas of the legislation I would like to address, my time before this committee will not allow me to adequately deal with all of them. Instead, we're going to focus our remarks on two particular areas of Bill 8: section 16, block fees; and subsection 9(4), which deals with payments to physicians.

Section 16 deals with what are commonly called block fees. An uninsured service is a medical service that the Ontario government does not or will not cover under OHIP. Block fees are charged by physicians to cover certain uninsured medical services. Typically, block fees include uninsured services such as telephone advice at the patient's request, renewal of prescriptions by telephone and completion of various forms and documents associated with medical assessments: drivers' physicals and that type of thing. The provision of any such service involves physician and staff time and a cost to the practice that is not billable to the ministry. Block fees should not be confused with procedures such as cosmetic surgery and uninsured diagnostic tests such as private MRIs.

Block fees are not extra-billing. They are one of two options available to patients to pay for uninsured services, as was previously mentioned. A patient has the option and freedom of choice to pay for each service not covered by OHIP as it is provided, or to pay a block or single fee to cover unlimited access to all uninsured services as outlined by the physician for a period of no less than three months and no more than 12 months. The physician must also provide the patient with a list of each fee and what the individual charge would be as an alternative to the block fee. The patient is further protected, as the decision as to which option the patient chooses cannot be a condition of the patient being accepted by the doctor.

Physicians are a self-regulated profession, and I am sure the committee supports doctors' and other allied health care professionals' right to be regulated by their professional colleges—in our case, the College of Physicians and Surgeons of Ontario or CPSO. As the committee is aware, the public interest is represented, since the governing council of the CPSO as well as various CPSO policy and discipline committees have both physician and lay members.

Ten years ago, physicians, under the leadership of the OMA and in collaboration with the CPSO and the government of Ontario, set up guidelines to regulate block fees. The OMA has firmly established guidelines for third party services which most physicians rely on in setting fees for physicians. Block fees are now regulated by the College of Physicians and Surgeons under CPSO policy number 6-00. The CPSO does its role as the profession's regulator and has done a good job of educating the profession and resolving concerns about this practice. Unless government has decided that this profession is no longer self-regulating, this section must be amended.

While I do not want to get into procedural matters, the introduction of jail terms in Bill 8 is astonishing, to say the least. Subsection 17(2) provides a penalty of $25,000 and a 12-month jail term for physicians. This seems excessively punitive and even vindictive, and makes me wonder why the bureaucrats want to go after hard-working doctors so badly. To put it in perspective, the general penalty the Provincial Offences Act allows is up to $5,000 for statutes which otherwise do not come with a penalty. If this is the benchmark, the committee has to consider the relativity of the offences in this light. In another example, the privacy act for personal health information, Bill 31, is more important by far than block fees, yet in 100 pages of legislation in Bill 31, I cannot find a threat to put a doctor in jail.

It is my recommendation to the committee that the law specifically empower the CPSO to govern block fees, and I have submitted this recommendation to the committee in writing.

I will now turn things over to my colleague Dr Koka, so he can address section 9 of the bill.

Dr Rayudu Koka: Thank you, Pierre. Mr Chairman, members of the committee, it is my pleasure to be presenting our case here and our concerns and recommendations regarding this important bill. I am a psychiatrist practising in this community for the last 17 years, since I arrived from England 17 years ago. I'm a proud Sudburian, a proud northern Ontarian and a proud Canadian. I am proud of our Canadian health care system, and we want to see that it is sustained and survives and we continue to provide quality health care to our patients and constituents.

I'm going to address only two concerns that we have, subsections 9(2) and 9(4). As a matter of principle, we think it is crippling to legislate that not only can you not be paid more than the amount provided for by the plan, but also you may not accept payment from any person other than those listed in the section, ie, OHIP and APP, the alternative payment plan. Nothing in the Canada Health Act, CHA, requires this. I think that's important. This would prohibit many concurrent forms of practice that exist in the system now. As a result, it would affect

accessibility and patient care if we were to go through this bill. As you know, the Canada Health Act contains no such restrictions, as I said earlier on. We believe these sections will interfere with the provision of health care in Ontario. They would outlaw sessional payments for psychiatrists, which have been well recognized for a number of years, and in fact recently the number of sessions that we need to provide psychiatric care in the hospital system has increased, because they were lacking—payments to many hospital-based physicians, including laboratory physicians for their in-patient work, payment by private employers to occupational health physicians. So I would like to touch on some of the examples that I can give from my own experiences in our communities here.

For example, in psychiatry we do provide hospital services, for which psychiatrists receive indirect service payment on a sessional payment. If we were to ban it because of this bill, there wouldn't be any way to pay the psychiatrists and we would not have any psychiatrists willing to work in the hospital system.

In addition to that, we also provide outreach services in the communities in northern Ontario, plus other communities in southern Ontario as well. For example, I go to Manitoulin Island to provide service to native community services. In these community clinics, I have an agreement with the native services that I get paid for services I provide to them. With this bill, that will be prevented from charging. I could be liable and I could probably be in jail. Therefore, I think we would be affecting the greatly-needed service that we provide for the population of these communities. The same applies with the outreach program in other areas, also with the Ministry of Health programs that we have.

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In addition to this, in our communities, plus other communities, we have patients who don't have a family physician. Of course, I will talk about my own community here. We have a population of 30,000 in the greater Sudbury area without a family physician. When they get admitted to a hospital, they don't have a family physician to take care of them. Not only that, being a regional centre, we have regional programs in the hospital system here. When they come from outreach areas, then they don't have a family physician either. Plus, about 40% of the family physicians don't have privileges in the hospital because they are all overworked; they don't want to have hospital privileges. So those patients will not have any family physicians either. So we have to go in a creative way to pay some other, alternative way to get the physicians to cover these patients; otherwise, there would be no patients to cover. If we were to force the physicians who have the hospital privileges to cover for these people, they would also give up their hospital privileges and walk away. The result would be a disservice to our community, our patients. Therefore, that is another flaw in this bill.

In addition to that, of course, Inco is one of the great employers here. They have an occupational health department. Some of our physicians work in the occupational health department there and, of course, they get paid by Inco or Falconbridge or other companies as well. If we were to prevent payment from these organizations as well, it would cause problems to those patients who are cared for in these systems.

Lab medicine, I don't have to say again, is going to be a big problem. I think it is important that we should maybe extend more of these people from whom we can get paid so that it will cost the Ontario Health Insurance Plan less. As a result, I think I have indicated in my submission that the government should prohibit the payment forms it wishes to outlaw and have the ability to expand that clause by regulation. This subsection should be deleted and a subsection should establish an ability to prohibit by regulation.

I think I said section 9(4) should be amended to read: "No person or entity, other than a physician or a designated practitioner, a professional corporation controlled by the physician or designated practitioner or a facility, may charge or accept payment for the rendering of an insured service to an insured person." This would reflect the intent of the current section 15(3.1) of the Health Insurance Act.

I hope I have given some examples that will help this committee to decide in the best interests of the patients whom we serve.

Dr Bonin: In closing I would like to say that as a physician on the front lines of health care, I cannot emphasize strongly enough that our health care system is in a poor and declining spiral, and when governments make changes to the system, it should be to improve it for the benefit of patients, not to increase the power of the bureaucrats in the Ministry of Health.

Bill 8 as it stands is harmful to the system because it makes Ontario a more difficult place to deliver medicine. At a time when we need to be doing everything to recruit and retain doctors and nurses, Bill 8 will make those looking to Ontario seek other options on where to practise their valuable skills.

This is important because the numbers speak for themselves. Currently, Ontario's population is about 11 million people. It will rise to about l4.5 million people by the year 2020. Even more significant, the number of Ontarians age 55 and older will grow to represent about 30% of our population. This will mean that the number of patients over 55 will equal the current population of the entire metropolitan Toronto area.

A growing population guarantees a sharp increase in the demand for medical care. The demand is heightened when that population is aging. Government has repeatedly stated its desire to hire more doctors, yet we are having trouble keeping the ones we have. Bill 8 will drive physicians out of the province or into retirement. In either case, they are gone forever and there is no one waiting in the wings to replace them.

As your committee moves on and hears from other people, I ask you not simply for minor adjustments to the legislation but significant change so that you don't end

up making the system worse. My patients expect it and deserve it. Thank you.

The Chair: We've got approximately 10 minutes left for questions. We'll start with the NDP this time.

Ms Martel: Thank you both for being here this morning. I appreciate it. I appreciate as well that you took the time to give us some suggested amendments as we move forward with the bill.

Dr Koka, let me start with you. In terms of the amendments you gave us to 9(4), does that cover all of the examples you provided in terms of the outreach clinic at Manitoulin, Inco etc? It covers all the possibilities of where you could be getting a payment that might now be prohibited under the bill?

Dr Koka: I think so, because if you delete the subsection and also if you put all the areas where you cannot be paid in the regulations, then that should be covered, hopefully.

Ms Martel: It's the concern about regulation that I have. With Bill 31, there will be an open process for regulation-making, where there will be a chance for public consultation. The minister referenced that sort of process yesterday but it doesn't appear in the bill in the same way as Bill 31, which has very specific references to how regulations will be done. Would it also be your recommendation that the regulation-making process be an open, public one so you see that, and that there is consultation, for example, with the OMA and others before the regs go into effect?

Dr Koka: Yes, I think it's important that the OMA be consulted, because they are deeper into it than I am. I am a practising physician. I don't know the ins and outs and what the policies are, so the OMA policy section should be able to help and suggest, I think. They were not liars either.

Ms Martel: Neither am I.

Dr Koka: We're just trying to see what is best for our patients in the practical terms of what I do now. If this were to go through as it is, then I may have to stop, my colleagues may have to stop, until I'm safe to be practising. I think the important thing is, as I indicated, we don't want the MRC here. We have medical review committee problems already; we don't want to face that here. As my friend said, we don't want to drive physicians out of this province, because they are a hot commodity. They want them everywhere, globally. I think we want to keep them here and to have them make this place more friendly. They are needed and we want them.

Ms Martel: I appreciate that.

Mr Khalil Ramal (London-Fanshawe): Thank you for your presentation. Just a question: You don't think that if you open the fee for family physicians, you will be allowing people to introduce indirectly a two-tier health care system? In the meantime, a lot of people from Sudbury have listened to the presentation from OPSEU and their opposition to a two-tier health system.

Dr Bonin: I'll answer that one. This in no way changes what we have now; it just preserves what we have now. It just doesn't make what we have now illegal and it won't put me in jail for practising the way I am. That's all we're asking for. We're not asking for any more. There is no two-tier system here.

Mr Ramal: That's why our government is geared toward a public system and is trying to enhance it. That's especially why we introduced Bill 8, in order to tackle the whole health care issue across the province.

I come from northern Ontario. A lot of constituents come to me and complain about doctors imposing fees on them in order to give them some service. In the meantime, they believe they pay enough taxes to be covered by the ministry.

Dr Bonin: This isn't extra-billing. If you come and see me for an insured service, I cannot charge you more for that insured service. However, if you come to see me for a driver's physical, a driver's physical is a non-insured service. OHIP does not pay for that. If your company requires you to have a physical examination as a condition of your employment, that request is coming from a third party. The Ministry of Health and OHIP should not be obligated to pay for a company's need for a medically unnecessary service. Therefore, that service is being requested by a third party. It's not medically necessary and OHIP should not have to pay for it. However, I'm not going to provide the service for free. I should have an option as to how I'm going to request the patient to pay for the service, or his employer who requires the physical examination. So this isn't extra-billing.

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Mr Ramal: Where would we draw the line? Do we keep it open for doctors to impose any charges?

Dr Bonin: No. Actually, extra-billing is clearly illegal and any physician who is caught extra-billing will be reported to—

The Chair: Everyone wants to jump into the fray here, but we're starting to run out of time. Dr Koka, a really brief response.

Dr Koka: The block billing is regulated by the college. You have the contract between the physician and the patient, clearly telling what you're going to do for this extra-billing. So it is up to the patient whether they want to get into this contract or not. It is not a two-tier system, it is not extra-billing, nothing. We cannot put extra-billing on these patients, no.

Mr Jim Wilson (Simcoe-Grey): Dr Koka and Dr Bonin, thank you very much. I know you're extremely busy people, especially here in northern Ontario.

What the government seems to fail to understand is that you're being made scapegoats and, as a profession, you're being made to apologize for block fees. If people would recall that debate many years ago, the government didn't have the public funds available to expand the number of insured services, like telephone calls, prescriptions over the telephone and extra conferences with patients that have nothing to do with their medically necessary conditions or services. We didn't have the money to expand OHIP or the insured services, so the federal government, under the Canada Health Act, allowed some

extra fees to come in to cover you for your time and expertise. What Liberals should stop doing is campaigning that you're bad guys, charging bad fees, and actually tell the public, "We don't cover these services. Perhaps they should be insured, but we don't have the money to actually do that."

I think you should be madder than hell. I think you shouldn't put up with this. I think this room should be packed today, because people in northern Ontario—especially when you think that the minister is now going to try and regulate many of these fees or arrangements.

If I look at this town in particular, there are hundreds of arrangements between doctors, hospitals, ERs, physicians, psychiatrists, native programs, and hundreds of individuals involved. Now this bozo of a health minister is going to try and regulate every one of those arrangements. Those arrangements for the most part are in place to try and attract physicians to this community. So while you have a minute left, could you try to enlighten the government as to why special arrangements—almost as many arrangements as there are individual physicians in the system—are in place today, outside of APP or any government program, to try and get you people here? I think it's going to drive you to the United States and other places, as you said in your brief.

The Chair: You have about a minute to respond to that.

Dr Koka: It's true, we have a number of arrangements to try and attract physicians and keep the physicians in the community. Sometimes people from southern Ontario ask me how I keep psychiatrists in Sudbury, as I am the one who tried to recruit and keep them here in the summer. I have a system here that works, because of the payment system that we have, sessional payments and other incentives that we can give. But of course if that is taken away, it is guaranteed that not only will we not be able to attract anybody here but we will lose them.

Mr Klees: Mr Chairman, if I might just for one second—

The Chair: Thirty seconds.

Mr Klees: With regard to the threat here of jail time, do you have any suggestion for this government as to what bail should be set at for physicians when you're thrown in jail?

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

ONTARIO FEDERATION OF LABOUR

The Chair: We're going to move on now to the Ontario Federation of Labour. We've got Irene Harris, the executive vice-president, with us today. Welcome, Ms Harris. You've got 30 minutes, the same rules as everybody else. You can use that as you wish. Any time remaining will be split among the three parties for questions, starting this time with the Liberal side. The floor is yours.

Ms Irene Harris: I want to thank the committee for the opportunity to have the Ontario Federation of Labour here today to give you our presentation. I'm sure most of you know about the OFL, but for those who don't, we represent unions all across Ontario. We have about 650,000 members and represent all sectors, from building trades to food workers to industrial workers and education workers. We also have a lot of health care workers in our membership. So what I want to say to you today is that our presentation really covers our view of the act from two perspectives: from health care workers who work in the system and whom we hear from regularly about what they're facing, and also from members who need and use medicare regularly.

I'm not going to read the brief today. I just want to summarize some of our key points and key concerns for you and let you know where we're coming from. As a starting point, let me say, especially to the government side, that we welcome a future-of-medicare act. We recognize that the Liberal government is faced with repairing eight years of damage to our cherished public health care system. I could use all my time going through the damage we've seen done over the last eight years, but I just want to highlight a few things, because they're things we are all coping with on a daily basis.

First of all, we have to acknowledge—I see our Conservatives have left the room, but that's all right.

Ms Kathleen O. Wynne (Don Valley West): I guess they know it all.

Ms Harris: Yes, I think they're probably familiar with the damage they caused.

In all seriousness, we've had a real problem in Ontario with the delisting of OHIP services—about $100 million worth of services. This is the kind of money the province has, so-called, saved. But what it's really done is shift those costs to people's pockets. According to statistics, individuals in Ontario pay $1,072 per person per year in out-of-pocket costs. What is significant is that people in Ontario pay more out of pocket than any province in Canada.

We've seen incredible problems with the privatization of lab services. We've seen drug costs skyrocket. Those costs to the province have gone up 130% since 1995-96, and yet you see drug companies top the Fortune 500 list for profit-making. At the same time, our seniors have been disgracefully treated in this province. Those who are in a hospital bed waiting to get into a long-term-care facility were whacked with a $40-a-day fee for that hospital bed.

In the home care sector we lost, across most of the province, all help for seniors with home care services. At the same time—and I'll touch on this later on home care—I want the government to note that we, as OFL, tried to find out where all this money has gone. We know that in the home care sector we lost work from the non-profit sector to the private sector. The Tories successfully privatized most home care services. We filed freedom-of-information requests to find out where that money has gone, how it's being spent and what services we are getting, only to find that the Conservatives made it so we could not access that information under freedom-of-

information requests. The way the legislation is designed, we cannot know that information. That is a disgrace. We wrote to then-Premier Eves, who said they would give us some, and gave us a lot of paper but not what we were after, and we'll be going to Premier McGuinty to try to get that information. This is the kind of thing a future-of-medicare act should deal with and should cover. It should give us this kind of access to information, and this legislation does not do that.

We've seen tremendous cuts in the hospital sector, and I'm sure you'll hear from other unions about that as you go through these hearings. But basically the loss of staff has been quite devastating. We also want to say to the government that when it comes to health care, it's more than doctors and nurses; there's a team approach in health care. When you break a leg, you need a paramedic to pick you up, and the driver of the ambulance drives you to the emergency room where a clerical person admits you. All kinds of people form together in a health care system, and we have to make sure the staff are built up.

We also saw, of course, MRIs and CAT scans moved out to private clinics. These things always used to be in hospitals, and we were insured for those services in the hospital sector. By moving them out to private clinics, that becomes very much threatened and that's where you get the two-tier system coming in. Some can buy their MRIs; some have to wait for OHIP coverage.

The Ontario Conservatives were clearly building an American-style health care system that let the private sector do the delivery. They always used to say, "We want it to be publicly funded, we want it publicly administered," but when it came to private delivery, that's really what they wanted, and we saw what they did in home care.

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Unfortunately, under this future-of-medicare act we don't see enough of this changing. Even yesterday we heard Minister Smitherman, who should know better, say, "We're for public administration, we're for public funding," but nothing about public delivery, nothing about, "Let's take all that privatization the Tories did, all the damage they did, and bring it back under the medicare house and get it publicly delivered as well." We really urge you to do something to get this dealt with under the legislation.

I also noted in his remarks yesterday that he said you're open to change and open to amendments. Clearly we've got to do something that deals with this American-style privatizing of our medicare system. This act really is the time to do that.

The preamble in the act has a lot of very positive commitments, but there are some things in the preamble that also need to be reflected in the legislation. You've got this wonderful commitment to principles, but when you read the legislation, there's nothing that puts any teeth to the principles. It's a real concern that all you're doing is keeping on that same road the Tories built, which is a very devastating one for all of us and will be worse if you continue along that road for the next five years.

For example, on the principle of public administration, you talk about accountability and public administration. We wonder why this legislation doesn't call for the boards of all health care organizations to be elected. Why do we have private boards running things? If you go back to the home care situation, we used to have non-profit boards involved and community boards running those services. You now have the private sector running them with no community control over what home care services are given, and there's no accountability there.

I mentioned the freedom-of-information requests we're after. Why can't we know about where home care money is being spent in the private sector? What services are we getting? What are the outcomes? There's nothing in this legislation that deals with that problem.

In terms of comprehensiveness of medicare, we've seen comprehensiveness totally eroded by user fees and the delisting of services. When I first read the legislation, it was so wonderful to see an act in Ontario that talks about the need for pharmacare for catastrophic drugs, that talks about the need for home care, that talks about primary health care being essential, which it is. Primary health care will do loads to help deliver health care services in Ontario. But when you read the legislation, it's never mentioned again. There's nothing in there that says, "Here is how we're going to build this, and here is how we're going to do that." We need to hear from you how you're going to do that. Surely something called the future-of-medicare act would have those pieces in it. We need some amendments that will give us those teeth.

The other thing in the preamble that I want to highlight is a small point, but it's in the act as well. You talk about our health care being consumer-centred. When I think about being a consumer—I buy groceries, I buy TV sets—I consume products. The health care and medicare services I get, which are so important to everyone, are not something I buy. I'm not a consumer. You're a patient when you're in that system, and I think we need to get away from the business lingo that is used throughout the legislation, and that consumer-centred piece is one part of that. We're patients. We don't purchase health care per se. We have a health care system; it's a social program that we're using.

So to be clear, if the Liberal government does support medicare and has a future-of-medicare act, we urge you to put in amendments to show that legislatively we support public, not-for-profit delivery of health care. Again, publicly funded is important, and we're also specifically against for-profit health care. Health care should not be treated as a business.

With regard to the Ontario Health Quality Council, we would like to see the act more specifically spell out how appointments will be made rather than just have them made by cabinet. We're really worried, if you start appointing individuals—and I know you're saying they're not going to come from any health care organizations—that you have a lot of individuals who are into for-profit

health care. We saw that at Sunnybrook, when they started that after-hours radiation business. It was a doctor who set up that whole thing. You've got to acknowledge that within the health care system there are many who would say health care should be treated as a business and should be allowed to make profits. That goes across the board.

If you have this health council, we need something that guarantees that all views are represented and that we're not going to end up with a majority of for-profit health care people on that council. If you proceed with that, it would seem to us to make sense that if at least it is all-party appointments, if there is at least some public way to make sure we don't have people on it to see that health care is used as a business, that would be a lot better.

The other thing we'd like to see is a health council report on the extent to which the Ontario health care system is meeting the principles of the Canada Health Act and also deal with this whole issue of privatization. To what extent is the private sector intruding on health care and treating it as a business?

With regard to opting out and extra-billing, we do not agree with subsection 9(4), which allows extra-billing if permitted by regulation. All that does is take the extra-billing issue and shove it behind a closed door where government can make a regulation on items it wants to allow extra-billing on. There should be no room for extra-billing in Ontario's medicare system, end of story. And there should be nothing in this legislation that allows anything like that to happen through regulation.

The next issue I want to deal with is queue-jumping. There's a big foofaraw about hockey players not being able to go out and buy MRIs. We think the real problem with queue-jumping is that we've got too much private sector health care happening. When they took those MRI and CAT scan clinics out of hospitals and allowed them to go into private clinics, that's where there's room for queue-jumping to happen.

Physiotherapy is another example. At one time, we used to have physiotherapy in hospitals. It was very easy. Your doctor gave you a referral and you'd go to your local hospital. What we saw over time was physiotherapy being moved out of hospitals and into private clinics where you don't have OHIP coverage. They can still charge you for services and often will say, "If you go to the hospital, the waiting list can be two to three months, but if you go to your private clinic with Green Shield or Blue Cross or whatever, you get a lot faster service."

That really is a form of queue-jumping. If you're someone who has extra coverage through work, you're going to get physiotherapy faster than someone who doesn't have that and is forced to wait, sometimes up to two and three months, for hospital service. That's really the essence of queue-jumping.

If the future-of-medicare act says, "We're going to take all this lab work, all this physiotherapy and MRI and CAT scans, all these things that should appropriately be in the hospital sector where we can guarantee that all people have coverage under OHIP," that's how we're going to deal with queue-jumping. We believe that if you have something in the future-of-medicare act that says, "We're going to recognize where the Tories privatized the system, and we're going to reverse that damage and get everything back into a publicly delivered system," a lot of these problems would get properly solved.

With regard to block fees, we don't believe they should be allowed. It's despicable that someone goes to a doctor and is told, "If you want all these other services, pay this fee up front and you'll have them covered." Some doctors don't even charge for these things.

I remember the old days, when you didn't have this problem; doctors were covered for this kind of thing under OHIP. If you have to have some kind of medical for work, why can't a doctor provide that and have coverage under OHIP? If I need a prescription renewed by telephone, why shouldn't that be covered under OHIP? What's the option? For my doctor to say to me, "If you want that prescription renewed, you're going to have to come in, have a visit and I'll charge OHIP, and then you can have your prescription"?

It's ridiculous that the system says there are now going to be some services lopped off OHIP coverage and you're going to pay for them out of your own pocket. It all goes back to one pocket or the other. Am I taking it out of my taxpayer pocket or out of my wallet pocket? I would put it to you that when you have all these extra fees, extra user fees and extra costs, at the end of the day it's the most vulnerable people, who don't have extra coverage, who don't have extra money, who can't pay for it, who get put at the end of the line or go without medical services.

0950

On accountability agreements: We welcomed the comments from the minister yesterday which said that would clearly not affect collective agreements and that we can look forward to amendments to that point. We were quite shocked to see the accountability agreement in the legislation. When they talked about accountability in the health care system, we thought "Great," because we do need accountability in the health care system. There's a lot that needs to be done in terms of accounting. But what you're doing in the legislation just didn't seem to make sense. We weren't sure what you were getting at and we were afraid of what you were getting at when all of the analysis was done.

In a future-of-medicare act, we think accountability should call for elected hospital boards and community control of home care, should say that freedom of information requests should exist to find out where the money's going and what programs it's being spent on. And what about whistle-blower protection? Wouldn't that be a good thing to have in a future-of-medicare act for people who want to do whistle-blowing on any problems they see? So, yes, we need accountability and that principle is important, but we just think you missed the mark on what it is we're calling people to be accountable for.

Finally, I just want to take this opportunity to urge you to take a second look at P3 hospitals, because it's very much a part of this whole future-of-medicare act. What we found is that more and more services were dragged out of hospitals and into private settings, and then when the Tories did the MRI-CAT scan clinics, you started to see more and more this eroding of health care. At one point they weren't touching hospital and physician services, but they sure were privatizing every other corner of health care that they could.

We called it privatization by stealth; that was really what was going on in Ontario. Unlike Alberta, where Ralph Klein just said, "Here's what we want to privatize," we had Mike Harris and Ernie Eves doing it by stealth in the corner wherever they could. When they moved to the P3 hospital model, they were then saying, "Here, we've found a way that we can let the private sector have a big piece in the hospital business." And let's face it, the private sector isn't there because they're good corporate citizens who don't need profit on hospitals. They need and want profit; they have shareholders; that's what they're in the business for.

You know, it's interesting; the P3 model is one they've had in Britain. We've shown over and over and seen that it costs more in the long run. I had the opportunity to be in Australia last year and met with a CEO of a hospital who told me he had been in a private hospital and in a public hospital. At the end of the day, they went back to the public model. I told him what Ontario Conservatives were doing here and he was surprised. He said, "But that's the British model. Haven't they figured out that you have essentially two bosses running a hospital? You have that private company that's going to run a whole bunch of services and then you have some things run by the public hospital board. Two masters trying to make things work in one spot." He said, "What happens in Britain is they can't even figure out, if something goes wrong in a hospital or something's out in a budget, which section of it was responsible, never mind the fact that what you're doing is privatizing certain services in a hospital that really should be in the public domain."

If the future-of-medicare act were really talking about the future of medicare in Ontario, we would need to see it say, "No more of this. We are just not going down the road of having the private sector be able to make profit from health care. We can do it better ourselves." We've shown that and that's what we need to do. We really urge you to take a second look at that P3 model. In the long run it costs you more. When it costs you more, government, no matter what government it is, is going to have to say, "How do we cut costs?" You cut costs by lowering wages or getting rid of staff or cutting services. This is not a good future of medicare for Ontario.

When you recognize the damage done in the last eight years, when you go back to the heart of it, those services that were privatized, where companies are now making big bucks off of health care in Ontario—that stuff has to get reversed. When you reverse that, you will save millions. We urge you that there has to be that commitment in a future-of-medicare act to say, "No more privatization. We want public delivery, not private delivery."

With that, I just want to thank you and urge you to make these amendments.

The Chair: Thank you Ms Harris. We have about nine minutes left, so we'll start this time with the Liberals. Ms Smith, three minutes.

Ms Smith: Thank you, Ms Harris. We really appreciate your being here today. Certainly you've covered the waterfront. I've made notes all over the place, so I'm only going to have time to address a couple of things.

I did appreciate your bringing up the seniors issue. It's near and dear to my heart. As you probably know, I'm travelling across the province, when I'm not doing this, reviewing long-term-care facilities. So I appreciate you raising your concerns there.

I was particularly interested in your concern about the accessibility to information regarding the CCACs. That's something I will take forward and look into. I wasn't aware that freedom of information did not allow you access to that information. Certainly we will look into that.

I'm glad that you've raised the issue of accountability agreements. You recognize that they don't apply to trade unions or collective agreements. I think it is important that we have accountability between our health care providers, hospitals, CCACs, long-term-care facilities and the government, and I think it will go a long way to ensuring that we continue to have publicly funded, publicly accessible health care in the province.

You also raised an issue on whistle-blowing. In section 13(7), there is a provision for whistle-blowing protection. I was interested in whether or not you thought that needed to be strengthened or amended in some way. Maybe you could provide us with that at another time. There is some protection there for whistle-blowing for workers who report on queue-jumping. It's in the health services accessibility section. So if you'd like to get back to me later on that, we'd welcome your input.

Ms Harris: The only thing I'd say on the accountability agreements is that this act will—hopefully the amendments will say it won't affect collective agreements. But anything you do in health care does affect collective agreements. You can't make changes in a workplace and not have it, at some point, affect the bargaining table. The private sector: The company makes money; people will bargain for better wages. If they're in trouble, you have to do other things. If you go ahead and do P3 hospitals, and you're then allowing the private sector to take over major services in that hospital, the accountability agreement per se might not affect the collective agreement, but certainly bargaining will be affected by privatization of a lot of services in a lot of hospitals. That's where we're worried about what you call accountability, this notion that the minister, with the hospital boards, can know certain things or do certain things.

The accountability will come if you have elected hospital boards, if you have a fully public system, com-

munity involvement and the private sector out of it. If you're saying that's where we're going, we would say to you, yes, that's going to build in a lot more accountability than what we have now. But I think the agreements per se, while they may not affect collective agreements, what you're doing in other areas certainly will affect collective agreements.

I'll look into the whistle-blower thing. I forget the third one.

Ms Smith: Sorry, it's 14(7).

The Chair: Let's go to Mr Wilson now.

Mr Wilson: Thank you, Ms Harris. Obviously, we're going to agree to disagree on many things. I've got to give you credit; you're extremely consistent over the years anyway, in terms of your approach.

I've always wondered the following, though: hard-working people in this province pay their taxes. In order to have access to the fundamental right of work, they pay you a union due. For access to a fundamental right in our society and in many workplaces, they have to pay a union due. So how is a block fee different from a union due?

Ms Harris: I think they're very different. To me, a block fee goes to what health-related services a doctor is providing to someone. As I mentioned, I think that they should be covered by medicare, by OHIP. Union dues—you're making the comparison; I'm not sure that there is a comparison. But what I would say to you—

Mr Wilson: There's a fundamental right to work. People pay their taxes; they expect medical services. You make the point that doctors shouldn't be allowed to charge any fee above their taxes. They can't work in many workplaces without paying a union due—a fundamental right to work.

Ms Harris: But I'm saying to you that OHIP should cover those services that doctors are paying. With regard to the Ontario Labour Relations Act, it does very clearly cover services that members get for their dues, sir, so I think you might want to take a look at that act. Fortunately, you didn't touch that section of it.

Mr Wilson: Well, I have. So does the College of Physicians and Surgeons act deal with allowing the CPSO, as a self-regulatory body, to determine by regulation what's in the block fee. I just don't see the difference.

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Ms Harris: The point I'm making, Mr Wilson, is that those doctors should get paid for those services. I have no argument. If my family doctor does prescription by phone or a special thing for my employer for a driver's licence or something, they should get paid for that, absolutely. I think family doctors do a lot more than they're recognized for. They should get paid for it.

Now, the question is, should I pay out of my pocket or should OHIP cover it? We're saying OHIP should cover it, because what has happened in Ontario is that we have taken more out of our pocket and more out of our pocket to the point where Ontarians now pay more per person per year out of pocket. We have the highest rate of any province in Canada, and that was in a boom-time period. It's irresponsible, it's inexcusable and it has to change.

Mr Wilson: I don't know where you make that up. We also spent more per capita on health care than any other government.

The Chair: OK, thank you. Your time has expired, Mr Wilson.

Ms Harris: You gave it to the private sector for the profits, sir.

The Chair: OK, thank you.

Interjection.

The Chair: Jim, please. You're eating into Ms Martel's time. You have the floor, Ms Martel.

Ms Martel: Thank you, Irene, for being here today. The minister conceded yesterday that he had made mistakes in this bill in a number of areas and that there were going to be significant amendments coming forward. He said nothing, however, about the privatization of health care services, and I don't think that's an accident, because I don't think the government has any intention of changing the road they're now going down, which is a road started by my friends beside me.

I asked him very specific questions about where are the provisions in the bill to ban the private MRI-CAT scan clinics and, of course, there aren't any and there aren't going to be any, just as there are no provisions in the bill to stop the P3 hospitals and there are no provisions in the bill to stop competitive bidding in home care. That's because the government has no intention of changing the direction it's now on.

My concern is the rhetoric versus the reality. The preamble of the bill talks in glowing terms about medicare and supporting publicly funded, publicly administered services, but when the rubber hits the road, the government has no intention of ensuring that happens. What's going to happen is that important health care dollars that should be going to patients are going to end up going into the pockets of corporations, like in the P3 hospitals, like at the MRI and CAT scan clinics, like the private bidders who get home care contracts—Bayshore and others.

Can you just repeat for me the concern of the federation with respect to the preamble, which has some flowery language about recognizing medicare, and the actual contents of the bill, which do nothing—absolutely zero, nada, nothing—to stop the privatization started by the Conservatives, now being carried on by the Ontario Liberals.

Ms Harris: I think when the minister talks about medicare being publicly funded and publicly administered, he also needs to say publicly delivered, and that's the big difference. The other thing is in the preamble. The preamble is wonderful. It acknowledges the need for pharmacare, the need for home care, accountability, but then when you go to the legislation, there's nothing in there that says, "Here's how we're going to get those things started."

We recognize that we might not be able to do it all in a year, but if you had legislation that said we're going to do pharmacare, home care and come back to not-for-profit public health care, then that would be a true future-of-medicare act for Ontario. It would be something that

we could all celebrate, and it would give leadership to the rest of the country, which is really, really needed.

The Chair: Thank you, Ms Harris, for coming today. We do appreciate your input.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1623

The Chair: We are now going to go on to the Canadian Union of Public Employees, Local 1623, from the Sudbury Regional Hospital. Joanne Arnold is here as president. Welcome. You probably heard the rules while you were sitting in the audience. You've got 30 minutes. You can use that time as you wish. Any time that is left will be split amongst the three parties for any questions they may have of you. The floor is yours.

Ms Joanne Arnold: Thank you very much. I appreciate your time this morning. Good Morning. My name is Joanne Arnold. I am president of CUPE local 1623 of the service and clerical bargaining units of the Sudbury Regional Hospital, Northeast Mental Health Centre and Northeastern Ontario Regional Cancer Centre group. I have been a switchboard operator-communications clerk for the last 26 years at the St Joseph's Health Centre site. I'm here today on behalf of the approximately 1,000 members I represent, as well as as a member of the community and a taxpayer.

The makeup of my members who work for the hospital includes clerical employees, registration clerks, ward clerks, communications clerks, dicta typists, secretaries, health records staff, clerk typists etc. It also includes the service employees: registered practical nurses, tradespersons, food service workers, housekeeping workers, central supply and reprocessing and linen employees etc. We believe that we are the front-line workers, the nucleus of health care in this community and the province. Direct patient care runs in and out of our hands 24 hours a day, 365 days of the year.

Since 1996, we have been faced with the restructuring of insurmountable proportions of the services we provide. Recently, a local recovery plan that was put on us is a three-year roller coaster ride to hell, and it was implemented in 2003. Why? Mismanagement. Who is suffering the most for that? The patients of this community. And now the introduction of Bill 8 in the Legislature, a bill that is supposed to change the face of medicare in the province of Ontario. I will return to this subject shortly. I would like to speak, though, about P3 hospitals at this point in time.

But first we'd like to say that we're pleased to hear that the Liberal platform, prior to the election, carried the party as a whole toward the removal of the Conservative's dumping of our public hospitals into P3 hospitals and the private hands of investors. Not only have you broken this promise, but you are prepared to now add six more hospitals to be targeted by you, and to this we say shame on you.

Locally, the waiting game has begun. Once again we are all on the edge waiting for the other shoe to drop. Words like "mortgage" are being tossed about for the capital project, and we must ask you, at what cost to the patient, at what cost to this community and at what cost to the employee? How will the loan be paid back while we certainly continually run deficits, and who will be accountable at the end of the day?

Then what happens to the operating budgets? If we continue to receive less and less from the government in public dollars, that can mean only one thing, that you are prepared to open the door to privatization, and again we ask you, at what cost to the patients, at what cost to the community and at what cost to the employee? And once again, who will be accountable at the end of the day for that?

We are all smart people in this room, and we know that if the hospitals are privately owned, the privateers are their own bosses and are only accountable to themselves and their investors, and lest we forget, private companies are also in the business to make profits.

Now returning to Bill 8, in December 2003 I read the bill prior to any legal opinion placed before me. Several issues jumped out at me that gave me grave concerns, particularly around part III, accountability. To be specific, section 19 of the accountability agreements in (a) refers to the value for money and any other prescribed matter, and (d) refers to "and any other prescribed matter."

Section 20, "matters to be considered": specifically numbers "5. fiscal responsibility," "6. value for money" and "12. any other prescribed matter."

Section 21, under "accountability agreements": The Minister of Health can direct either or both to (1) enter into an agreement with him or her, or (2) enter into an agreement with him or her and any one or more persons.

Section 22, "compliance," says the Minister of Health "at any time" can issue a directive.

Section 24, under "termination," says, once again, "at any time" the Minister of Health can end an agreement he does not see appropriate and issue a new compliance directive.

Section 26 under "consequences": When the parties fail to comply, the Minister of Health then takes the ultimate powers given him with this bill and orders one or more prescribed measures.

Section 27, changes to the term of employment: Whatever orders made will be deemed, as per (a), shall be deemed mutually agreed.

Section 28, changes in funding or agreements because of funding: Once again, should funding changes occur and agreements need to be altered, as per (a), they shall be deemed mutually agreed.

So to recap this in a short fashion, the Minister of Health, in sections 19 through 28, will carry the ultimate power as it is written today to force us into an agreement. If we do not comply, then he can step in and order it done and, if he does not think it is an appropriate agreement, he can terminate it and create one of his own and order it

complied with. When funding changes occur, he then carries the power to walk in and adjust any agreement he sees fit and, again, it shall be deemed mutually agreed upon by the parties. We don't know about you, but where did we get any say in this matter?

Finally, under section 30, "non-liability," we are astounded to see the broad legal immunity tabled as protection for the powers that be, should we wish to challenge who is accountable at the end of the day.

From our perspective, we see Bill 8 as it is presented today as a serious threat, and you must realize that it is being viewed as a direct hit on our rights to free collective bargaining. We as employees of this hospital and province have the right to earn a decent living without the constant wondering if we will wake up tomorrow and be in the same boat British Columbia ended up in with their government and Bill 29.

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The service and clerical employees are the lowest-paid employees working in the hospital system, but the easiest target for privatization.

Our local in the last year has seen numerous cuts to the services that we provide to the patients of the Sudbury General Hospital and the community that we live in, to the tune of 73,095 hours in total. That is just in my local alone for one year. Yet we certainly have not seen any reduction of that magnitude from the management portfolio. In fact, we are seeing quite the opposite. We see a continual influx of consultants, managers and executives being hired.

The Chair: Ms Arnold, I'm sorry to interrupt you. If there's going to be conversation, out of respect to the delegation, could we have it outside the doors? OK?

Ms Arnold, I'm sorry. I just wanted to make sure you had our full attention.

Ms Arnold: Thank you.

Can someone answer this question for me: What direct patient care does additional management provide, other than doing studies and duplicating work already being done by the existing executives of the day?

To wind down my presentation today, the hospital employees of CUPE local 1623 see Bill 8 as a threat to their livelihoods, their homes, their children's education, their retirement and their physical and mental health. We have seen an increase in workloads, workplace injuries and sick time, while the services dwindle down, one day after the other, and we see no end in sight.

We bring and give a lot to the patients of this region and provide a great contribution to the economy of this community. If we do not see amendments to this bill under part III that protect our fundamental rights to maintain and uphold free collective bargaining and know that at no time will any government be able to walk in and cut our wages in half and take away our benefits that we have worked hard to achieve for years—therefore, we ask that you consider the following amendments and change Bill 8 before it becomes passed as law:

(1) No trade union shall be required to enter into an accountability agreement or be the subject of a directive;

(2) No collective agreement shall be the subject of an accountability agreement or of a directive;

(3) No accountability agreement or directive shall directly or indirectly affect the continued operation and enforceability of a collective agreement or purport to amend its terms;

(4) No employer shall be required or authorized to enter into an accountability agreement that directly or indirectly interferes with its ability to comply with the provisions of the collective agreement, nor shall any directive have such effect.

(5) Notwithstanding sections 21, 22, 26, 27 and 28, no accountability agreement entered into under section 21, compliance directive entered into under section 22, or order made under section 26 shall: directly or indirectly affect the continued operation and enforceability of a collective agreement; purport to amend, vary or discontinue the terms of a collective agreement; require the parties of a collective agreement to amend, vary or discontinue the terms of a collective agreement; directly or indirectly interfere with the ability of the parties of a collective agreement to comply with the terms and conditions of a collective agreement.

One final thought: The thought of the unlimited powers of the government to impose the options of value for money and any other prescribed matters as stated within the context of Bill 8 as it stands today will only lead to further chaos and turmoil with the hospital employees of this community and this province. The one who will suffer for this at the end of the day will be the patient.

Please consider your current position on Bill 8 and make the necessary amendments. On behalf of the approximately 1,000 members of CUPE local 1623 of Sudbury Regional Hospital, the Northeast Mental Health Centre and NEORCC, I would like to say thank you for your time and your interest in this matter today.

The Chair: Very good. Thank you. We've got about 21 minutes left and we're going to go to the PCs first, then to the New Democrats, and finally to the Liberal Party.

Mr Klees: Thank you for your presentation this morning. I think you've helped us considerably by zeroing in and actually making some very specific amendment recommendations this morning. I'm interested in your lead-up to the specifics.

We make reference to the fact that this government has broken many of its promises already, and we heard—and you will no doubt hear—the parliamentary assistant recant on many of these issues. We heard the minister in his opening statement yesterday apologize and, in fact in quite an embarrassing tone, suggest that someone made a major blunder in drafting this legislation. You've certainly picked up on it.

I have to wonder, though. First of all, I can't believe that the drafting took place in two or three minutes; I have to believe that a great deal of thought went into this. So, if in fact a great deal of thought went into it and we have the kind of draconian legislation that you have

before you—which does exactly what you're suggesting it does, by the way: override an awful lot of agreements, whether they be collective agreements or other agreements, as we heard this morning. Let me ask you this: Do you believe that the Minister of Health will make the changes that he said he's going to do?

Ms Arnold: Well, no. In all honesty, at the end of the day I think he will continue to leave the open door there. We had an emergency teleconference last night with our governing body, the Ontario Council of Hospital Unions, and I understand that there were some comments made by Mr Smitherman yesterday regarding the absolute changes that need to occur under accountability. But the one word that apparently came forth through that whole conversation was that he will not open up: "current" collective agreements. Well, let me be very clear to everybody in this room: Every collective agreement from CUPE up to ONA are opening up this year. So when I say "current," that means that when they expire, we're no longer current.

Mr Klees: You see, I don't believe him either. I don't believe very many people in this province believe very much what this government is saying. However, there is a way that this committee can at least send a strong signal to the minister, and that is if this committee would agree to move a motion to adopt the specific recommendations for amendments that you've made in your presentation.

Chair, I'm willing to make that motion for consideration by this committee. There is nothing stronger than members of the government committee here joining with us in making a unanimous recommendation to the minister to adopt these specific amendments that are being proposed. I'd like to make that motion.

The Chair: It would be my preference at this time to deal with motions after we've heard from members of the public. I'm certainly prepared to entertain that motion at the appropriate time. I leave that to the committee as to whether they would prefer to deal with the motion now or deal with it in the future.

Mr Klees: Well, there is a motion on the floor. I think if, subsequently, you want to deal with it in some other way, we can deal with the procedural matters, but I do believe you have a motion on the floor.

The Chair: I do, Mr Klees. I also have an awful lot of people who would like to speak with us today.

Mr Klees: This could take about two seconds.

The Chair: I wish it would. I have a feeling it won't.

Mr Wilson: By the way, I'll second the motion.

Ms Smith: Mr Chair, I don't believe this is an appropriate time for such a motion.

The Chair: Let me consult with the clerk. We have what I think might be a compromise—I'm hoping you'll find it to be a compromise—and that is, if you are prepared to submit that motion in writing, we would hear from the members of the public up until the noon hour; then we would take the period when we're not hearing from the public—I think that out of respect for people who have taken time out of their day to speak to us, we would use the period between 12 and 1:30 to debate and vote upon that motion. Would that—

Mr Wilson: I'd like to speak to your comments. I don't think there's any greater respect for Joanne than to adopt what she said. You don't have any choice, by the way, as chairman when there's a motion on the floor but to deal with it, unless there was something agreed to in the—

The Chair: OK. Well, it needs to be submitted in writing to begin with. We may want to start that process going. The motion isn't officially on the floor until it's submitted in writing.

Mr Wilson: Give us one minute and it will be in writing.

Ms Martel: If it would be at all helpful in terms of timing, I would just like to indicate that I would support the motion.

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Ms Smith: Mr Chair, may I suggest that we move to Ms Martel's portion of the questioning so that we don't spend any more of the—

Mr Wilson: There, it's in writing.

Mr Klees: Should I read it into the record, Mr Chair?

The Chair: It needs to be photocopied and distributed to the members. So if we are going to deal with this, and it looks like we are going to set our time period back, why don't we recess for 10 minutes at this period while it is photocopied so that we all have it in front of us.

Ms Wynne: Mr Chair, is it not possible for Ms Martel to ask her questions while the motion is being photocopied? Can we not carry on and then, when the motion comes back—

The Chair: We could do that, if that's what you prefer.

Ms Wynne: I'm just suggesting that it uses the time better.

The Chair: Is that what you would prefer to do?

Ms Martel: Yes. Thanks, Joanne, for being here this morning. I want to actually focus on privatization, because there would be some in the room who would clearly understand what's happening in the hospital system in this community right now; there would be others who wouldn't, some of the committee members who are new and don't have a sense of the history.

You talked about your concern about a mortgage. My concern is that the Sudbury Regional Hospital would be one of those hospitals that will be up next for the mortgage scheme, which would be a P3 scheme. That's very much my concern. So I think it would be helpful for the committee if you could give a sense of what is happening right now, or a better way to describe it is what is not happening right now in the community with respect to construction at the hospital, which may well lead—I think will absolutely lead—to a mortgage scheme or a P3 scheme, and what kind of impact you are concerned that will have on your members, particularly because under the current recovery plan, which has nothing to do with a mortgage scheme, your members have already lost—what did you say?—73,000 hours. So

if you could just put it in that context for the committee, I think that would be helpful.

Ms Arnold: We have been sitting dormant for several years through the restructuring process. We had a south tower built, which went way over budget, extremely over budget. It was supposed to be about $150-some million and it ended up at $350-some million. It's absolutely ludicrous. We've had committee after committee come in. We have an empty south tower sitting there. It was supposed to be state of the art, ready to go, and it's sitting dormant. It's got ghosts in the hallways at this point.

The last government walked in and carved out the 64 long-term-care beds that were going to be initiated and put them out to St Joseph's Villa, which is going to have to build another sector in their villa in order to incorporate the 64 beds.

Again, we're still sitting empty. We're still waiting for government dollars to show up on our doorstep to complete the project. More and more we're hearing Ms Kaminski speak about a mortgage, and that mortgage is going to be very costly because they anticipate possibly taking a mortgage to the tune of paying back $4 million and $5 million a year out of the operating budget. If that's the case, right now we're still running a $7-million deficit this year alone. So on top of the other $4 million or $5 million we have to pay back on the mortgage, that is going to cost jobs and it is going to cost services in this community.

As Ms Martel spoke about a moment ago, my local has already lost through the recovery plan, which is a whole different three-year roller coaster ride we're on, 73,000 hours. As we do the direct-patient care, the front-line workers with the patients, we're about to continue to lose this year and another year to come. The only thing that's going to affect this whole process—it's going to cost us jobs, it's going to cost the patients their services and their right to fundamental health care.

Ms Martel: It's worth pointing out that the hospital, over the three-year recovery plan, is trying to save $20 million now.

Ms Arnold: Yes.

Ms Martel: It already has a deficit of $7 million. It's awaiting news from the Ministry of Health about a commitment that most people in the community think was made for $3.7 million and there has been no word from the ministry about that coming before the end of the fiscal year. So the deficit this year could be over $10 million. On top of that, there is certainly very vocal discussion about a mortgage. When you have a mortgage, it assumes you have some savings to pay the mortgage payment. This is a hospital, since its inception, that has never had an operating saving. It's always had an operating deficit.

So what do you think it means if your members are cut, if ONA members are cut, if OPSEU members are cut? What do you think that's going to do to patient care in this community, when already the recovery plan is having a negative impact on patients?

Ms Arnold: It's going to create chaos in the health care system, because if you are going to be cutting the services out of the hospitals, there is nothing set up in the communities for these people. It goes across all sectors of health care. It is going to mean a great deal against the patient. It is going to harm them. They are going to wait for longer times to get into the hospitals for what services remain at the end of the day. There is going to be no pushing into the process, into getting back into the system. There is nothing going to the community. There are no dollars coming from the government. We have seen several different pushes toward, "We're going to get money in Sudbury to complete this project and get a move on." Now I'm hearing we're going to have a summit. How many more sit-downs are we going to have about the Sudbury Regional Hospital to discuss how much money we need? We need dollars. We need committed public dollars to this hospital in Sudbury to complete it and deliver it publicly.

Ms Martel: Thank you.

The Chair: Ms Smith, do you have questions of Ms Arnold?

Ms Smith: Yes. I wanted to address some of your concerns that you raised in your presentation. I'm sorry I missed the beginning, but I did have a chance to review it. Thank you for providing us with a written statement.

First of all, I don't know if you have seen the statement made by the minister yesterday.

Ms Arnold: No, I did not.

Ms Smith: I'll give you a copy before you go. He's clear in his statement where he says, "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."

Again, later in his statement he says, "The bill does not apply to solo physicians, group practices or labour unions. We will offer amendments that make that abundantly clear."

He doesn't use the terminology "current collective agreements." He says it does not apply to collective agreements, it does not open collective agreements. So I'm not sure where that language, that translation, came from, but it's not implicit in his statement of yesterday.

He goes on to say, "The ministry would establish accountability agreements with the board of directors, and the board is then required to establish a similar performance agreement with the CEO. We will be introducing amendments which will clarify the process for entering into accountability agreements....

"The intent here is not to take away any of the authority of the governing executive boards, but to clarify our expectations for deliverables."

That really is the intent of the accountability agreements, to clarify what we expect as deliverables. There is an agreement between the ministry and the hospital, and it's to provide some accountability in the system that I think most Ontarians want to see. They want to know where their taxpayers' dollars are going.

I hope some of that calms your fears about the vulnerability of collective agreements. I don't believe they're vulnerable under these accountability agreements at all,

but I understand that you'll continue to have your concerns. We'll provide you with the language of the statement yesterday, and hopefully when the amendments come out, you'll be satisfied.

I also just wanted to address some of your concerns with respect to sections 22 to 26 on compliance. Again, you have concerns about the broad language that's in place on compliance directives. I think that we will be introducing some amendments there as well. We are talking about a framework right now for amendments. We will be introducing some amendments that will put more specifics around that and certainly more protections. I hope that you'll be satisfied. I would be interested to hear what you'd like to see in those areas to strengthen them or feel that you're more protected.

Ms Arnold: Well, first of all, the term "deemed mutually agreed upon" is pretty one-sided, one person making all the decisions.

Ms Smith: Just so you're clear on that, on section 26 that applies to what is in the legislation as accountability agreements between the CEO and the Ministry of Health. It doesn't affect collective agreements or individual employees.

Ms Arnold: And I understand that. I understand that you're saying that, although the bill doesn't say that. The bill is very broad and wide open at this point in time. My concern is that if you are going to have one person, even that one person making the decision about a CEO, I don't think that's accountability; I think that's a dictatorship. You need to have an elected committee that is going to make the decisions. I don't even think that compliance is appropriate. I don't think that there should be anybody in there forcing a compliance agreement. I don't even believe in the accountability agreements. I think that we need to have an open process where people become accountable through elected bodies and report back accordingly and make the changes, not just reporting back. They need to be able to make the changes as well and move forward with those changes accordingly. But it's not one person making that whole, sole decision.

1030

Ms Smith: I don't think it's the one person. In the scenario that we're developing, it would be the board that's accountable to the ministry. The hospitals do have boards in place, and the board would be accountable to the ministry.

Ms Arnold: Absolutely, and our board was appointed. So thank you very much. It wasn't elected.

Ms Smith: I think some of my colleagues have questions.

The Chair: Let's go to Ms Wynne and then to Mr Brownell.

Ms Wynne: I just had a question, and thank you, Joanne. I just want to acknowledge the turmoil that you're in here in terms of the health care system, and in just about every sector that we look at, the same kind of turmoil pertains. I think we need to acknowledge that, and so we're trying to put legislation in place that's going to prevent that from continuing and happening again.

You referenced Bill 29 from BC. As I look at Bill 29, there are really specific and very draconian statements about collective agreements and the government's ability to reach in and deem them void or change them or really disrupt the relationship between employer and employee. Can you talk about the specifics that you see in this bill? I don't see them. We've said that there are going to be changes in that accountability section, but do you see the same kind of language as in Bill 29 in this bill?

Ms Arnold: I look at what happened to my brothers and sisters in BC, as well as other people in the health care system in BC, and I'm concerned that overnight, they have lost jobs. They have had their wages cut in half. They have had their benefits taken aware from them. Those are things that people have worked long, hard years for. The cost of living isn't rolling back with it. The problems in the health care system are now being retaken out on the individuals who are left behind.

Ms Wynne: So you're worried about that, but you're not suggesting that the Bill 29 language is in Bill 8.

Ms Arnold: I'm not saying it's there, but Bill 8 is so very broad right now, and the ultimate powers are very broad. You can see them. They're very much there. So it's left wide open for interpretation.

Ms Wynne: So you want that tightened up—

Ms Arnold: Absolutely.

Ms Wynne: —but I just wanted to be clear that I hadn't missed something in Bill 8, some specifics from Bill 29 that were there. Thanks.

The Chair: There's about a minute left, a minute and a half.

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh): First of all, thank you for your presentation.

You mentioned about pharmacare and home care and the lack of any meat in this bill with regard to those two. You alluded to the preamble. Has CUPE or your organization had any thoughts or any written submissions with regard to what you would like to see? I know that we are saying it's important to the future of the health system, and there's nothing in here. Have you dialogued in any way with written comments that we could take back and perhaps put in so that the future will be recognized in the bill?

Ms Arnold: I personally did not speak about—what did you say? Pharmacare?

Mr Brownell: Pharmacare and home care.

Ms Arnold: I did not speak about either of those issues in my presentation. I'm sorry. There is a gentleman here, Michael Hurley, from the Ontario Council of Hospital Unions. I'm sure he will be touching base on those issues from a CUPE perspective, because he's also from CUPE.

Interjection: It was the previous person.

Mr Brownell: Oh, it was the last—I'm sorry. I wrote on the top of your paper here. I apologize for that.

Ms Arnold: That's OK.

Mr Brownell: I've been hearing that more and more and more, yesterday and today, and it's a big concern of

mine. For the last speaker, I didn't get in to comment on that. I apologize for that.

Ms Arnold: That's all right.

Mr Brownell: It's a big issue.

The Chair: Thank you, Ms Arnold, for joining us.

There's a motion that's going to be placed on the floor now. It needs to be read into the record.

Mr Klees: I move that the following amendments be adopted:

(1) No trade union shall be required to enter into an accountability agreement or be the subject of a directive.

(2) No collective agreement shall be the subject of an accountability agreement or of a directive.

(3) No accountability agreement or directive shall directly or indirectly affect the continued operation and enforceability of a collective agreement or purport to amend its terms.

(4) No employer shall be required or authorized to enter into an accountability agreement that directly or indirectly interferes with its ability to comply with the provisions of a collective agreement, nor shall any directive have such effect.

(5) Notwithstanding sections 21, 22, 26, 27 and 28, no accountability agreement entered into under section 21, compliance directive entered into under section 22 or order made under section 26 shall:

(i) Directly or indirectly affect the continued operation and enforceability of a collective agreement;

(ii) Purport to amend, vary or discontinue the terms of a collective agreement;

(iii) Require the parties of a collective agreement to amend, vary or discontinue the terms of a collective agreement;

(iv) Directly or indirectly interfere with the ability of the parties of a collective agreement to comply with the terms and conditions of a collective agreement.

The Chair: Thank you, Mr Klees. Are there are any speakers to the motion?

Mr Wilson: The reason I'd second the motion is that it's consistent with the approach our party took when the social contract was being introduced. There has only been one precedent in the history of the Ontario Legislature that unilaterally opened up collective agreements, and we were very consistent in opposing that because the very nature of democracy is, whether you like what's in the agreement or not, the parties sit down and bargain. At the end of the day, they agree to live with that agreement during its term. So I commend Mr Klees for being consistent. Also, I don't see any harm in having government members support this. If the minister meant what he said, Joanne's language, madame President's language, is very consistent with following that up and putting some teeth where his mouth is.

The Chair: Thank you, Mr Wilson. Let's go to Mr Duguid, then Ms Martel.

Mr Brad Duguid (Scarborough Centre): In light of the fact that we have a number of deputants who are here today with busy schedules, I don't want to belabour this issue. I will explain why I have difficulty supporting this at this time.

The government side is certainly looking forward to bringing forward amendments that address these concerns, and we will be doing so. We're committed to doing so. It's going to happen. To do this now, I think, is to do an injustice to all the other deputants we are ready to hear today. I think we want to hear what they have to say on this issue before we decide where we're going to go on it. I think that's part of what these hearings are for. This is highly unusual, on the first day, after hearing from three people, to start making motions and decisions. We will be moving forward in the future to address this matter, but we think it's not appropriate to be moving this motion or voting in favour of it at this point in time.

Interjections.

The Chair: Ms Martel, you have the floor.

Ms Martel: Thank you, Mr Chair. I appreciated the revisionist history by Mr Wilson here this morning, because I remember the debate on the social contract. His leader, Mike Harris, said, "Do more. Cut more. Impose the social contract now. Never mind any negotiations." He was very clear: "Cut more, fast, hard. Never mind negotiating with people; just impose the cuts unilaterally." That was Mike Harris's position, so let's just, for the record, correct what Mr Wilson had to say.

Very quickly, I'm just going to quote what the minister said yesterday in support of why the motion should be moved. He said in his remarks yesterday, "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 … explicit." I think the language that you gave to us this morning, Joanne, makes that explicit. In the absence of anything from the minister to date, because we don't have any other language before us, I think it is appropriate that we send a very clear signal that the minister means what he says. If he says what he means, these would be the references in the bill that would have to be taken out and these would be the changes that would have to be made. We should just very quickly support the changes you recommended this morning.

The Chair: Thank you, Ms Martel. Mr Delaney?

Mr Bob Delaney (Mississauga West): One very brief comment to follow on what Mr Duguid said. Joanne's points are very eloquently stated, but they're already part of it.

The Chair: Thank you, Mr Delaney. Any further speakers? Mr Klees for a second time.

1040

Mr Klees: With respect to Mr Delaney, if they're already part of this bill, pray tell where. The reason that Ms Arnold has presented these specific amendments is because they certainly are not anywhere to be found in the bill. For us to believe the minister when he told us that he would undertake to do that—I think there's a great deal of mistrust of the minister to follow through on that. This government hasn't followed through on one thing they said they would do before the election. This committee has an opportunity here to actually show some

response now to someone who took the time to make a very succinct presentation to this committee, and it's not mere rhetoric—very precise wording that does precisely what supposedly the minister said he would do.

I cannot believe that the members of the government on this committee are now doing some more sidestepping on this issue. Who has, I pray, told you people to do this? Who gave you the direction? There are six members of the committee, all members of the government. You have three members of the committee here who say, "Look, this is consistent with what the minister has said." Isn't it a coincidence that every member of the government is now taking the position that they refuse to vote in favour of this motion? Surely there's been a directive from somewhere, and this is the government that said, "We're going to do government differently."

I would ask the members opposite to think about the words of their leader during the election campaign. He said he was going to free up members of the backbench; he was going to empower members of the Legislature; he was going to make the committee process more meaningful. We have an opportunity here. I strongly urge the members of this committee on the government side to step outside of the bounds, remove the shackles that the party has put on you and vote in favour of this very commonsense motion that's before the committee now.

Ms Smith: I believe that we are living up to our commitment to actually consult the people of Ontario, which is a concept I recognize the member opposite is probably not familiar with. But we are consulting with people. We are here to listen to deputations from a number of people today and over the next week. I believe this motion is premature.

Mr Klees: Premature?

Ms Smith: Premature, yes. The minister has made the commitment and we will follow through with that.

Mr Klees: What's the appropriate gestation period?

Ms Smith: I would ask that the member actually allow me to make a statement, as I politely listened to his.

The Chair: Mr Klees, I think we all listened to you.

Mr Klees: I'd be happy to.

Ms Smith: Thank you. I just think that we should move forward. We have a number of people who are waiting to present. We're here to listen. Certainly we hope to hear a great deal more. I'm glad that we have on the record that the member opposite is committed to the sanctity of collective agreements. That's good to hear. At the risk of allowing him yet another speech, I think we should call the question.

The Chair: There was one further speaker, who I think is prepared to pass.

The motion is on the floor, then, moved by Mr Klees. All those in favour of the motion?

Ms Martel: Recorded vote, please, Chair.

Ayes

Klees, Martel, Wilson.

Nays

Brownell, Delaney, Duguid, Ramal, Smith, Wynne.

The Chair: The motion is lost.

Interjections.

The Chair: Why don't we have a recess for five minutes.

The committee recessed from 1045 to 1057.

WEST NIPISSING GENERAL HOSPITAL
HÔPITAL GÉNÉRAL DE NIPISSING OUEST

The Chair: I call the committee to order again, please. Mr Brouillette and Mr Campeau, thank you for coming this morning. I think you were sitting through the morning. You understand that you've got half an hour. You can use that any way you like and then we will split the remaining time among the three parties. The floor is yours.

Mr Raymond Brouillette: My name is Raymond Brouillette. Beside me is Yves Campeau, who is the CEO of our hospital. I am the chairman of the board of governors of the West Nipissing General Hospital, located in Sturgeon Falls, on the Trans-Canada Highway, approximately one hour east of Sudbury. Our population is predominantly of francophone origin—in excess of 75%. The West Nipissing General Hospital is one of only a few hospitals in Ontario that has achieved full designation under the French Language Services Act, 1996. I am a retired businessman and have been a voluntary member of the board for 10 years. I have been chairman for the last three years.

I am pleased with the opportunity to provide to you, on behalf of the board of governors of the West Nipissing General Hospital, our comments and concerns in regard to Bill 8.

Bill 8 is entitled Commitment to the Future of Medicare Act. On the surface no one will argue against the preservation of medicare. However, we see no evidence of linkage between the preservation of medicare and some of the current provisions contained in Bill 8.

Our hospital board of governors feels it has been broadsided by the unexpected underlying message the government is conveying by introducing this bill. Whether it was intended or not, the message being sent by government is that hospital boards and CEOs are in effect squandering public dollars without accountability and without regard for patient and community health care requirements.

One year ago, the West Nipissing General Hospital was required to submit very detailed information regarding all aspects of its operation, including governance, to the third party hospital review panel. This panel was led by Mr Al Rosen, a well-respected forensic auditor.

On March 21 of last year, I received a letter from Tony Clement, Minister of Health at the time. A copy of this letter is attached to my presentation. In his letter, the minister advised us that the government was allocating

$300 million to Ontario hospitals to help address hospital pressures and $50 million to reward and recognize those hospitals that were fiscally responsible and demonstrated innovation. The minister went on to inform us that the West Nipissing General Hospital's share of this new funding was $389,500. In the absence of any information to the contrary, our board assumed that if we were granted this sum in additional funding as a result of the audit, the third party hospital review panel had to have believed that we were acting very responsibly.

In that letter the minister further stated:

"I also asked Mr Davies and Mr Rosen to provide me with an analysis of systemic issues and to submit recommendations to me in that regard.

"Their recommendations are expected in the coming weeks and will be useful to the government and hospitals as we work together to develop and build on existing strategies to strengthen our health care system, including a multi-funding framework and enhanced performance expectations.

"This government remains committed to working with you to create the right environment to foster improved care, innovation and ensure health services remain sustainable for patients."

On August 1 of last year the minister wrote to me again—copy attached. In that letter the minister stated: "I am planning to release the report of the third party hospital review panel and share the results with each hospital in the very near future. The report highlights many suggestions that would enhance the ministry-hospital accountability relationship and we will be working with you in considering how to move forward on these suggestions."

The third party hospital review report has never been released. I estimate that over $1 million was spent to produce this report, both in direct dollars and resources allocated to the review process by both hospitals and ministry staff.

As you can see by the comments of the previous Minister of Health, it was the intent of government as recently as six months ago to work collaboratively with our hospital. You can now understand my earlier comment in regard to our board's surprise and disappointment with the direction that the current Minister of Health is taking with the government's relationship with Ontario hospitals. In its present form, Bill 8 will destroy all trust and collaboration achieved by these two important partners.

I will now summarize the amendments that we believe are required to Bill 8 in order for it to restore trust and accountability between the partners, an element that is truly necessary if we are to preserve medicare in Ontario.

The West Nipissing General Hospital believes that the health care system should be accountable to the taxpayers of Ontario and we want to do our part to ensure that this happens. However, we take issue with the way in which Bill 8 attempts to enhance accountability. We believe that the accountability provisions of Bill 8 do not sufficiently recognize the interdependent nature of the relationship between health care providers and government, one characterized by trust, mutual respect and collaboration.

One of the most important amendments is to ensure that the accountability agreements are negotiated and not imposed. Directing hospitals to sign agreements undermines the collaborative approach adopted by both government and hospitals to develop a multi-year funding framework and performance agreements for hospitals. Imposing agreements on a hospital undermines the role of the board in ensuring that the necessary health care services are provided to the community.

Further, as currently drafted, there is no provision for multi-year accountability agreements. This is currently being contemplated by the multi-year funding initiative developed jointly by government and hospitals through the joint policy and planning committee. To build on this work and in the interests of promoting stability within the health care system, we suggest that Bill 8 should provide for multi-year agreements.

We would also suggest that compliance directives in Bill 8 are inappropriate in the context of a negotiated agreement. We are particularly concerned with what we see as yet another intrusion upon the role of the community and the hospital board, and the very real potential for undermining voluntary governance in local communities.

In particular, we cannot endorse provisions which allow the minister to make an order that may result in a material change in a person's employment, including reduction in pay or change in benefits. We propose that these provisions be deleted. Under the Public Hospitals Act, the terms of employment of the chief executive officer are the board's responsibility to determine and modify as they deem appropriate.

The bill fundamentally reduces government accountability by removing the requirement for the minister to act in the public interest as defined by the Public Hospitals Act. By removing the requirement of the minister acting in the public interest, the minister is less accountable to the public in ensuring the accessibility to health services in the community where the hospital is located. This is a serious breach of a key principle in the Canada Health Act.

We support the establishment of the Ontario Health Quality Council and believe that it could play an integral role in enhancing accessibility and accountability. However, we would suggest amending provisions in Bill 8 which at present narrowly limit its membership, function and reporting powers. Such amendments would strengthen the potential effectiveness of the council.

We believe that any initiative to enhance accessibility to publicly funded health care services must include a commitment to ensuring that there is a mechanism by which to prescribe and monitor wait times. As currently drafted, Bill 8 does not appear to address this very critical issue.

We are also concerned that section 9 may potentially prohibit payment of hospitals, laboratory physicians and other types of physicians to which hospitals make direct

payments for insured services, thereby inadvertently reducing access to health care services. Therefore, we recommend that this provision be deleted from the bill.

I would like to conclude by insisting that the West Nipissing General Hospital fundamentally endorses the intent of Bill 8 to enhance accessibility and promote accountability within the health care system. However, we take issue with the way in which these proposed changes would ultimately eliminate the collaboration developed between Ontario hospitals and the government over the past years and undermine the role of local voluntary governance of public hospitals. Therefore, we cannot support the bill as currently drafted, but look forward to seeing positive amendments to the bill once the public hearing concludes.

1110

The Chair: Thank you, Mr Brouillette. We're going to start the questions this time with Ms Martel. You've got six minutes.

M^me^ Martel: Merci, monsieur Brouillette et monsieur Campeau, d'être venus ce matin.

Je voudrais savoir, est-ce que vous avez une idée de pourquoi le gouvernement a changé son approche à propos des hôpitaux, à propos des conseils ? Vous avez attaché des lettres à propos du ministre qui disent qu'on va avoir de la coopération, qu'on va travailler avec les hôpitaux, qu'on va travailler avec les conseils. Mais en ce moment, nous avons un projet de loi qui est complètement contraire à propos de l'approche : on va imposer des contrats, etc. Est-ce que vous avez une idée de pourquoi il y a un tel changement d'attitude en ce moment à propos de la coopération, à propos de travailler avec vous-mêmes ?

M. Brouillette: De ma part, je crois que le gouvernement ne fait pas confiance aux gens qui sont en place. C'est une des raisons qu'ils l'ont introduit le bill. Ils veulent prendre plus de contrôle de ce qui se passe dans les hôpitaux.

M^me^ Martel: Vous avez un très bon résultat à propos du projet qui a été fait par—qu'est-ce que c'est, le nom ? The third party hospital review. Dans votre cas, il n'y a pas de problème chez vous dans l'hôpital.

M. Brouillette: Je crois qu'on a certainement réussi à démontrer qu'on faisait un bon travail chez nous, que le gouvernement n'a pas de raison de venir essayer de nous attacher les mains en arrière du dos. Si on a les mains attachées en arrière du dos, c'est difficile de faire notre travail. Comme on dit toujours en anglais, « It's a two-way street. » Il faut être capable de travailler ensemble librement.

M^me^ Martel: On doit avoir de la confiance.

M. Brouillette: C'est ça.

M^me^ Martel: Vous avez parlé d'un changement, d'amendement, et on apprécie beaucoup votre changement. Je voudrais parler un peu du conseil qui est dans le projet de loi. Moi, j'ai un problème avec le conseil parce qu'il apparaît que ce conseil est en place seulement pour « reporting » ou « monitoring ». Je voudrais avoir un conseil qui peut faire des recommandations au gouvernement si on a besoin de plus de fonds, par exemple, pour la santé publique, si on a besoin de plus de fonds pour le traitement du cancer, etc. Est-ce que vous voulez avoir un mandat plus grand qui peut dire au conseil, « Vous pouvez faire des recommandations aussi », non seulement faire de la surveillance, mais faire des recommandations à propos des projets de loi de la santé, à propos des fonds pour la santé? Est-ce que vous êtes en accord?

M. Brouillette: Du côté des fonds, si on regarde ce qui s'est passé chez nous dans les dernières 11 années, par exemple, on a eu une augmentation de « base funding » de 1,8 %, je crois, sur une période de 11 ans, qui n'est sûrement pas satisfaisante si on veut continuer à offrir les services qui sont en place présentement, si on ne veut pas mettre de côte certains programmes.

C'est rien de nouveau. Si on regarde ce qui est arrivé du côté des salaires, du côté du coût d'équipement, du côté du coût d'énergie, continuer à opérer un hôpital avec 1,8 % d'augmentation sur une période de 11 ans, ce n'est pas acceptable. On peut couper, couper, couper, mais quand on est rendu aux os, il ne reste plus rien. Il y a quand même des limites.

M^me^ Martel: M. Campeau?

M. Yves Campeau: Si je peux aider à répondre à la question aussi, il était clairement l'intention de notre conseil d'administration, oui, de vouloir dire que le conseil doit avoir le droit de faire des recommandations.

If it's only a reporting structure, unfortunately, I think it will not only be a waste of time, but it's going to be very difficult to find anybody with any kind of competence to want to spend time sitting on a committee if all it does is report without knowing what will ever happen to that.

Quand on parle de la constitution du comité, il est intéressant de noter que le gouvernement réserve une place sur ce comité pour un employé du ministère. Ce comité est prévu d'être de neuf à 12 membres. Si on veut avoir des gens qui ont des expertises dans tous les endroits, ça ne laisse pas beaucoup de places. Il est curieux qu'ils ont réservé une place pour un employé du ministère, mais qu'ils n'ont pas réservé des places pour une infirmière, pour un représentant de laboratoire. Why have they not reserved some places for health care practitioners, front-line workers who are on-site every day?

Ms Martel: It's a good question. Just a final point, because you referenced waiting lists: I raised the point with the minister yesterday that Cancer Care Ontario has said since 1999 that the optimal waiting time for cancer treatment is four weeks, and they've never been able to meet that. They report annually on the fact they are not meeting their waiting times for cancer treatment. I'm not interested in another body by another name that's just going to report on waiting times when there's no mechanism for the government to have to respond to that. I'd be much happier to see a conseil that will actually make recommendations to the government that say, "Here's what you need to do to get those waiting times reduced," whether it's for cancer, for a hip replacement,

cardiac surgery, whatever it is. There's nothing in the bill that allows that now. It's just a surveillance and monitoring and reporting body, which is going to be like every other body that monitors and reports and surveys.

Mr Campeau: The most difficult task before this government and any other government, before they even talk about introducing all kinds of reporting structures, is that they have to stand up and say, "We've analyzed the resources; we've analyzed the needs. This is what the province of Ontario is prepared to promise to its constituents in terms of wait times. It's appropriate to expect to be seen within X amount." Then we can have reports, and if the reports fall short of that, then there need to be recommendations on how to improve it. But unless you establish the benchmarks, what does reporting really bring to you?

The Chair: Thank you, Mr Campeau.

M^me^ Smith: Merci, monsieur Campeau et monsieur Brouillette. Je suis très contente que vous soyez venus aujourd'hui. J'espère que la route de Sturgeon a été bonne. Ce n'est pas toujours le cas au mois de février, alors j'apprécie bien votre voyage. Vous avez noté que le ton de ce projet de loi n'était pas à votre goût. Hier, le ministre lui-même a dit dans son discours que le ton n'était pas « appropriate » quand il a présenté le projet de loi à ce comité. Je vais juste vous lire un peu de son discours pour présenter son point de vue sur le ton.

"It's clear that we didn't get the tone of the bill right in some areas. For example, the penalty provisions are too harsh. I accept that. And I want to confirm that we have listened to concerns about the penalty provisions, and will be adjusting them." Il a adressé d'autres concerns aussi dans son discours que je vais vous présenter après.

I'd like to go through some of your presentation, and I'll speak in English if it's OK, because I speak better in English on these topics; pas assez de pratique. You discussed the third party hospital review panel. I noted with interest your concern about the review and the fact that you did receive funding but never got a copy of the review report, and you noted that $1 million was probably wasted on that exercise. One of the things we're concerned about is such exercises, and that's why we're trying to introduce more accountability into the system. As you know, my local hospital, North Bay General Hospital—and I know that you both probably deal with Mark regularly—had similar concerns where they had a review, they never got the report and they don't know what it said. They did get some money, but how are you supposed to learn from a third party review if you're not given the facts? I agree with you about that concern and I think you'll see, in future, that under this government there will not be that kind of exercise, where the results go nowhere.

With respect to the provisions in Bill 8 that you discuss in particular on page 2 of your proposal: You're concerned about accountability agreements being negotiated. Certainly we are committed to discussions and negotiations. We are committed to bringing forward a number of amendments, because it's been acknowledged there needs to be more process, more meat on the bones. I think you'll see that we're looking at more details surrounding the negotiations, and specifically on the point of when an entity would be directed to enter into an agreement. It would certainly be after a long process of negotiations. If it were felt that it couldn't be reached, we would look at directing one. Certainly there would be a long process before that was reached.

I certainly agree with you that the joint policy and planning committee is doing some good work on multi-year funding, and I don't think that the accountability provisions we're looking at will in any way jeopardize that. We hope they will work in tandem with that.

1120

Again, you talked about compliance directives, and I think you'll see in the amendments that are going to be brought forward that there will be notice provisions and there will be a process followed before a directive or an order is ever issued. I think the compliance directive portion will be kind of like when you negotiate a contract and someone is in default. There's always a notice provision to allow the other side to redress before you go to the next stage. I think that's the kind of thing we were looking at in these provisions to make sure that it is a negotiated agreement and that there is give and take and there is dialogue before any actions are taken.

Certainly the ministry and the minister himself have been working with OHA in looking at the specific issues you've raised, and also particularly with respect to the public interest question you've raised. We're looking at incorporating that concept into the legislation as well.

I was interested that you noted specifically about the council—I think one of my colleagues wants to discuss with you your views on the council, but you did mention wanting to know more about wait times. The minister actually used that in his presentation yesterday as his one example about what the council could report on. So, again, I'll give you a copy of that and perhaps that will address some of your concerns about the council and reporting on wait times and looking to improve on wait times.

I certainly appreciate the tone of your presentation today. We want to continue to work together. J'apprécie bien que vous soyez venus aujourd'hui. Je vais demander à ma collègue Ms Wynne, qui avait des commentaires et des questions sur le concept de conseils. Merci.

Ms Wynne: Thank you, but I'll be doing it in English; I apologize. My passive French is better than my active French.

I just wanted to clarify your concerns about the make-up of the council. In part I, section 2, the way the wording in the bill is currently, it's fairly open in terms of considerations about who would be on this council and I think that's intentional, so that the council would look different at different points in time. Can you just talk to us a little bit about what your specific concerns are or what your specific recommendation would be.

Mr Campeau: I mentioned earlier that I think it could be more specific, and in one part the minister or the

government has indicated that they do want an employee of the Ministry of Health to be on the council.

Ms Wynne: But not as a voting member?

Mr Campeau: That's fine, but why not allow others, such as front-line workers, to also sit as members? If they decide that it's the recommendation of government that they not vote, then we would address that. But why be specific on one side? It just appears that the bill is one-sided. So when it suits the government, they do reserve a spot but don't think of the others. When we talk about the accountability agreements, they're directed, they're not negotiated.

Ms Wynne: As I see it, the specific exclusion is, "A person who is a member of the board or a senior staff member of a health system organization may not be a member of the council." Are you concerned about that exclusion or do you want more specific language around inclusion?

Mr Campeau: Obviously there are board members in the province of Ontario who could bring in excess of 30 years of experience in health care that could be very useful to council, and just by sitting on a board you no longer qualify.

Ms Wynne: So in fact it's that section that is of most concern?

Mr Campeau: That's one section.

Ms Wynne: OK. I just wanted to clarify that.

Mr Campeau: Mr Chair, could I ask one question directed to the members of the Liberal Party?

The Chair: Why don't we hear from the member of the PC party and at the very end I'll allow you that option.

Mr Campeau: Sure. Thank you.

Mr Klees: Thank you very much for your presentation. Mr Campeau, to you, I heard the parliamentary assistant indicate that she was prepared to provide you with information relating to statements made by the minister. She also said that under her government there would be no withholding of important reports such as the one to which you referred. In the presence of the committee I'm going to ask the parliamentary assistant to undertake to make a phone call this morning to ensure that you receive that report, and I'm going to ask the parliamentary assistant to confirm for us that she will undertake to provide you with the third party review report. Mr Chair?

The Chair: Certainly you can ask. It's your six minutes. Whether you choose to answer, Ms Smith, is up to you.

Ms Smith: Unfortunately, Mr Klees is again undertaking gamesmanship. I wish that you would just stick to the presentations and allow these people to have their say. Your government didn't provide them with the report. I don't know where the reports are at. I will find out what the status of the report is, but I'm unable to undertake that we will provide it to him at this time. I don't know what the status of the reports is.

Mr Klees: With respect, you are the government now.

Ms Smith: With respect, Mr Klees, it was your government that didn't provide the reports in a timely fashion.

Interjection.

The Chair: Mr Klees—

Interjections.

The Chair: Quiet, everybody.

Interjection.

The Chair: Mr Wilson.

Interjection.

The Chair: Mr Klees, you've asked the question. Ms Smith, is that your answer? Are you finished?

Ms Smith: That's my answer.

The Chair: Thank you.

Mr Klees, you have the floor.

Mr Klees: Mr Campeau, it's unfortunate. We know that that report is now the property of the current government. I would fully expect that you would receive that report, because I agree that you should have that work that was in process—it cost a great deal of money to put it together. I will be very interested. I'll certainly follow it up to ensure that now this new government that has ownership of that report, which would be very helpful to you, would release it to you. I trust that there will not be any excuses along the way not to do so.

You indicated that you have been a board member voluntarily for 10 years. Can I ask you how you feel personally, as a volunteer, about the obviously changed attitude toward board members? Number one, you are not allowed to sit on this advisory council. I heard the parliamentary assistant say earlier to another delegate that as many voices as possible should be at the table so they can hear and get input, but yours is excluded. I would suggest that probably Mr Campeau would be excluded as well. How does that make you feel, as a volunteer, about the attitude of this government?

Mr Brouillette: First of all, we're called "governors." I feel that if we are limited to a certain point where we can't properly do our work, we are not governing any more. We have to have a certain amount of liberty to do what we are supposed to do as governors. If the government puts too many restrictions on us, we just can't do it. We can't do a proper job.

Mr Wilson: Do you think, sir, this will increase your liability as a board member? It's got to be an issue. I dare say some MPPs wouldn't put up with the liability exposure you currently have as a board member, because you're not very well protected under the Corporations Act or any of the old acts. This one actually imposes not only restrictions but more onerous things to follow—paperwork to fill out and more responsibilities in terms of a performance agreement of some sort that we don't even know what it's really going to look like. Are you worried about liability, and do you think your legal fees might go up as a result of this, certainly your liability insurance? Perhaps either gentleman could answer.

The Chair: And if it could be a brief answer.

Mr Campeau: Yes. In fact, we've had discussion at the last board meeting. Not only are board members

concerned about liability, but the first step is that board members are concerned about whether they are going to be staying on. Of course, yes, we haven't seen the accountability agreements, but if it's a non-negotiated one and it's one that's directed, before signing, board members will decide, "I can live with this or not, and if it's not, I'm gone." I don't think we'll have board members who are going to put themselves in the position of being liable for something that they can't produce.

The Chair: Thank you, Mr Wilson.

Mr Campeau: My one question?

The Chair: Yes, your one question. This is it. It's brief, isn't it?

Mr Campeau: Yes, it is brief. We've heard, actually from the parliamentary assistant—and again, I apologize for not hearing the minister's speech yesterday—that the minister indicated that it was absolutely not the intent of the bill to open up collective agreements. A two-part question: Was it then the intent of the bill to open up other employment contracts, including contracts with chiefs of staff, CEOs and other senior management people at the hospitals and, if so, with what regard to contract law would that be put in?

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Ms Smith: The provision that you're referring to is going to be clarified in the amendments and it does refer to only the CEO of the organization. The CEO would enter into a performance agreement with the board and, as part of that, there would be the provision that in extreme circumstances—and we will be defining that it is in extreme circumstances—there may be repercussions to their salary if accountability measures aren't met. That's the provision that we envision in order to enforce some accountability.

But before we leave your presentation, I just wanted to make sure there was a clarification. Sorry, Chair. On the council membership, we are precluding members of health system organizations from sitting on councils. That would be stakeholder groups—and this will be clarified in the amendments as well, because there has been some discussion around what a health system organization is—but it would not preclude a board member from a specific hospital, only a member of the OHA or the OMA or the large stakeholder groups, because they would come wearing that specific hat. But it would certainly allow a board member with expertise, who has had a lot of experience, to sit on that board. I just wanted to clarify that so you didn't go away with any misapprehension.

The Chair: Thank you for that clarification. Gentlemen, thank you for coming this morning.

SUDBURY AND DISTRICT CHIROPRACTIC SOCIETY

The Chair: We'll move on then to the Sudbury and District Chiropractic Society. We have two gentlemen with us: Dr Michel Brosseau and Dr Randy Koski. Or perhaps three. Did I miss another page? No. The agenda mentions two names and obviously there are three of you. Would the mystery person identify himself for Hansard?

Mr Fred Johnson: Yes, I'm Fred Johnson.

The Chair: Thank you. The rules are exactly the same. You've got 30 minutes to make your presentation and to use as you wish. The remaining time will be split amongst the three parties for questions. The floor is yours.

Dr Michel Brosseau: Good morning. My name is Dr Michel Brosseau. To my left is Dr Randy Koski, and you were just introduced to Mr Fred Johnson. I'm president of the Sudbury and District Chiropractic Society. Dr Koski here is vice-president. We're going to be going through, briefly, what chiropractors have as an education, our abilities, and some of the studies that have been made about chiropractic, and then Mr Johnson will be speaking as an individual who has benefited from chiropractic care as to the microcosm, let's say, of these macro-studies that Dr Koski is going to report on.

So without any further ado, I'll just pass the floor right over to Dr Koski.

Dr Randy Koski: Hopefully this will be a brief review for everyone. We've been around for over 100 years. We were founded in 1895. We have acts in all provinces and the Yukon Territory. We're the third-largest primary contact profession. What we offer is a non-invasive, preventive, holistic and drug-free approach to health now supported in the scientific literature, which we'll expand on in a second. Chiropractic traditional management of low-back pain has proven to be the most clinical and cost-effective.

Our education: we require a university bachelor's degree in approved sciences, which is then followed by four years of academic and clinical training at a chiropractic college. Our education is similar to that of an undergraduate medical training in quality and content. We focus on the neuromusculoskeletal system, using manual and drugless treatments, which is a big load on the current system. Our licence requirements include successful completion of provincial and national board exams.

Our scope of practice includes the diagnosis, treatment and prevention of disorders arising from the spine and other joints and their related tissues. We're regulated by the College of Chiropractors of Ontario, which functions the same as the College of Physicians and Surgeons of Ontario.

There have been six formal government studies confirming the clinical cost-effectiveness and safety of chiropractic, which in my mind are the top three when you look at any health intervention. They were done in Canada, USA, Britain, New Zealand, Australia and Sweden. I'm going to go over three of them.

The Meade study, which was done in 1990, was a randomized controlled trial within a real-life community setting, with several long-term follow-ups. The findings of it were that our management was more effective than hospital out-patient management, which includes a medical doctor and physiotherapist, and the results were main-

tained at follow-ups. They recommended enhanced public funding for chiropractic care to actually decrease the load and save a bunch of money, which I'll address in a second.

The second study that I'm going to go over is from the Agency for Health Care Policy and Research, the AHCPR guidelines, which are from the US, done in 1996. That entailed a literature search with 23 multi-discipline experts, and their findings were that early physical activity, NSAIDs and manipulation is supported in the scientific literature as the preferred approach for back pain.

The Mercer study in 1998 was a retrospective analysis of claims data from four of the largest Canadian disability insurers and three large national employers. Their findings were that the utilization of chiropractic care was shown to be associated with a decrease in other health benefit costs such as drug claims, short-term disability and long-term disability.

The final study that was done and commissioned by the Ministry of Health to review OHIP data for potential cost savings with chiropractic resulted in the Manga report. That came out in 1998. It was estimated that if $200 million was spent to remove financial access barriers, our utilization was expected to increase by 10% with associated decreased utilization of the free care. It was also estimated that four out of five people who consult a chiropractor have previously been in the free system an average of six months. The overall savings over two years was estimated to be $380 million to $770 million in direct costs. In other words, the money would be returned back to the system as a worse-case scenario, plus $1.25 billion to $3.77 billion in indirect costs. When we listened to Pran Manga report this, he had said that there was no response to the study. That's confusing to me. I'm not sure where the results ended up.

What I'd like to do is turn this over to Dr Brosseau, who's going to put a local spin on these reports and apply it to the bill.

Dr Brosseau: There are 30,000 people in Sudbury without a family physician. It is our contention that, with appropriate use of chiropractic care as part of the health care system supporting the local physicians and local hospitals, we can reduce that number by 5,000 to 10,000 people without incurring any extra costs.

I'm going to pass the floor over to Mr Johnson so that you can see that when Professor Manga made the report about indirect cost-savings—Mr Johnson will be addressing his personal situation. Essentially, what we're looking at here is one case in one office. These are the kinds of situations that go on all the time in chiropractor's offices across Ontario. Take it away, Mr Johnson.

Mr Johnson: I'd like to thank everyone for giving me this opportunity to speak today. I found myself in a position over a three-year period where my health continuously deteriorated. I started out with an unlimited capacity to work. In 1999, I had seven employees and owned and ran four businesses. Then it all came crashing down.

Over the course of two years, 2000 to 2002, I was forced to close my businesses, and my wife and I sold our house at a loss to move to Sudbury to be closer to a hospital. I had tests, specialists, medications and surgeries. I regularly blacked out, fell down and was unable to pick up my two-year-old son. This is one of these things you can't believe happens to people until it happens to you.

I was caught up in a regular medical system with specialists. In one instance, I'd lost 40 pounds in one month, and the specialist's answer was to keep taking the medication and come back in four months. The math there doesn't look very good for me. He told me very clearly there was no known cause for my illness and there was no known cure. The best they could do was manage my condition.

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My family doctor filled out the forms that classified me as having a long-term disability and told me, "You know what? There are some things worse than death, and you've got it." But I'm quite thankful. I had a personality that would not accept this new life of suffering. I had saved sufficient financial resources to look for solutions, and I started by going to a naturopathic doctor. He put me on a strict diet and prescribed homeopathic medication. In 12 days my situation stabilized.

I was later referred to Dr Mike here by two nurse practitioners. They told me he had great success treating people like myself who had slipped through the medical system.

I've spent the last unemployed 18 months just trying to get healthy again, eating right, sleeping a lot, going to the gym every day and seeing Dr Mike, who is far more than a regular chiropractor. I spent about $3,000 in the past year: $2,000 on medication and about $1,000 in visits to his service. The truth is, it was a bargain. I started waking up in the morning not being sick and without pain. I can go up the stairs without needing a rest. I can play with my kids. I've gotten about 80% of my life back. As I said earlier, I'm quite thankful.

I had a personality that would not accept the life I was handed and I had the money required to do something about it. In the last several years, I've met a lot of people who are sick and who simply can't afford to access the alternative medical system. The truth is, we really do have a two-tiered medical system. I also feel that if I'd had a better understanding of my illness 20 years ago and treatment options, I could have accessed our country's non-drug, private, two-tiered medical system when the symptoms first appeared. I could have avoided years of being sick and the cost to the medical system of repeated hospitalizations and surgery, and I could have been working and paying taxes all that time.

Once again, I'd like to thank you for listening to my story. Please remember, there are a lot of people out there who don't fit into our standard medical system. They fall through the cracks. They're probably not here today to speak for themselves.

Dr Brosseau: There are two points I would like to address here, and recommendations or requests—I'm not

quite sure of the correct terminology. One of them has to do with section 10. Apparently, the Ontario Chiropractic Association is not included as one of the stakeholder organizations to deal with OHIP negotiations. So I would strongly request or urge or ask that you have that happen, given the fact that we are 2,500 strong. We do a lot of work that is very effective and cost-effective for the province, so don't forget about us.

The other point is the Ontario Health Quality Council. One of the things I would like to point out is that over the last few years, Canadians have literally voted with their feet when it comes to health care. They've dished out billions of dollars on "alternative health care," as you see here in this one example. So one of the things I would strongly recommend is that on that council you have a voice or a number of voices that speak for people who are looking for natural therapies. It's not to say that we don't need the hospitals or we don't need the medical doctors we have now. Of course they're very, very necessary. But the thing is, let's not forget that there are people out there who are voting with their feet, taking charge of their own health care, seeking practitioners who are familiar, at least, with some of the alternative health care techniques—homeopaths, naturopaths, chiropractors etc.

The Chair: Very good. Thank you for your presentation. You only used up about 10 or 11 minutes, which leaves each party with six minutes to ask you some questions. We'll start with Ms Wynne.

Ms Wynne: I just want you to know that I'm only here today because I was able to go to my chiropractor before I came.

Your concerns, then, are on section 10. I just want to clarify with you that the wording that is in this bill is exactly the same as the wording in the Health Care Accessibility Act. In other words, the minister doesn't need legislative authority to enter into these kinds of agreements with other organizations. It's very possible that there are other organizations that should be listed here, but the way the wording is in the bill, the minister is able to enter into those agreements. Can you just talk about why that's problematic, and do you understand why it's been written this way? It's open, as opposed to being exclusive, right?

Dr Brosseau: As a front-line practitioner, I'm not familiar with the mechanisms of the architects of our society. So the thing is, it's a matter of when I saw that only the Ontario Medical Association, the Ontario Dental Association and the Ontario Association of Optometrists were allowed, let's say, to have negotiations with our health plan, I was going, "Oh, what's this? Are we being excluded?"

Ms Wynne: I don't know if you have a copy of the bill, but I got a call from the chiropractic association in Toronto long before we came on the hearings, and I asked this question. If you look at subsection (3), "The Lieutenant Governor in Council may make a regulation providing that the minister may enter into an agreement under subsection (1) with a specified person or organization other than an association mentioned in subsection (2)." So in fact you're covered there.

Dr Brosseau: Wonderful.

Ms Wynne: I just wanted to reassure you of that.

Do I have more time, or is that it?

The Chair: Yes, you do.

Ms Wynne: The other point I wanted to make and just ask you about was, you were worried about the representation on the council. Similarly, the language has been left open enough that in fact there can be representation from a whole bunch of different groups.

I think the issue is, to list every single person or every single organization that might be represented was seen as a problem. So the language has been left open enough that it would represent the diversity that's in the community. There are only a couple of specific exclusions, but chiropractic is not one of them.

Dr Brosseau: When the HPLR was entered into law 15 years ago, or whenever it was, I believe the College of Physicians and Surgeons put in a quality assurance program to try to keep health care quality up. The problem with that is that essentially what happened was that Dr Jozef Krop, an excellent physician who uses alternative methods, unfortunately, according to their standards, wasn't living up to their standards. In truth, he was actually exceeding the standards, but there ensued a 10-year witch hunt of a well-meaning physician.

I just wanted to make sure that those of us who are doing everything we can for patients don't get caught up in some kind of legalistic jargon that doesn't allow us to do the best that we can for the people we're working with.

Ms Wynne: The intention of this bill is to promote wellness, to set standards that are going to allow us to measure how well we're doing in terms of those wellness—and I think that discussion about allopathic versus alternative medicine is going to go on for a long time. Thank you for your points.

The Chair: Are there any other questions? There are about two minutes remaining. If not, I'll go to the PCs.

Mr Wilson: Thank you very much for your presentation. Thank you, Mr Johnson, for your personal story.

Correct me if I'm wrong, and I often am, but I think the short title of this bill is the "future of health care" act. You're not in it, nor will your patients' statistics or Mr Johnson's recovery be caught in it.

Roughly how many people, first of all, visit chiropractors in Ontario, or even in this region, on an annual basis, would you say?

Second, shouldn't we be massively worried that your profession isn't part of the future of health care in this province, by law anyway?

Dr Brosseau: This is what the thing is. I'm a little at a loss here, because they're saying that we are and you're saying we're not.

Mr Wilson: Clearly, the government, as you correctly pointed out, delineated in the act three professions that are in. Then there is the catch-all phrase that says he can also go—

Interjection.

Mr Wilson: But there are 22. I am the minister, along with Shelley Martel and Frances Lankin, who brought in the Regulated Health Professions Act, which incorporated and gave self-governance to the 22 regulated health professions in the province.

You've left out 18 regulated health professions, so why wouldn't you at least put a clause in saying that this also applies to members of the 22 regulated health professions, which are nurses, nurse practitioners—all you've mentioned are physicians, dentists and, what was the other one?

Dr Brosseau: Optometrists.

Mr Wilson: And optometrists. You've left out every other regulated health profession. So I hope—and I will bring a motion forward in that regard—that there will be some reference to all of the other health care professionals in this province.

I'll give you a chance to comment for the record because, as the government says, we're here collecting evidence, and they'll go back and think about these comments. Do you have anything on that?

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Dr Brosseau: In a nutshell, what I would ask is, whatever bills or regulations are voted on or passed through the House, allow us to do the work we're doing. Personally, I get a tremendous amount of satisfaction from seeing a person in a really bad state, and then a few months later, they're working part-time, and sometime after that, they're back to living a full life.

I realize that basically some of the negotiations here will probably affect me for the next 20 years of my career. The thing is, it's a matter that, yes, I'd like to see some consideration given to the fact that, as chiropractors, we're out here and we can not only enhance people's lives and quality of life tremendously, but also save the government of the day, whatever it happens to be, literally millions and millions of health care dollars in ancillary care, as in disability pensions etc.

It's a matter of: You guys are the architects; I'm just a front-line guy. Put the words in and allow us to do our work.

Mr Wilson: Governments have struggled with chiropractic fees. I think we pay 30% or so of the visit to, what, a $75-dollar limit?

Dr Brosseau: It used to be $220 maximum in a year. Then Professor Manga made the report to the government of the day. After he proved to the government that we could save them millions of dollars, the $220 maximum was reduced to $150.

Mr Wilson: Well, you probably didn't vote for us.

Dr Brosseau: At the time, everybody in the province was taking a hit. We did too, and that's fine.

Mr Wilson: I think governments have been slow to recognize the value of chiropractic services, and the association has consistently tried to correct all of us on that. Secondly, I think only three provinces even partially covered the fees at that time.

Do you want to comment on that? This says that from now on the government is only going to talk about people who are currently covered or rendering fully insured services. So it actually, in my opinion, closes the door to chiropractic services. It says unless you're caught up in this bill—because this is their future vision for health care—you might as well not even have any more chats about a partial fee, let alone reinstating the over $200.

Dr Brosseau: One of the greatest frustrations we all face, as practising chiropractors, is the barrier to access due to fees. We see people on a regular basis who could return to work, who could pick up their grandchild, who could go on with their lives, but for fate or because of their situation, they cannot access the services we can provide.

Again, I don't have the position you have, of being able to see the whole health care system. What we did today was present to you what we have as far as training is concerned, what the research has shown us and real people who come to our offices. It's up to you to look at the whole system and provide a fair and equitable future for all Ontarians. How you do that—well, that's your job.

Mr Wilson: I appreciate it. We do thank you for coming. Thank you, in particular, Mr Johnson, for giving us a real-life example of what you've been through, and the best of luck to you.

The Chair: Ms Martel.

Ms Martel: Thank you to the three of you for coming this morning.

Let me go back to section 10. It is true that much of part II of the bill, which is called Health Services Accessibility, incorporates a particular bill previously passed, which is called the Health Care Accessibility Act. It is true that the language that currently appears in Bill 8, with respect to section 10, is the same as what occurs in the Health Care Accessibility Act.

Having said that, if I look through the rest of part II, there were significant other sections added that are new and that don't appear in the former Health Care Accessibility Act. So you raise a legitimate concern about looking at section 10 and saying to yourself, "I'm excluded," just as dental hygienists would look at that and say, "I'm excluded," and the balance of regulated health professions that are not included.

It seems to me that we need to come forward with an amendment to that section that either does not specifically reference any association and leaves it all to regulation, and so allows the minister to enter negotiations with groups, or we list all the regulated health professions so there will be no misunderstanding about who is included and who is excluded. So I think there is a way to deal with that.

I don't pretend to know why in the former bill, the Health Care Accessibility Act, only three groups were listed. I have no idea. Perhaps I should, but I don't; there might be a legitimate reason. But it seems to me that to deal with your concerns and others from regulated health professions, we need to make some amendments in that section. Then it would be very clear that the minister can do these things and you can feel assured that you are going to play a legitimate role in the health care system. So we give you that undertaking.

I appreciate the concern you raise with respect to the council, in terms of the council having a representative who would speak from the perspective of alternative therapies and alternative medicine. I think you raise a good point with us this morning that that is something we should be looking at.

I have some additional concerns about the council in terms of what its mandate really is. I don't feel very happy that if it's just a group that is going to make a report to the minister, that's going to get us very far down the road in terms of either ensuring that Ontario's health care system is actually living up to the principles under the Canada Health Act or, secondly, that there is going to be any movement whatsoever on incorporating alternative therapies and medicine into Ontario's health care system.

I would much prefer to see a council that has a much broader mandate, that can actually make recommendations to the minister about changes to the health care system—legislation, policy, funding—versus just essentially reporting on health outcomes. I think there are lots of groups that can do that now. We don't need much more of that. We need to move from the outcomes to actually implementing recommendations for change. I don't know if you've had a really good look at that section and want to comment or if you feel the comments you made suffice.

Dr Brosseau: What you were saying about either list us all or don't list any seems simple to me. Then, I would add, there would be no confusion, there would be no consternation and we could move forward.

The Chair: Thank you for coming, doctors, and thank you, Mr Johnson, for your personal story.

ONTARIO COUNCIL OF HOSPITAL UNIONS, SUDBURY

The Chair: We'll go on now to the Ontario Council of Hospital Unions, Sudbury. Michael Hurley, the president, is here. You've got 30 minutes. You were here; I think you know the rules.

Mr Michael Hurley: Thank you very much for allowing me to make a presentation this morning, and thank you to the committee for traveling. It's very much appreciated that you're going throughout Ontario to have hearings.

The Ontario Council of Hospital Unions represents 27,000 members working in public hospitals in Ontario: registered practical nurses, cleaners, dietary staff, laundry staff, maintenance staff, paramedics and technologists. We represent a fairly wide range of hospital workers and clerical staff, and we've very proud of the work we do.

Last year through the SARS epidemic, we coped, with others, in the hospital system. Some of our members are still not back at work. We still have four members who have never been able to return to work. One woman brought SARS home to her twin boys, who thankfully have recovered. That kind of illness is a fact of life for people who work in institutions like hospitals.

Our average wage is $17 an hour.

We've lived through the hospital restructuring commission—they've certainly lived through it here in Sudbury—hospital closures, transfers of programs, huge layoffs of staff, and through that entire period we've struggled collectively to try to keep Ontario's hospital system working.

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It disturbs us greatly that it appears the new government is embarking on its own reform revolution within the Ontario hospital system, driven primarily, we fear, by fiscal considerations. During the SARS epidemic, we had to close two hospitals in Ontario and the Minister of Health had to admit that the system was at the point of collapse and had no excess capacity to cope. That certainly was true of the workforce. The thought that the Minister of Health would now accrue to himself power to order institutions to transfer programs or reduce services, and would be able to reduce their funding to accomplish that, is a huge worry for us.

Frankly, we perceive Bill 8 to be an attack. I know that's a shared perception, not only among the workers in the hospital system but among its managers as well. You heard some of that this morning from the delegation from Sturgeon Falls.

The accountability provisions, which are defined as setting out performance goals and objectives, are, we fear, lifted straight from British Columbia's example of performance agreements, where hospital CEOs are rewarded with bonuses—or penalized with penalties—if they meet performance targets of staff and budget reductions set for them by the Ministry of Health. The fact that the Ministry of Health has been importing senior bureaucrats from British Columbia who may have been involved in drafting this legislation may be coincidental, but this worries us.

In British Columbia, for example, as I'm sure you know, hospital CEOs are told they have to reduce their administrative support budgets by 7%. That's their annual target. I don't know how we'll be able to cope with those kinds of staff reductions in hospitals. The SARS virus lived for a month in the North York General Hospital because the hospital wasn't cleaned properly. There aren't enough cleaners in Ontario's hospitals. That's the sad truth.

It may seem fairly easy and fiscally prudent to set a target of a 7% reduction, as they do in BC. But the outcome will be that a system that is already struggling to cope to serve the people of Ontario will not be able to with its current workforce, unless of course you reduce the compensation of that workforce, bring in private contractors, bring in people who will do the work for less money, which is the other companion piece to this that had to be introduced in BC to make the performance agreements effective; that is, legislation that allowed current collective agreements to be swept away and people to be brought in to do work. In the case of British Columbia, wages fell from $18.50 an hour to $9 an hour, pensions were eliminated and so were benefits. This is a

big concern to us, because the 3% wage increase our members got last September and the 3% they got before that—in fact, the 1.5% real growth in their wages over the last 25 years—is not actually the reason that health care spending is spiralling out of control.

I would pin the reasons on a few culprits, but one would be the escalating cost of drugs. There is nothing in this legislation that deals with that fact. There are huge annual increments in the cost of drugs, which are fuelling hospital budget costs. The fee-for-service system for doctors is hugely inefficient as a form of compensation and, because it pays for piecework, drives up the cost of health care.

Last, the third macro-driver that we would point to that's driving up health care spending is the proliferation of private delivery in the system. In this area, we're deeply concerned. We were very optimistic to hear during the campaign that the 21 private MRI-CAT scan clinics would be brought back into the public system and that P3—public-private partnership—hospitals would not be on the agenda for the new government. So we are very disappointed that those private clinics exist outside the system and there hasn't been any mention of them in the throne speech or subsequently from the government, that I'm aware of, and that around the P3 hospitals, not only have they not been stopped but in fact two have been approved: William Osler in Brampton and the Royal Ottawa Hospital in Ottawa.

When we met with the Ontario Hospital Association in November, they told us that there are another six in the works, including Uxbridge-Markham-Stouffville, the Salvation Army Grace in Toronto, St Joseph's in Hamilton, Grimsby, the Centre for Addiction and Mental Health in Toronto, and Runnymede. The OHA also told us that us that they've been meeting with the capital working group of the Ministry of Health, headed up by Michael Decter, now the head of the Canada Health Council, and that they had a meeting of the minds that the $8.9 billion that the hospitals require to refurbish themselves, to rebuild aging infrastructure—the OHA and the Ministry of Health have agreed that the hospitals should have unfettered access to private capital in order to be able to undertake that rebuilding.

I know there's this technical dispute going on between whether a lease or a mortgage is a preferable form of a private-public partnership hospital. From our point of view, at the end of the day, it's the bank that owns your home. If you miss payments, they actually do take it back. It has happened to some of our members. The same is true of the hospitals. So we believe these hospitals that have been approved, green-lighted, are in fact P3 hospitals.

We believe that Bill 8 is necessary to provide some degree of accountability to what will be a proliferation of private providers throughout the health care system in the hospitals and in the private clinics, that there will have to be accountability agreements. This is one of the glaring weaknesses in terms of the government's approval of the P3s, that in fact there has to be a method to make private sector interests meet the government's expectations. There has to be a legal mechanism to require them to do that.

I'd like to talk about the P3 hospitals for a minute because in terms of accessibility, they make a mockery of accessibility. We commissioned a study by Arthur Donner, Doug Peters and Lewis Auerbach. These guys weren't union stooges or anything. One was the director of audit operations formerly for the Auditor General of Canada; one worked for Paul Martin as his under-secretary of finance; one was the TD Bank's senior economist. They calculated in a report they did, which we provided to the Minister of Health, that the borrowing costs for the P3 projects would be 14% higher than if the projects were financed by traditional borrowing. That's over the life of the contract.

We know from Britain, from the British Medical Association Journal, from the first 18 P3 hospitals that were built and studied by health economists there, that in addition to the higher borrowing costs, there were profit costs that averaged between 15% to 25% a year that had to be stacked on to the higher borrowing costs. They found that that came at the expense of access, that there would be typically 30% fewer beds and 25% fewer staff. There would be, for example, 14% fewer nurses, 38% fewer support staff.

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In terms of the accessibility-to-medicare act, if it's true, as the Ontario Hospital Association says, that we're poised to see not just two P3s but another six and then everything, then we can expect the downsizing across the hospital system of about a third of its beds. In fact, Britain has seen a radical downsizing, the largest in its history, as a result of going with the P3 schemes. We'll also see across the system 14% fewer nurses, we'll see fewer doctors and, our particular concern, 39% fewer support staff so that companies like Carillion, Amex Bank and EllisDon can have profits which are, in current terms, huge, and for 30-year contracts—or, in the case of the Royal Ottawa, a 66-year contract.

In terms of access to health care, the P3 question is a pivotal one, and unfortunately this bill is a bit of a Trojan horse. It purports to provide people with access to the health care system. It purports to impose accountability agreements on CEOs and to make them accountable, but in fact we're poised to deliver the heart of the health care system that is protected by the Canada Health Act, which is basically doctors and hospitals. That's all we've got that's covered by the Canada Health Act. The hospitals are moving over to private delivery. There will be reduced bed stock, reduced staffing levels and there will be reduced access. We will have less access to health care. That is a fundamental problem that we're going to be facing. Unless the government deals with that broader question then this is Orwellian but it's also highly cynical, because it purports to provide to people some legislated guarantee, and it's only actually necessary because their legitimate and current right to access the system is evaporating because of government policy as we speak. There are some fundamental problems around this.

In British Columbia, where the performance agreements are modelled on, the attack is on the support staff. People have decided they can reduce hospital budgets if they can pay people half of what they're paying them now—the clerical staff and the cleaners and the people who make the food—and if they can roll back the nurses' salaries they can effect savings while sending huge, unprecedented, unbelievable sums of money in profits to corporations, many of them foreign corporations, which have come to feed on the health care system which is our pride in Canada.

When we reviewed Bill 8 and had a lawyer review it, we were disturbed to see that the accountability agreements appear to be lifted from British Columbia in terms of a way for government to coerce managers to wring savings from the system, again while ignoring the macro-drivers, the drug companies and the private delivery, which are actually the culprits in the escalating costs here.

In terms of the matters to be considered, like value for money and fiscal responsibility, if nurses were to consider value for money, they'd be working in Texas, not in Ontario. It disturbs me to read in Minister Smitherman's comments yesterday that he favours a consumer-centred health care system. Consumer, purchaser, buyer of services: That isn't the health care system that I've grown up in where, as a fundamental right of citizenship, I have access, irrespective of my ability to buy services, to doctors and hospitals.

The criteria, including, of course, number 12, "any prescribed manner," which is consistent through the legislation—so much of this accountability section is left to subsequent cabinet regulation to define, and it freaks us right out. It worries us greatly, because this is such a central part of the Ontario public sector. The ability of the minister to issue directives compelling people to act; the ability to vary those directives at any time; the ability to deem people to be in compliance with those directives, to break employment contracts, to reduce wages or benefits, to make people comply and define them, all supposedly in pursuit of accessibility—these provisions have us mystified.

We've been reassured that it's not the intent of the government to attack collective agreements. In communication we had from the minister's staff to CUPE, there was a reference to current collective agreements. The minister made that reference in his scrum yesterday. I just point out to you that we have centralized bargaining in our sector, where nurses have a collective agreement and technologists do and support staff do—master agreements—so we don't spend a lot of taxpayers' money in futile replications of the same pattern. But all those agreements are up this year: ONA's and OPSEU's for nurses and technologists expire March 31; support staff agreements start expiring September 28; then October 4, they're all open. So when people talk about, "Don't worry; your current collective agreements are protected," that's not very reassuring to us; not at all.

We would ask you to reconsider the accountability provisions. Joanne Arnold from the Sudbury Regional Hospital proposed amendments around the collective agreement concerns, and we'd certainly like you to take a look at those. But frankly, the accountability provisions are hugely flawed, and there's no way that any genuine reform of the health care system in Ontario can be accomplished overnight in a hastily written bill and then cobbled together with amendments that satisfy different constituencies when what's really required is an honest and democratic discussion about the health care system and its needs and the problems that are facing us, and some legislation that follows from that kind of process that perhaps, ideally, we could all endorse. So I really appreciate your giving us the opportunity to make a presentation to you this morning.

The Chair: That's wonderful, Mr Hurley. Thank you.

We've got about 12 minutes left, four minutes for each party, starting with the PCs.

Mr Klees: Thank you, Mr Hurley, for your presentation. You made reference to the amendments that were proposed by Ms Arnold. I don't know if you were here before, but we moved a motion here to in fact adopt those. You saw the members of the government vote against those. Does it concern you that there is an outright rejection on the part of the government members of this committee of those amendments?

Mr Hurley: It worries us, Mr Klees, because we were quite believing of the commitments that were made around the P3 hospitals, and now we have a profound difference of opinion with the government about whether we have P3s or not. We think we do; they say they don't.

These are not trivial matters for members and their families. They go to the ability of people to live and feed their kids and send them to college and stuff. So it isn't enough for us to hear reassurances and it certainly was disturbing. I'm just hoping that, in the processes that you have, we will see amendments. We won't actually be reassured until we actually see amendments for sure.

Mr Klees: Given the fundamental flaws of this legislation, it's interesting—whether it be the employee sector, whether it be the professionals, whether it be chairs of boards, there hasn't been a stakeholder who has come forward who has applauded this bill. It is so fundamentally flawed even the minister was embarrassed. I don't know how a minister could allow this legislation to get this far and then have to appear before a public committee to say, "I'm embarrassed at what I'm bringing forward," unless the minister didn't read the bill before he came to committee. But given its fundamental flaw, would you agree that it's probably in the public interest for this bill to be withdrawn and that truly we look at the principles you've outlined—in fact, the principles in the preamble are not bad—and go back, and start from day one here to build something, as you say, in a conciliatory way that actually gets us closer to where we need to be?

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Mr Hurley: It would certainly be our preference, Mr Klees, that the legislation be redrawn and there be a genuine process that was consultative and democratic

that could allow people to talk about some of the challenges the bill purports to attempt to address.

The Chair: Thank you, Mr Klees.

Ms Martel: Thanks, Michael, for being in Sudbury today. I want to focus on the privatization. You had a meeting, I gather, with the minister on January 13, yourself and Sid Ryan. Can you tell the committee what Mr Smitherman had to say about P3 hospitals?

Mr Hurley: We had a disagreement about whether or not there were P3 hospitals, but he did say that there were another six hospitals that had requested the opportunity to explore access to private capital. He disputed the comment that had been made by the president of the Ontario Public Services Employees Union at the Centre for Addiction and Mental Health who had said she had been told by her CEO that he had been told by the minister that they had been green-lighted for a P3. He disputed that, but he did say that these were in the works. They wouldn't look like Brampton and Ottawa, but no decisions had been made at this time on those six. Subsequently the Star said there were seven.

Ms Martel: Did he say anything about the private MRI and CAT scan clinics?

Mr Hurley: No.

Ms Martel: So we have before us a bill that in the preamble purports to recognize medicare and purports to affirm our commitment to universality, portability, accessibility, comprehensiveness etc, except the bill says nothing about stopping further privatization of health care services. So the bill says nothing about stopping the two P3 hospitals in Brampton and Ottawa, which will use public money that should go to patients and instead line the pockets of the private consortiums that are going to build the hospitals, not to mention the six others that are coming. It says nothing about cancelling the private MRIs and CAT scans, which of course the government promised to do before they were elected. Noting that, what do you think about a preamble that talks in glowing terms about medicare in a bill that does nothing to stop the privatization that the Conservatives started and the Liberals are now embracing and moving forward on?

Mr Hurley: I regret having to say this, but I'm afraid it's a bit of doublespeak, actually. It's a bit of a smokescreen. People are being reassured, and certainly all the hoopla was around Mrs Smith in rural Ontario, who would have access to these services and wouldn't be queue-jumped by a Toronto Maple Leaf player or something. That all sounded very positive, but pursuing the policy of privatization simultaneously with purporting to provide accessibility is completely inconsistent. The privatization policy will dramatically undermine accessibility, and it will mean that Mrs Smith, at the end of the day, will be queue-jumped, no question about it.

Ms Martel: If you thought the government was serious about protecting medicare and protecting publicly funded, publicly administered, publicly delivered health care services, what would you see in this bill with respect to trying to implement that? I'm thinking specifically about the current services that are privatized, that the government now seems not intent on reversing.

Mr Hurley: The government would be taking measures in the legislation to reacquire into the public delivery system those private clinics and those private hospitals. This is a fundamental question of health policy. If you think health care spending is unsustainable now and if you think the system is strained now, then adding another 30% in terms of costs can only make the system more expensive and diminish accessibility. It's a fundamental question facing the health care system that can't really be ignored. It should be, you would think, addressed in this kind of legislation.

Ms Smith: Thank you, Mr Hurley, for coming and sharing your views with us. I think you and I will probably agree to disagree on a couple of things, as you have with the minister. I would point out that the government has ensured that the two hospitals you addressed continue to have ownership and control of the facilities and the health care services are delivered publicly and the taxpayer investment is sound.

With respect to the six others that you mentioned, that you kind of suggested were heading toward privatization, I just want it to be clear that no decision has been made with respect to any other arrangements with respect to other hospitals. The ministry is working in concert with the Ministry of Public Infrastructure and Renewal on a health infrastructure financing and procurement framework to be applied to emerging hospital projects, and the framework will be based on the key principles of public ownership, public accountability and public control. I think you're aware of that, and I do believe you've misled somewhat by indicating that there has been a deluge of private hospitals developing around the province.

That being said, I would like to just speak to you for a moment about your concerns with respect to Bill 8 and the linkages that you've drawn to BC legislation. Actually, before we move to that, I would just like to point out in response to something my colleague Mr Klees said when he was in the room, that this legislation has been brought forward precipitously, that I think it's a statement about this government that we've brought forward this legislation for public consultation after first reading. I think it's important that we get public consultation and input into making this bill the best bill possible in order to protect medicare. So I appreciate that people like you are coming out and giving us some constructive criticism and some concerns, but I do want it acknowledged that it was brought forward after first reading, which is early in the process, and I think we all agree that some improvements can be made, and certainly the minister made that point yesterday.

With respect to the BC legislation, I would ask you to just point out for me exactly where you see the similarities lie between the BC legislation, which we have had the privilege of taking a look at, and this legislation, because I see nowhere in this legislation where we address collective agreements or that collective agreements are going to be opened up or that there will be the ability of boards of hospitals to do such a thing.

Mr Hurley: You shouldn't confuse our concerns around Bill 8 with our criticisms of BC's Bill 29, which was legislation aimed directly at health and education sector collective agreements. But Bill 8 does allow the cabinet to define those people who will subsequently be the target of ministerial orders that could have the effect of breaking their employment contract or downgrading their wages and benefits. That's clear. We have a legal opinion which we'd be happy to share with you around that.

Also, Bill 8, in defining health service providers or entities, leaves room for trade unions to be captured by the definition of "entity." So these compliance directives—the similarity with BC is around your accountability agreements, which are modeled on the performance agreements in British Columbia and which target savings in support and administration sectors and reward or penalize CEOs based on their ability to reduce their budgets in those areas. That is alarming because hospitals are already short staffed.

Ms Smith: I would just question how you come to the conclusion that our accountability agreements are modeled after the BC performance agreements. Where are you drawing that from? I would also question, just as a second part, when you talk about fiscal responsibility and value for money. There are 12 issues, as you noted, related to accountability agreements. I think you would agree with me that shared and collective responsibility is one that we'd like to see in accountability in our health care system, that transparency is something we'd like to see. Would you agree with me that transparency is something you'd like to see?

Mr Hurley: I'd like to see the government be accountable to the people of Ontario for its health policy. I think that in terms of this legislation, unfortunately the government is introducing policies which are going to dramatically undermine accessibility. In this legislation, you're shifting all of the burden to the people who work in institutions, in terms of their accountability to you. There is none flowing the other way. That's the debate I'm trying to engage you in.

With respect to credibility, we can split hairs with an axe over the question of the P3 hospitals. We thought we had a clear commitment around the P3 hospitals; now we don't. So I think you can understand, then, that when you tell us that we have nothing to fear in this legislation, you have a credibility deficit with us that can only be addressed by seeing some significant amendments.

Ms Smith: I think we have indicated that there will be amendments brought forward, specifically with respect to collective agreements and the effect of this legislation on unions. That has been stated over and over. You've seen the statement by the minister. I understand you want to see the writing, and you will in time see the writing. If I could just—am I out? I'm done?

The Chair: You're actually over. I thought that was a great summary by you both. Thank you very much, Mr Hurley.

We stand recessed until 1:30.

The committee recessed from 1233 to 1335.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 139

The Chair: We're going to call back to order again. Our next delegation is from Mr Bill Kotsopoulos, the president of the Canadian Union of Public Employees, Local 139, Sudbury.

Mr Kotsopoulos, would you come forward. Please have a seat wherever you feel most comfortable. You have 30 minutes to make your presentation. You can use that any way you choose. At the end of your presentation we'll split the remaining time among the three parties. This time around the questioning will start with Ms Martel. The floor is yours.

Mr Bill Kotsopoulos: Thank you for the opportunity to speak here this afternoon. I am the president of CUPE local 139. We serve approximately 530 members in our union, both service and clerical. We all work at the North Bay General Hospital in North Bay. You'll have to excuse us for our tardiness this afternoon. About 14 of us drove up from North Bay and we got lost in Sudbury, so thank you for your patience.

The question I'd like to have you consider is, why are hospital workers up in arms about Bill 8? A usually mild-mannered group, very kind and generous, always giving in the hospital setting, this group of people has become very concerned with Bill 8. I'm sure you've had very many other speakers this afternoon talk about different aspects and parts of the bill. The one that concerns CUPE local 139 in North Bay is the collective agreement and what possibilities the government may have in dismantling our collective agreements. This is the main point I would like to stress this afternoon.

I'm sure you've had other speakers talk on many different topics, but our collective agreement is between our employer and the members. We have a unique situation where our employer has work for us and we promise we will do that work for a set wage. When that agreement between the employer and the employees is threatened in any way, it creates a certain amount of stress for our employees. To have our wages possibly tampered with, and our benefits as well—these are the things that are crucial to every single employee and the jobs we do in the hospital. Everybody needs to earn a fair wage. With our wages we look after our families, we look after the food, water, clothing and shelter that we all need to survive in this country. And if anything does happen to us at work, we also need our benefits, our dental plans, to be protected. With the interpretations of Bill 8 that we have before us, as far as a CUPE local, we find that our collective agreements might be in jeopardy.

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With the stress that has gone around our hospital in the last couple of weeks, I don't find that our employees are able to focus on their jobs. They're thinking so much about the possibilities of having our wages rolled back and our benefits decreased. This, I find, to be very pertinent, because it will reflect totally on our patient care. When we go to the hospital, our minds should be focused

on our patients. Whether it is the clerical staff we provide, whether it's the RPNs or the paramedic services, we need our staff to focus on their jobs; even our housekeeping staff, who I believe strongly have one of the most important roles in our hospitals. We need every single employee to be focused on their jobs. The only way we can take that stress away from them is to assure them that our collective agreements are going to be intact. Whether they are current or upcoming collective agreements, nobody has the right to come in and start to dismantle them. All we are asking for as hospital workers is fair wages for fair work.

I'll go back to an example of our housekeeping staff. As the rumours around our hospital have been filtering for the last two weeks, if our housekeeping staff in the hospital have their wages decreased, we know there will be a large influx of employees coming into the hospital, temporarily working for a little while until they find employment elsewhere, and then leaving the hospital setting. We know that if the wages are rolled back in a very crucial sector—housekeeping—I'm not saying they're going to do a lesser job, but they might not be inclined to be as dedicated to their job as I can attest the housekeeping staff we have at North Bay General Hospital are.

In the last couple of years we've seen a lot of different things arise in the hospital. Last year we dealt with SARS. This year we're dealing with influenza, as we have in other years as well. With these outbreaks, with the fear of SARS that hit Ontario last year, especially in the Toronto region, I find it is our housekeepers who are at the front line of fighting this. They are on the front line of defeating that disease that was going around in our province. It's the same with the influenza outbreaks we are having to deal with in our hospitals. Our housekeeping staff are the front-line people, and if they don't do their jobs properly, it's going to be very difficult for our nurses, our doctors and our paramedics to do their jobs as well. If disease runs rampant in our hospital because our housekeeping staff has had their wages rolled back, we find that is also going to affect patient care in the province and in the rest of our hospitals.

It's interesting; on the shirts of some of the members who have travelled with me over 100 kilometres this afternoon to attend this presentation before the standing committee it says "CUPE: We are the Canadian Union of Public Employees." And there's a little line after that which says "On the front line." This is something that struck me on the way up here, as I was watching the members with these shirts on. It's absolutely right. When CUPE put that line in there, on a lot of our letterheads and on our T-shirts, they were exactly right: We are the front-line workers. We are the ones who are dealing with SARS, we are the ones who are dealing with influenza on a daily basis, and it is because of us that we are winning the battles in a lot of these areas in our hospital.

How important is it to have a collective agreement in a workforce? Our collective agreements are so important to us. They give us the security of knowing we're going to work tomorrow, we have a safe workplace to work in, we have wages that are acceptable for the work and we can provide for our families. The collective agreements give us the security to do a job that we have to do in the hospital.

As a paramedic, the last thing that I need to worry about on a daily basis is whether a bill that may come into play in Ontario, like Bill 8, may threaten my wages. That's the last thing I need to worry about. We go on calls on a daily basis, and what we find is that we have to concentrate 100% on our patient care. We have to focus strictly on the patient that we have before us and give them the proper treatment and care that they are due in this province. I'm so proud to live in a province like Ontario, because I've not seen any other in Canada like this one.

Paramedics and training: This is what we have to concentrate on as paramedics, future training to improve our skills so that we can provide better care for the people and the public of Ontario. The last thing we need as paramedics is to be concentrating on the possibility of our collective agreement being dismantled, whether it is the current ones that we have or any upcoming collective agreements that we are negotiating in the future.

Why are hospital workers so up in arms? I have the pleasure of being the president of this local. I know quite a few of them, and I talk to them on a daily basis. Just recently, I divulged to them at a membership meeting a secret that I never had told them before, and that was, as I travel around the hospital from floor to floor—in the emergency department, X-ray, CAT scan—I watch my members work on a daily basis. I am so proud of the 530 members that I have in my local because of the job they do. When they're there every day, they know that I am here to protect their collective agreement as the president, and they know that, at the end of the week, they have a fair wage to take home and their benefits are still intact. These workers are very, very confident in doing their job because there is no worry, there is no threat at that time to their collective agreements.

With the introduction of Bill 8, I can tell you that in the last couple of weeks the stress in our hospital has increased dramatically. Everybody is worried about wages being rolled back, and they're not concentrating on their jobs. I can see it on their faces every single day. I can see it with the paramedics I work with, and I can see it in every aspect that CUPE provides employees for at North Bay General Hospital. I find that such a simple thing as an agreement between an employer and an employee has so much effect on the people; it does.

I urge you strongly that the amendments that we are seeking today—I have provided a brief before you today—are to go back to the government and tell them that CUPE in North Bay and in Ontario wants to protect its collective agreements. This is a very important thing for the workers. We are not very highly paid. Some of us in different sectors of the hospital have different wage grids, but we are very much affected if we are having our wages cut back. This is something that I wish to relieve

the stress on our workers so they can get back to the job of fighting influenza, SARS, if it ever hits back, or anything else that comes up in the future. A lot of the Web sites that I've been visiting lately are showing that there is evidence of different diseases that are coming out into the public.

We need to have our housekeeping staff, just for an example, not going to work worrying about their wages. We need them to go to work and worry about the cleaning that they do. It is absolutely amazing to see these people at work. They have such pride in their jobs. Another word that CUPE often uses in its literature is pride—pride to be in the union, but I've looked at that word "pride" and taken it to be the pride in their jobs.

1350

I don't think we are asking for the government to throw this bill right out of the House. I think the amendments we have put forward are reasonable. I believe strongly in preserving this collective agreement for all of the workers in Ontario and all of the hospitals.

The freedoms that we have in this province are to find work, and work in a safe environment, so that we can provide for our families. The threat that has come to us recently with Bill 8 and the concerns we have for it—I emphasize strongly the amount of stress that it has put on my workers. I myself have taken that stress, but I've taken on the position as president of this local to also try to ease their fears and to take that fear and the energy that is involved in it and direct it in a direction to do something about Bill 8, and not just sit back and be fearful of it. I have tried recently at some general membership meetings to encourage them to let go of the fear and to focus our energies on just making some changes to the bill, because we are not opposed to the bill in whole. We would like to see some amendments to it that would give our workers the security again that they're looking for.

I will be very brief and close with a simple example that was presented to me once. There was a master, a teacher, and a student. This student tried so hard to catch his master in any sort of mistake. He tried for years and years to do it. The master, as the teacher, was quite aware that the student was trying to do this. One day the student thought, "OK, I think I've got him on this one." He had a small bird, and he put it in his hand. He put his hands behind his back and he asked his teacher to guess which hand he had the bird in. The teacher, being wise, having many years of learned experience, knew that the student was trying to catch him again with some sort of trickery. The teacher replied to the student, "Well, I don't know exactly what hand it is, but the answer is in your hands."

I say to you, as a standing committee, please go back to our government and tell them that the hospital workers want their security. The hospital workers are the frontline people in many diseases that are arising in this province, and the bird is in your hands, as a standing committee, to go back to our government and plead our case to them that we just want our collective agreement preserved, and consider the amendments that we have put forward before you.

I thank you for the time that you've given me to speak here. I thank you on behalf of the 530 members of CUPE local 139 and North Bay General Hospital.

The Chair: Thank you, Mr Kotsopoulos. We're going to start with Ms Martel.

Ms Martel: Thanks, Bill, for coming here today, and thanks to your members as well who came with you, took the time to drive here to participate in this process.

Let me begin with the concerns you've raised with respect to collective agreements and the sections in the bill that the legal opinion that was done identified as being of particular concern to health care workers.

Yesterday, the minister in the committee said, "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." He told the committee that some wording to that effect, potential amendments, would be provided to the committee—we hope, sooner than later. We don't have that yet so we're operating in a bit of a vacuum in terms of what the government is actually going to propose. It is helpful that you have reiterated some of the proposed wording that could relieve members of their concern with respect to collective agreements, and we saw the language earlier in a presentation by Joanne Arnold, who also represents CUPE hospital workers here in Sudbury. So I appreciate that you've reiterated that.

One of the questions I had, though, was the amendments that you've proposed very specifically relate to collective agreements, and I understand why. But there's another section in the bill that I think could also be used, without even dealing with collective agreements, that could impact on your members. This has to do with the compliance directives. The compliance directives, section 22 in the bill, make it really clear that, "The minister may at any time issue a directive compelling a health resource provider or any other prescribed person, agency or entity to take or to refrain from taking any action that is specified in the directive or to comply with one or more of the prescribed compliance measures."

Taken to its extreme, perhaps, some would argue, a minister could then decide that he wants to amalgamate food services or amalgamate laundry services or contract out food services or contract out laundry services in a hospital and could certainly compel an agency or an entity, a hospital board, to do that, as the language currently stands. Is that of concern to you and could CUPE also bring forward amendments or recommendations about how to deal with that section, which doesn't say anything about collective agreements but could be just as damaging to your members if they lose their jobs through the privatization of positions that you now hold?

Mr Kotsopoulos: Absolutely. Thank you for the question, Ms Martel. Absolutely. There were so many different aspects of this bill that I could have spoken on this afternoon. I was just taking the concern from our membership meetings, and that was centralized on the collective agreement. But absolutely; we have a very deep concern about the compliance directives and the

possibility of privatization. I've been very active in our community about informing the public about any sort of privatization, P3 hospitals, contracting out. We believe that the language that we can negotiate in the future, as well as the current language in our collective agreement, can preserve our jobs, that no employer has the ability to go out and contract some of these services that you had mentioned, yes.

Ms Martel: It's going to depend on whether or not a minister's orders or directives would override a collective agreement, and that's not spelled out. It's not referenced one way or the other. The legislation is silent. You could, and you would as a good trade union president, do everything you can in that regard, except that if a minister's compliance directives overrode the collective agreement and the minister was intent on consolidating services or contracting out, no matter what you did as the union president, no matter what was in the collective agreement, that could still be lost. That's another concern that I have. The legislation is silent on what prevails in terms of directives over collective agreements. I think that section is going to have to be dealt with as well.

You also talked about privatization, and I appreciated that you—

The Chair: Could you summarize, please, Ms Martel?

Ms Martel: You quoted the minister by saying, "We are slamming the door shut on two-tier, pay-your-way-to-the-front-of-the-line health care in Ontario." If the government doesn't stop the P3 hospitals, and they haven't, and if the government doesn't shut down the private MRI and CAT scan clinics and move that technology into public hospitals, do you really think the government is slamming the door on further two-tier private health care?

Mr Kotsopoulos: To answer the first part of that, the sweeping powers of the Minister of Health are a very great concern to us. We worry about the possibilities of the minister making such a directive and coming in and pretty much dismantling our collective agreement. We are very concerned about the sweeping powers that the minister may have. I agree with you. During the election there were a lot of promises about MRIs and CAT scans and saying no to P3 hospitals, but we haven't heard any sort of direction from this government at this time that they will not and stop that direction.

1400

The Chair: Ms Smith, did you want to lead off? I've also got Mr Duguid and Mr Delaney, and we've got four minutes.

Ms Smith: I will just say that I want to apologize to Bill that I didn't get here for the beginning of your presentation. I apologize.

Mr Kotsopoulos: That's OK.

Ms Smith: I got caught up in an long-term-care issue that I'm also working on. But we will get to chat, I'm sure, many times because Bill and I live in the same town, and I know a lot of his workers. I have received e-mails and lots of concern from your workers on the collective agreement issue.

Let me just say—and I'm going to pass this on to my colleagues—that in his statement yesterday the minister made it very clear that this bill does not apply to collective agreements, nor would accountability agreements apply to trade unions. I'll give you a copy of his statement so you have that. I don't believe that collective agreements or your workers are at risk from anything in this bill. If anything, we're protecting medicare, we're protecting publicly funded medicare for all citizens of Ontario, and that will apply to all of your workers.

Let me just pass on to my co-workers. I'm happy to continue the conversation with you at home.

Mr Kotsopoulos: Absolutely. Thank you. I can do this whole presentation for you again in North Bay.

The Chair: You lucky woman. Mr Duguid.

Mr Duguid: Mr Kotsopoulos, I want to thank you for coming here today as well, and for your passion that you've shown us for the concern for the employees that you represent.

You talked about stress. I think it's being felt through the entire health care system. I've got a sister who's a nurse in North York. She was on the SARS unit the entire time, and I can tell you, everybody in those institutions is feeling stress right now and it's still a factor of burnout from that SARS scare.

I'm going to read to you, though, a letter that was written by the minister to Sid Ryan, just very quickly in the few seconds I have left to help clarify to you and maybe put you at ease in terms of the government's intentions.

It says: "Dear Mr Ryan,

"I am extremely troubled by recent statements from CUPE that Bill 8, the Commitment to the Future of Medicare Act, will allow for opening collective agreements and threaten the job security and livelihood of Ontario workers. This is patently untrue.

"Here are the facts, the same facts that I told you during our meeting on January 13.

"The intent of Bill 8 is that accountability agreements are established only with board of directors of publicly funded health care institutions. Labour unions are not subject to and will never be subject to accountability agreements. Bill 8 cannot open collective agreements. You know this, because I told you that when we met. In fact, during our meeting I conveyed our openness to explicitly state in the bill that labour unions are not subject to the legislation.

"Further, collective agreements are protected by various pieces of legislation in Ontario. Bill 8 will not reduce that protection."

I understand the concerns that were raised. I understand why there were some people who were questioning certain parts of the bill. I guess my question to you is, now that you've been given this information, and given that Mr Ryan had this information as of January 13, will you endeavour to make sure that your members are made aware of our intentions, so that the stressful environment they're already operating in can be eased somewhat?

Mr Kotsopoulos: Absolutely. I would love to go back home to North Bay and have another meeting and relieve

their stress, as much as I tried the other day at a general membership meeting. I know that there is an informal draft coming up very soon—I think on Thursday of this week. I note that there is a final draft March 9 of the amendments to Bill 8 that are going to be presented by the minister. I think when I can actually see something concrete that spells out very, very clearly, with all sorts of interpretations from the legal firms and from the public as well, at that point I can go to my members and tell them to get back to the job of looking after patients and the hospital, which I'm still trying to do now. But I want to give them 100% assurance. I think when we see something final, at that time I can really do it and do a better job.

The Chair: Unfortunately, the time has expired for the government side. We will have to put you on next.

Mr Delaney: My points had already been made, so I'm done.

The Chair: That makes life easier. Mr Wilson, four minutes.

Mr Wilson: Yes, I've been on the side of the government where your time expires. Believe me. That's why I'm on this side now.

Bill, you did a great job, as Joanne Arnold and Michael Hurley did before you, in terms of, I don't find myself very often in my 14-year career agreeing with the labour movement on too many points of law.

Ms Martel: That's true; that's true.

Mr Wilson: That's why I have the largest plurality in Canadian history.

Having said that, I do respect the points you make. Here's the point I'd like to make, and that is that unless you get rid of the whole accountability agreements and compliance directives—Ms Martel was bang on in her comments—I don't know how it can't affect your membership. For instance, if a compliance directive says, "The CEO, or the board, shall come within budget this year," and we heard evidence today that local hospitals—$7 million. I know from three years as health minister that it's always been over budget. In the past it was always moral suasion. As awful as it was playing out in the media and the pickets and everything, the minister never had a compliance directive that said, "You shall be fined $100,000 if you don't go my way."

I had to go into those hospital boards; I had to take the crap from the media, the unions and everyone else. It's all part of the democratic process. I sign up for it. I ask 100,000 voters in my riding every four or five years to put me through this again, so I can go out there. But it was moral suasion. This is the first time in the history of health legislation, outside of public health legislation—you, as a paramedic, know that sometimes a medical officer of health has to give a directive and it has to be followed. This is the first time a minister has said, "You shall do X." If, for example, the compliance agreement says, "You shall balance your budget," and that means laying off 30 or 40 people, then it affects your members.

Mr Kotsopoulos: Absolutely.

Mr Wilson: I just want you to take back that we're going to do our best—Mr Klees moved a motion earlier today with Joanne Arnold's wording—because I don't think that's right. I think part of asking people to vote for you and part of being an MPP is to get beat up once in a while, to have to go in and argue and then come out and explain to the media and the public what you've agreed upon.

The Chair: Thank you, Mr Kotsopoulos. We appreciate your presence here today and your input.

SUDBURY AND DISTRICT LABOUR COUNCIL

The Chair: We'll now move on to the next delegation this afternoon, the Sudbury and District Labour Council: Alexander Bass, president, and John Filo, past president. Is that right? You know what the rules are.

Mr John Filo: This is Alexander Bass, or Sandy Bass, as he is affectionately known, and I'm John Filo. I want to welcome this committee to Sudbury. Bienvenue à Sudbury, and for my Lebanese colleague:

Remarks in Lebanese.

I see he's out of the room at this moment.

The Chair: You've got to say that again. He'll be impressed.

Mr Delaney: On his behalf, then:

Remarks in Lebanese.

Mr Filo: The Sudbury and District Labour Council represents 15,000 unionized individuals in greater Sudbury and the surrounding area. We represent a myriad of occupations, from custodial staff to university and college professors, assorted trades, professional government workers and of course a great variety of health care workers.

Incidentally, in welcoming this committee to Sudbury, I forgot to mention that I missed the reception committee: all the pickets and the Ontario Provincial Police security phalanx that we had under the previous government.

To say we are deeply concerned that the present Liberal government will deal with medicare in a pragmatic manner that benefits the entire population of Ontario is an understatement. Basically, we want honesty, decency and fairness, and we feel that we're getting spin, glibness and semantics. Our own Sudbury MPP, for example—and I'm sorry that Rick isn't here to defend himself—so vocal when in opposition in prodding the Tory government to rectify the problems with our regional hospital, has become an apologist for his colleagues, citing the bogeyman of the unexpected deficit that the Eves team imposed on the province. Didn't anyone listen to Gerry Phillips or the Fraser Institute, whose report was authored by an individual close to the Harris-Eves government?

Even the title of this bill is reminiscent of the way in which the previous government labelled their bills. The label often was the most progressive and positive aspect of the bill, while the body of the bill sought to accomplish the diametric opposite, as in some ways Bill 8 does.

I want to comment that I heard the words from Monique Smith accusing Hurley of misleading people. Do I have to remind you about the Oak Ridges moraine

or Highway 407? One of your colleagues read a letter from Sid Ryan. I can read from Hansard, I can read from your program, from your platform: You are the ones who misled.

1410

Democracy in Canada and Ontario works well when systems are implemented that are characterized by openness, transparency and accountability, and corporate privacy issues are subservient to the right to know of the citizens and taxpayers who pick up the tab. Checks and balances are necessary, though not often sufficient to prevent fiascos such as those plaguing the federal Liberals. What, then, is the rationale for conferring on the minister the power to direct any health resource provider, person, agency or entity, which may include unions, to enter into accountability agreements with the minister? Further, such wide-ranging powers are being bestowed on the minister in other areas of the bill that are too all-encompassing and ill-defined, thus allowing the minister to play fast and loose with the content and the target populations to which they may be directed.

The labour movement is categorically opposed to the privatization of any component of our health care system, because it's a device to reduce the role of government by spouting the propaganda that private enterprise is more efficient and desirable, whereas public services are costly, inefficient and undesirable. The real motive, however, is to allow favoured groups to generate profits at the expense of no-income and low- and middle-income people. We know that the easily treated medical problems, the ones with high profit margins, are the ones that get privatized, while the costly and intractable problems are left in the public sphere, making the cost much higher there. The siren song of lower taxes and less government has its appeal, but in a closed economic system, the expenditures have to be transferred somewhere. Privatization ensures that costs are directed from those most able to pay to those least able.

Private enterprise, in a holier-than-thou gloating, is quick to use examples such as the sponsorship scandal in Quebec to trumpet the advantages of the private route. To place in perspective the revulsion we experience when it is revealed that hundreds of millions of dollars are channelled by a government to a privileged few, we have to recognize that the resources that private enterprise—as represented by Enron, Tyco, Nortel and the dot.com multinationals—squandered amounted to trillions of dollars, four orders of magnitude higher. Ask any senior who invested in mutual funds for a retirement benefit how the investment has fared over the past few years because of private enterprise efficiency. In the end, it must be emphasized that it was the private sector that benefited from the corrupt misuse of moneys in the Quebec example.

John Kenneth Galbraith said that right-wing economists, who we believe are inordinately influencing this Liberal government, believe that the poor have too much money and the rich too little. The modern neo-liberal, he alleged, is engaged in one of man's oldest exercises in moral philosophy: the search for a superior moral justification for selfishness. As a commentary, we will track very closely this Liberal government to see which of its left-wing promises and which of its right-wing promises it's going to keep. We suspect the left-wing promises are going to be shelved and the right-wing promises are the ones they're going to subscribe to.

If, as mentioned in the preamble, catastrophic drug costs and primary health care based on assessed needs are central to the future of medicare, please drop the other shoe and deal with this shortcoming in a revised bill.

Successive governments in the past have used their surgical skills in delisting services and procedures, not only to reduce costs but also to facilitate the burgeoning expansion of the two-tier model of health care for uninsured measures. How cleverly has the private sector taken advantage of this subtle progression, until now we have the inexplicable prohibition of queue-jumping for medically necessary services but not for medically delisted services. This is broken. Design legislation to fix it.

Are we going to have the Ontario Health Quality Council peopled with lackeys to the present government, paralleling the model established by Harris and Eves? Locally, we had independent, community-minded persons removed from agencies, boards and commissions and replaced by card-carrying ideologues, some of whom performed their duties without regard to the impact on the community, but toadied up to the powers that be.

User and/or block fees create barriers to access. These must not be allowed through regulation or in a revised bill.

Our friend Jim Wilson noted that union dues have to be paid by people working in a particular industry, and asked why doctors shouldn't charge block fees. That's like comparing apples and oranges. You see, doctors pay fees, professional engineers pay fees and lawyers pay fees to practise their professions. Those are income-earning entities. A patient doesn't go to a doctor to earn an income, Mr Wilson, so you're way off on your analogy there.

I regret that my presentation has provided little detail concerning some of the other parts of the bill that we have serious problems with, but I am confident that ONA, unions such as OPSEU and CUPE, and the Ontario Health Coalition will amplify the concerns with this very flawed legislation.

Remarks in Lebanese.

The Chair: I'm not sure if we have a Lebanese translator. You've used up about eight minutes of your time, which leaves us with seven minutes each for questions, starting with the government side.

Do you want to go first, Ms Smith, or do you want to pass it on to Mr Delaney?

Ms Smith: I'll start and then pass it on.

I just wanted to address some of the concerns you raised about your Sudbury MPP. I think the fact that the Minister of Health was able to visit this community within three months of taking office and, together with your local member, Mr Bartolucci, is planning a summit

to deal with the log-jam that has built up with respect to your regional health facility, would indicate that your member is diligently working on your behalf. I believe that all in northeastern Ontario will see some movement on that in the near future. I would just note there is movement; that is coming in. Certainly, problems that have built up over the last five years are being addressed in short order.

I note in the second paragraph of your presentation that you talk about openness, transparency and accountability. Those are all themes that run through Bill 8, and I think we do have common ground on that. You also talk about the necessity of checks and balances, and that is exactly what we're looking for in implementing accountability agreements between health care providers or health care institutions and the Ministry of Health. I wonder how you feel that an accountability agreement would not provide some checks and balances between these institutions and the ministry.

Mr Filo: Let me go back to the first part of your answer about Mr Bartolucci and that he's doing this and that. It's what we call in the gambling profession "all on the if-come." This is what he said in Hansard: "We demand that you send the cheque and get the project on board again." That doesn't mean tomorrow or the next day or the next month. Sure, he's got some plans, but they're in the future and they're indefinite.

The other point you make about checks and balances: Somebody like Saddam Hussein or George W. Bush would be pleased with the powers you're conferring on the minister. There are no checks and balances there.

Mr Smitherman is a rational, reasonably decent person, but eventually you'll get somebody in there who won't have the same perspective he has, and he then has autocratic power. There are no checks and balances there. Can't you see that, Monique?

Ms Smith: I don't see it the same way you do. I do appreciate that you see our minister as being reasonable.

We intend to bring amendments to this legislation, and I think you've been here through some of this morning's presentations and heard us talk about the fact that we're bringing in amendments to add some flesh to the bones. We did note that this was brought out after first reading and that we were open to much consultation. That's why we're here; that's why we're travelling the province. So we do intend to bring more heft to the provisions you're talking about, and certainly some safeguards so that the concerns you've raised with respect to unfettered discretion will be addressed.

I did want to ask you a question just before I pass on to one of my colleagues. You spoke about the health quality council and your concerns about the membership. What would you propose as being an appropriate membership for that council?

Mr Filo: It's been proposed already. Something democratically elected, representation from various sectors and so on. I'm not here to write the regulations, but the staff that you have, with the resources that are at your disposal, can surely see that's the way to do it, rather than by appointment.

1420

Ms Smith: Thank you for your input. I think one of my colleagues has a question.

The Chair: Mr Delaney, do you have a question, or Mr Duguid?

Mr Delaney: I just have a point that was brought up here, more in the way of clarification. At the moment, Ontario has no defined way of knowing whether health care dollars are currently being spent wisely. The auditor can count up how much is being spent, but this bill is a way in which we can place a value judgment on how well the money allocated to health is being spent. The Commitment to the Future of Medicare Act, 2003, if passed, would create an innovative way of doing just that, which is the Ontario Health Quality Council. This health quality council and the other measures in this bill in fact toughen prohibitions against two-tier medicine and they enhance health sector accountability. That is their intent. The proposed act, in fact, would close down various loopholes that may result in extra-billing and in user fees and enhance the ability of the Ontario public to monitor and to enforce such a provision. Finally, a lot of what's in Bill 8 is about establishing new accountability frameworks with our health care partners that demonstrate to the public—and that's the key part, to demonstrate to the public—that they're receiving value for the money expended on health care. Was there any specific provision that you wanted to raise a specific point on?

Mr Filo: I thought I did. It's the appointment of the members to the health council. Sure, all the provisions and the mandate of the council are motherhood and apple pie, but if you appoint people who are going to toe the party line and not give you a view that's representative of the community, how much worth is that?

Mr Delaney: I posed several such questions yesterday to the Minister of Health, and I think, as you see, the drafts of the bill continue to evolve. I'm hopeful that the questions that I posed and some of the ones you've raised will be answered.

Mr Filo: Can I respond to that, Mr Chair?

The Chair: Very briefly. We've got about 10 seconds.

Mr Filo: To me, the symptom of flawed legislation is the very fact that you have to introduce so many amendments. Was this bill written on the back of an envelope? Was this guy you brought in from BC the one who sketched it out for you? Don't forget that if the legislation is well focused and well prepared, amendments would be minimal. Here you have to make many, many amendments to address the shortcomings.

Mr Klees: Thank you very much for your presentation. In fact, the question you just asked is one I've been asking for the last couple of days, although not in those words. But how we could come to the point where the Ministry of Health, with all of its resources, very well-paid people in the policy department, people who have been drafting and recommending legislation for years as a profession, could end up handing to the minister a piece of legislation such as we have before us—

Mr Filo: Junk.

Mr Klees: —is beyond me, although it's not beyond me, because I don't for a minute, as I don't believe you do, believe that the minister was not aware of what this legislation says, that those who put it forward for first reading were not fully aware of the powers that it was in fact conferring upon the minister, the incredible implications that it has, not only to labour unions' collective agreements but for every stakeholder and every health care worker in the entire health care field. What does confound me is that they thought they could get away with it. But as we're seeing from all of the representations, they can't. But what they are facing now is a problem of such a flawed piece of legislation that it won't be recognizable if they in fact do all the things that are being recommended and that they're already agreeing to. I've made a suggestion: I think the parliamentary assistant should take it upon herself to make a phone call to the minister this afternoon and say, "Look, let's not waste anyone else's time here. Let's withdraw this legislation. Let's start over, and let's really look at the principles we've set out in the preamble"—which are laudable—"and get to work and craft something that really does reflect our intentions." Would you agree with that?

Mr Filo: Of course.

Mr Klees: Would you make that recommendation to the parliamentary assistant?

Mr Filo: I'd be pleased to make that recommendation. Monique Smith, please go back to your cabinet and recommend to them that they scrap this bill and start anew on the basis of the consultations you've held across the province. Furthermore, the motion that was moved by Frank Klees—I would expect that one of the members of the government would be the first person to move a similar type of motion once these hearings are over.

Ms Smith: Mr Chair, I can assure the presenter that we will be looking at that type of amendment. The minister stated that in his presentation yesterday. We've stated it during pretty much every presentation today. It's pretty clear that we will be doing that. I thank the presenter and Mr Klees for the recommendation. It's unfortunate that Mr Klees does not want to travel the province and get input from the citizens of Ontario on this legislation, which we think is important, and that's what we're doing. We'll continue to do that, and we'll come back to you.

Mr Duguid: That was just not their style. They're not used to it.

Ms Smith: I know consultation is not your forte, but we'll continue.

The Chair: Your time has not expired, Mr Klees. You still have more time. You had the floor. You did invite that exchange, but you still have time left.

Mr Klees: I did, and I'm happy that we've got some time. I don't need to be lectured to about consultation. I know full well about consultation. One of the best consultations Ontario has is an election. Let me remind members opposite and everyone who is listening that there were very specific commitments made by the Liberal Party and by Mr McGuinty during that very broad consultation. I would expect that at least some of that consultation that people voted very strongly—a lot of my colleagues aren't here. We got voted out of office based on that consultation and those promises that were made by the Liberal Party. How about keeping some of those commitments? What you're doing now with this legislation is an about-face on those fundamental consultations. Why should anyone waste their time coming forward and consulting with you when you didn't keep your promises on the first consultation? That's my question to you.

Ms Smith: To the presenter?

Mr Klees: It's to you, not to the presenter. The presenter knows full well that your credibility is very quickly eroding in this province.

The Chair: OK. We have a gentleman sitting at the end of the table who has been kind enough to make presentations to us.

Mr Klees: I can use my time in any way I choose.

The Chair: That's what I'm saying. The cross debate between the members perhaps should—

Mr Filo: I appreciate the question, Mr Klees, whether I agree with your statements or not. I have to say that, by and large, I agree wholeheartedly with the points you've made. I think I'm a little old-fashioned, but I think morality and ethics have a place in the community and that nobody should make promises lightly. I know that once in a while you make a promise and you can't live up to it and you have to do some sort of penance for that. You can't make promises and then say, "Well, look, sorry. That was then, this is now."

The Chair: Thank you, Mr Klees. Ms Martel, seven minutes.

Ms Martel: Thanks, John and Sandy, for coming today. I think it's worth putting on the record some of the powers the minister has, because in point of fact, although there has been some discussion about amendments, it was not terribly clear to which sections and what kinds of changes were coming forward, with the exception of a promise that collective agreements would not be eroded. The minister has very broad powers, which I think people need to think about again.

1430

Compliance directives, section 22: "The minister may at any time issue a directive compelling a health resource provider or any other prescribed person, agency or entity to take or to refrain from taking any action that is specified in the directive or to comply with one or more of the prescribed compliance measures."

Subsection 22(2): "In any directive under this section, the minister may specify the time or times when or the period or periods of time within which the health resource provider or any other prescribed person, agency or entity to whom the directive is issued must comply with the directive."

Look at section 24, termination: "The minister may at any time terminate an accountability agreement or a com-

pliance directive, and may at any time vary a compliance directive or issue a new compliance directive."

Section 26: "Where, in the opinion of the minister, any person, agency or entity described in section 21 or 22 fails to enter into an accountability agreement, fails to comply with any terms of an accountability agreement or fails to comply with all or any part of a compliance directive, the minister may make an order providing for one or more prescribed measures."

Those are just four examples in the accountability agreement section of the very broad powers of the minister. We have no clear sense of how those broad powers are going to be curbed. John, may I ask you, why are you worried, as you listen to this language, about the very broad, perhaps unwieldy, powers of the minister?

Mr Filo: Because not even my wife has those powers in my household. I mean, my children do, but my wife doesn't. It's too much. It's too indefinite. It's too vague. A person who has an unscrupulous bent can do it to advance an agenda that's contrary to the community interests.

Ms Martel: You talked about the preamble. You said, "If, as mentioned in the preamble, catastrophic drug costs and primary health care based on assessed need are central to the future of medicare, drop the other shoe and in a revised bill deal with the shortcoming." I'm assuming you mean in a revised bill bring forward some actual provisions that put this into place. I'll just give you a couple of examples.

The preamble talks about pharmacare. There is no other reference to pharmacare. The preamble talks about home care. There is no other reference to home care in the bill; certainly not a provision to end competitive bidding, for example, in home care. The preamble talks about the prohibition of user fees, while at the same time the government is musing very publicly about a means test for seniors for Ontario drug benefits, which would result in user fees for many seniors if they are above the income test. Is that what you mean, that maybe the government should get past the rhetoric in the preamble and get to some detailed provisions in the bill which put some of this into effect?

Mr Filo: Exactly, Ms Martel. If you look at the costs that are involved with these miracle drugs that they're putting on the market, I think there's a saving of millions—no, not millions of dollars; tens or hundreds of millions of dollars—to the health care sector if somehow or other the cost of those drugs were brought under control and if there were a public method of distribution devised so that the cost to the individual would be nothing because it would be paid through their taxes and the cost to the system would be minimized.

Ms Martel: I wanted to just talk about the functions of the council, because I questioned the minister about this yesterday. My concern with respect to the council is that it appears to be a council that will primarily do monitoring and reporting. Monitoring and reporting on health outcomes are fine, but if there's no mechanism to force the minister to respond to the reports and the outcomes, then there is no accountability. The minister tried to say yesterday that this council is an accountability mechanism that's going to force him to do something. Well, no, it's not, because all they can do is report and monitor. They can't even make recommendations about how money can be spent. Can you give me a sense of how effective, in terms of really dealing with health care policy and the changes that have to be made, a council will be that can only essentially monitor and report and not make any recommendation for change, either to legislation, to health care policy, to funding or to even dealing with the results of the outcomes they're reporting on.

Mr Filo: The federal ethics councillor, Mr Wilson, had real teeth when he had his judgments vetted by Chrétien concerning Chrétien's double dealing. If the health council is appointed and is staffed by people who are sympathetic to the government, will do exactly the same thing. They won't even recommend. So we need something similar to what the Auditor General does in the federal government, where they make a statement, they have resources where they do significant cost-effective audits, and they present the report to the Parliament—to the Legislative Assembly in Toronto—and the government is forced to act on it.

Ms Martel: So they do have the power for recommendations. Because if you look, the only power this council has about recommendations appears in subsection (4). It says, "(4) In a report under this section the council may make recommendations to the minister but only in regard to future areas of reporting."

Mr Filo: I've been in the union movement for 30 years, and a word like "may" has absolutely no impact. Words have to be like "must" or—

Ms Martel: "Shall."

Mr Filo: It has to be mandatory rather than permissive.

The Chair: Thank you, gentlemen. We appreciate your coming forward.

ASSOCIATION DES TRAVAILLEUSES ET TRAVAILLEURS SOCIAUX DE L'ONTARIO, CHAPITRE DE SUDBURY

ONTARIO ASSOCIATION OF SOCIAL WORKERS, SUDBURY BRANCH

The Chair: Our next speaker is from the Ontario Association of Social Workers, Sudbury branch: Marie Turcotte, who I understand will be addressing us in French. You have 30 minutes, Ms Turcotte. You can use that any way you like. At the end of the 30 minutes we will split any time remaining among all three parties to ask you questions. The floor is yours.

M^me^ Marie Turcotte: Je fais partie de l'exécutif provincial de l'Association des travailleurs sociaux. Nous sommes incorporés depuis 1964. Nous sommes un peu

plus de 3 000 membres répartis dans 15 chapitres à travers la province. Tous les membres ont un degré universitaire en service social. Vous trouverez ci-joint le texte de la présentation en anglais, mais ce que je vais donner en français, c'est plutôt un résumé, puis je vais souligner les points importants.

Premièrement, nous voulons féliciter le gouvernement de vouloir inscrire dans ce projet de loi 8 l'universalité des soins de santé qui est déjà garantie dans la loi fédérale. Tout système à deux vitesses de santé contrevient à la loi fédérale. Nous trouvons que la Loi 8 telle qu'elle est présentée actuellement n'assure pas l'implantation des principes contenus dans la Loi canadienne sur la santé, et ne va pas améliorer le processus démocratique, la transparence puis la coresponsabilité dans le système de santé. Elle n'empêchera pas l'érosion du système par la privatisation et les corporations à but lucratif et le système de santé à deux niveaux.

Il va falloir plus que ce qui est écrit dans le préambule de la loi. Il va falloir des initiatives plus concrètes. En Ontario, on ne devrait pas allouer des cliniques privées offrant des « CT scans » et des « MRI » à des clients qui peuvent payer pour des tests non médicalement nécessaires alors que ceux qui ne peuvent pas payer ou qui ont des problèmes médicaux plus sévères doivent faire la queue dans le système public.

Dans les établissements de soins à long terme, 60 % des lits sont réservés pour ceux qui peuvent se payer une chambre privée ou semi-privée, réduisant ainsi l'accès à ceux qui ne peuvent pas payer ces taux. Dans ces mêmes établissements, des familles emploient parfois une personne pour donner des soins à leur parent parce qu'ils considèrent les services inadéquats. Alors, qu'arrive-t-il aux plus pauvres ? Risquent-ils de manquer des soins de base comme être lavés, nourris, changés à chaque jour ?

1440

Pour ce qui est des soins à domicile, encore là on n'en parle pas vraiment dans le bill. Depuis les coupures massives du temps des conservateurs, les services ont été réduits presque exclusivement aux soins personnels. Les services d'aide pour le ménage et l'épicerie ont presque été éliminés. L'accès à la physiothérapie, l'orthophonie, l'ergothérapie et les services sociaux ont été privatisés. Alors, les personnes en milieu rural ou dans les petites communautés ne peuvent pratiquement pas accéder à ces services. Des compagnies offrent ces services aux centres d'accès aux soins communautaires, mais pour réduire leurs coûts, ils emploient des personnes avec moins d'expérience ou avec moins de qualifications et qui ne sont pas prêtes à s'éloigner des grands centres pour aller offrir leurs services.

Nous supportons le fait que la Loi 8 ne permet pas aux médecins de se retirer de OHIP, mais la plupart d'entre eux facturent pour de plus en plus de services. Il est difficile de savoir si c'est légal ou pas. Juste pour avoir la liste des services que les médecins ont droit de facturer selon leur Ordre, il faut payer 100 $.

Nous nous opposons à ces dépenses surnuméraires, aux « block fees », que certains médecins facturent une fois l'an. Avec le peu de médecins disponibles, les patients seront peu portés à porter plainte ou à refuser de payer, de peur de ne plus avoir de médecin. Quelque 900 000 Ontariens n'ont pas accès à un médecin dans le moment, puis tous ceux qui déménagent à Sudbury, par exemple, ou dans d'autres villes de certaines régions savent qu'ils ne pourront pas trouver un autre médecin avant plusieurs années s'ils déménagent dans une autre localité.

La Loi 8 n'offre aucune garantie ou initiative concrète pour assurer les soins de santé de base à tous les Ontariens selon les principes de la loi canadienne; par exemple, pour les soins à domicile, les médicaments, les appareils pour la mobilité, et une liste de services couverts par OHIP qui devraient couvrir l'ensemble des services dont les gens ont besoin. Dans la dernière décennie, 100 $ millions ont été éliminés en réduisant la liste des services assurables à travers OHIP.

Au sujet de la création d'un conseil pour évaluer la qualité des services de santé, les membres du conseil devraient être élus ou proposés par des groupes représentant les patients, les usagers des services et des experts, et non être nommés par le gouvernement. Il devrait comprendre des membres de toutes les régions géographiques de l'Ontario, même celles qui sont isolées. Aucune personne qui a des intérêts financiers dans le domaine de la santé ne devrait y siéger.

Ce conseil devrait pouvoir investiguer si le système de santé se conforme aux principes d'inclusion, d'accessibilité et d'universalité. Ceci comprend le système à deux niveaux, les frais pour les usagers et la facturation surnuméraire. Ce conseil devrait avoir le pouvoir de faire des recommandations et de conduire ces opérations de manière transparente pour le public.

Assurer un contrôle démocratique et de la transparence : nous craignons que la Loi 8 donne trop de pouvoir au ministre sur les individus et les organisations. Les ententes au sujet de la coresponsabilité fiscale devraient être établies conjointement avec les établissements et après consultation publique quand c'est possible pour éviter un contrôle autocratique de la part du gouvernement; par exemple, l'arrêt de la construction de l'hôpital régional ici depuis trois ans à partir de la décision d'un ministre.

Nous croyons que le système de santé est redevable à tous les gens de la province et non seulement au ministre de manière pyramidale. Tout le système de santé devrait être régi de façon démocratique, avec des conseils d'administration élus, membriété ouverte, possibilité de consultation et de représentants de groupes concernés, rapports financiers des hôpitaux ou des autres établissements de santé rendus publics, l'input des usagers et des employés du système de santé qui constatent des lacunes graves.

En conclusion, nous voulons dire qu'il faut arrêter l'établissement de corporations à but lucratif, de cliniques privées qui imposent des frais aux usagers et qui paient des salaires exorbitants à leurs administrateurs ou à leurs employés. Ils vont attirer les meilleurs

employés du système public dans leurs rangs et accroître encore plus la pénurie de personnel dans les établissements publics. Alors, plus de lits ou de départements devront être fermés. Les patients devront payer de plus en plus de services. Les frais de consultants et les frais légaux augmenteront.

Aussi, tous les hôpitaux de type P3 devraient être éliminés.

Les services non cliniques comme la nourriture, la buanderie, l'entretien ménager, les tests de laboratoire et les thérapies sont essentiels et doivent demeurer sur une base non lucrative.

Ce qui arrive souvent, c'est que les compagnies privées prennent leur clientèle parmi ceux qui sont couverts par les assurances privées ou le WSIB et ainsi ne permettent pas aux hôpitaux de retirer ces revenus, au détriment du système public de santé.

Le gouvernement libéral s'est compromis dans la campagne électorale à réduire la privatisation et la reconstruction du système medicare, et nous espérons qu'il gardera ses promesses. Merci.

The Chair: Thank you. The translation doesn't keep up with you. You finished before I finished listening. My apologies.

We do have about 20 minutes left. We're going to start this time with the Progressive Conservatives. You've got about six or seven minutes, Mr Wilson.

Mr Wilson: Thank you very much for your presentation.

You must have social workers, though, who work in public facilities and you must have social workers who work in private facilities, who do private consulting for school boards, for example, that sort of thing. Your comments dealt mainly with the public institutions, but do you have anything to say on behalf of those social workers who run a legitimate business, who are happy—I have two in my own family—working in a private setting, as you would say? I would just say it's another form of employment. I'm just wondering. I go back 14 years with your association and you never say anything about all those thousands of people who work in private settings.

M^me^ Turcotte: Disons que comme travailleurs sociaux on a vraiment à coeur l'intérêt des gens, surtout des plus pauvres, des classes les plus démunies. Actuellement, c'est à travers le système public où on voit que les droits de ces personnes sont plus négligés. Ceux qui peuvent se payer des services privés, il n'y a pas de problème là.

Mr Wilson: In terms of the public institutions, I've had the occasion, as I told the committee yesterday, to visit five hospitals in the last three months because of a sick friend and elderly parents, not just for a day but every day except two, and that's yesterday and today. The social work staff have been fantastic, very good. It's a young man who's dying. He actually works for the Ministry of Health and they've been very, very helpful. Those are major hospitals in Toronto. Do we have almost no staff in other hospitals throughout the north here, for example? What's the status of social work in the hospital setting these days?

M^me^ Turcotte: De plus en plus, les postes de travailleurs sociaux sont menacés dans le système public. Dès qu'il y a des coupures, c'est souvent un des postes qui va partir. C'est dommage, parce qu'il y a vraiment un grand besoin pour toute l'intervention des travailleurs sociaux, surtout pour assurer le suivi lorsque la personne sort de l'hôpital puis qu'il n'y a pas de crise majeure dans la famille du côté de la santé mentale qui fait que la personne retourne à l'hôpital. Ça va coûter encore plus cher au système que si on avait pu assurer un suivi de ces personnes-là.

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Mr Wilson: It's too bad in one sense that you don't have a higher profile in our hospitals. At Mount Sinai Hospital in November, I guess because the social worker was so busy, the poor kid had to be there three weeks before he saw the social worker, but on the first day he saw the chaplaincy team. I'm not telling you something you don't know, but raising the profile of social workers, as you're doing today, isn't such a bad idea. I mean that sincerely.

M^me^ Turcotte: C'est une des priorités de l'association canadienne dans le moment. Je peux vous dire que je travaillais moi-même dans les soins à domicile avant, et dès qu'il y a eu la privatisation des services de thérapie à domicile—c'est très dommage, surtout pour le nord de l'Ontario. Ça ne s'applique pas juste aux travailleurs sociaux. C'est les physiothérapeutes, les ergothérapeutes etc. Les gens veulent mais ne peuvent plus se permettre d'aller dans les petites régions rurales éloignées parce que ça ne rapporte pas à l'agence qui les engage. Alors, il y a toute une population laissée-pour-compte.

The Chair: Thank you, Mr Wilson. Ms Martel?

M^me^ Martel: Merci d'être venue cet après-midi. Je l'apprécie beaucoup.

Je voudrais parler de la santé à but lucratif. C'est bien clair que le Parti libéral avait dit clairement avant les élections, premièrement, qu'ils allaient terminer tous les hôpitaux privés, et, deuxièmement, qu'ils allaient aussi annuler tous les contrats pour les CT scans-MRIs, les cliniques privées, et rendre de nouveau cette sorte de technologie aux institutions publiques.

Dans votre conclusion, vous dites clairement qu'il faut arrêter l'établissement de corporations à but lucratif. Je pense que vous voulez voir clairement dans le projet de loi les détails à propos de comment le gouvernement va le faire, c'est-à-dire annuler les hôpitaux privés et, deuxièmement, annuler les cliniques privées pour MRI.

M^me^ Turcotte: Oui, puis on a besoin du côté public de ces appareils qui existent dans ces cliniques. On veut surtout prévenir l'érosion du bon personnel, des bons technologues, ceux qui s'en vont au côté privé et ensuite on manque de personnel dans le système public. On a besoin de retenir ces gens-là. On veut avoir tout ça plus concret dans la Loi 8.

M^me^ Martel: L'autre problème autour du « poaching », pour utiliser le mot anglais, c'est que les

frais ou l'argent qu'on aurait pu utiliser pour les patients est de l'argent qui est donné au profit des corporations. Alors, vous manquez deux fois, à cause du fait que vous perdez les professionnels du système public parce qu'ils peuvent peut-être obtenir plus de frais et, deuxièmement, l'argent qui aurait été utilisé pour les patients et au service des patients est utilisé, au lieu de ça, pour les profits. Alors, c'est bien clair qu'on doit mettre fin à tout ça si on appuie vraiment le medicare.

Deuxièmement, vous dites que les membres du conseil devraient être élus ou peut-être proposés par les groupes représentant des partis ou des patients. Alors, vous voulez avoir une sorte de mécanisme où les groupes, par exemple les groupes pour les personnes âgées, peuvent nommer quelqu'un et le gouvernement doit accepter cette personne. Est-ce vrai?

M^me^ Turcotte: Il faut absolument que ce conseil-là soit élu de façon démocratique, sinon il va devenir un organe du gouvernement. Il ne faut pas qu'il y ait personne qui a aucun intérêt, soit financier ou politique, dans ce conseil-là. Il faut vraiment qu'il soit la voix du peuple, puis qu'il ait des pouvoirs plus grands pour pouvoir investiguer si le système de santé fait ce qu'il est censé faire.

M^me^ Martel: Alors, changer le mandat du conseil parce qu'en ce moment c'est trop restrictif. Ceci dit seulement que le conseil peut surveiller ou faire des chiffres, faire des statistiques à propos de la situation de la santé, mais ne peut pas offrir vraiment des recommandations concrètes pour améliorer la situation de la santé. Alors, améliorer ou élargir ou ajouter quelques responsabilités au conseil.

M^me^ Turcotte: C'est ça.

M^me^ Martel: Est-ce que vous voulez voir aussi une situation où le conseil peut faire des recommandations à propos de comment le gouvernement doit faire face aux résultats des rapports? C'est-à-dire, s'il y a un rapport qui dit qu'il faut dépenser plus d'argent pour la santé publique, est-ce qu'il y a une obligation, une responsabilité de la part du ministère, de dire oui ou non ou pourquoi, au lieu de seulement continuer à faire un travail qui obtient des chiffres mais qui ne permet pas du tout une possibilité de faire des recommandations?

M^me^ Turcotte: Oui, on leur dit clairement dans le texte que nous voulons que ce conseil ait le pouvoir de faire des recommandations au ministre.

M^me^ Martel: Le gouvernement doit répondre ou, sinon, doit dire pourquoi pas au public.

M^me^ Turcotte: De façon transparente pour le public.

M^me^ Martel: Finalement, vous dites au début, « Nous trouvons que la Loi 8 telle qu'elle est présentée actuellement n'assure pas l'implémentation des principes contenus dans la Loi canadienne de la santé et n'améliore pas le processus démocratique, la transparence et la coresponsabilité dans le système de santé. » C'est assez sévère comme observation, je dois vous dire, parce que c'est bien clair que le gouvernement dit publiquement, « Voilà un projet de loi qui va améliorer la situation de medicare, qui va garder tout ce qu'on veut avoir dans le système de santé. » Mais vous dites clairement qu'il y a une grande différence entre les détails dans le projet de loi et la « rhetoric ».

M^me^ Turcotte: L'intention est bonne, la rhétorique est bonne, mais nous voulons des initiatives concrètes, peut-être des détails plus substantiels dans le corps de la loi.

M^me^ Martel: Alors, des détails concrets à propos de comment le gouvernement doit vraiment protéger le système de medicare ici en Ontario.

M^me^ Turcotte: C'est ça.

M^me^ Martel: Merci.

The Chair: Thank you, Ms Martel. We'll go to the Liberals now for seven minutes.

M^me^ Smith: Merci, madame Turcotte. On apprécie bien votre présentation aujourd'hui. J'ai quelques questions pour vous.

Je voulais vous dire premièrement que je suis en train de faire une revue de ces établissements de soins à longue terme à travers la province. Pendant mon travail, j'ai bien su la valeur de la présence des travailleurs sociaux dans ces établissements. Ils ont une grande valeur. C'est bien apprécié. Ceux qui ont une travailleuse sociale ou un travailleur social sur leur staff sont très bien servis. Alors, je voulais juste vous faire remarquer ça en passant.

J'apprécie bien aussi vos craintes sur les soins à domicile que vous avez notées. C'est tout à fait une crainte de ce gouvernement qu'on ait eu des coupures dans le système de soins à domicile, et on essaie au fur et à mesure d'adresser ces concernes.

J'avais deux questions spécifiques que je voulais vous adresser sur votre présentation. Je devrais vous dire que j'ai essayé de suivre votre présentation en français et en anglais, et votre traduction n'est pas tout à fait égale. Alors, je vais avec la présentation en français.

M^me^ Turcotte: Le texte français fait juste résumer certains points.

M^me^ Smith: Je vais vous poser mes questions en anglais, mais vous pouvez me répondre en français parce que je comprends bien. C'est juste parce que je ne m'exprime pas toujours aussi bien en français sur les termes.

With respect to block fees, I had a question. You suggested that it's difficult to know what's legal and what's not. To have a list of services provided by a physician, you have to pay $100. I just wondered what you were referring to then. We've had some discussions around block fees—there's a provision in the legislation now—and we're looking for directions specifically from the presenters on how they think that block fees can be better managed or dealt with. So I just wondered what your experience was, because I didn't quite understand what you were getting at.

M^me^ Turcotte: Je ne peux pas parler pour les autres, mais moi, personnellement, je ne suis pas claire exactement sur ce qui est permis par l'Ordre aux médecins, à quel point ils peuvent facturer des frais additionnels. Puis je ne pouvais pas avoir la liste non plus de l'Ordre des médecins à moins de payer 100 piastres.

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M^me^ Smith: Votre médecin ne vous donnerait pas la liste sans payer?

M^me^ Turcotte: Comme je n'y vais pas souvent, il n'est pas accessible.

Je sais que tous nos clients ne vont pas contester ce que le médecin demande, puis les frais qu'il demande. Ils vont probablement juste les payer sans se demander s'ils sont légitimes, s'ils sont justifiables, parce qu'ils ont bien trop peur de se retrouver sans médecin. Alors, vous pourriez avoir un abus du côté des médecins à ce moment-là.

Ms Smith: That's a concern we have heard about lack of information surrounding block fees, as well as accessibility, feeling that there's kind of a "key money" system, that you have to pay the block fee in order to retain a physician. We've heard those concerns.

I just wanted to ask you as well about the formation of the council. You've proposed that you think they should be elected and that they should be representative of users of the system and experts from various areas in the province, and I totally agree. Coming from northern Ontario, I'm always a proponent for northern representation.

You've also gone on to say that they shouldn't have a financial interest. If we took that strictly, that would include not having nurses, who are probably paid within the system, or not having doctors, who are probably paid within the system. That's not what you mean, right?

M^me^ Turcotte: Non.

Ms Smith: You would allow for those kinds of participation. You're talking more private provider interests?

M^me^ Turcotte: Oui.

Ms Smith: OK. I just wanted to clarify. I think one of my colleagues had a question for you as well.

Ms Wynne: I apologize. I'm going to speak in English. I can't produce it as well as I can understand it.

Two questions. The first one is following up on Monique's question about the democratically elected council. Can you explain what you mean by that? Are you talking about another level of government? I'm just not sure how that would work.

M^me^ Turcotte: Ce qui est proposé, c'est que les membres seraient nommés par le gouvernement. Alors, c'est à ce point-là qu'on s'oppose. On veut que les membres de ce conseil-là soient proposés par des groupes, par les usagers des services, par les régions, par des groupes d'intérêt, pour être vraiment plus démocratiques, pour être la voix du peuple et non un organe d'un gouvernement.

Ms Wynne: The issue being the representation from around the province of various groups.

M^me^ Turcotte: Oui.

Ms Wynne: My second question is a more general question. I take your points. I understand that there's clarification needed.

You made the point that you thought the principles and the preamble were good, so do you think it's a good idea for us to be attempting to put into legislation a bill that would reaffirm our commitment to medicare? Do you think this is a good direction to be going in? Given that there are amendments that need to come, given that there are changes that need to be made to the legislation, which we've acknowledged, do you generally think this is a good idea, or is this something that is not worth doing, that shouldn't be attempted?

M^me^ Turcotte: Il y a tellement d'amendements qui devraient être faits au projet de loi que je suis d'accord avec le monsieur qui a proposé la recommandation à Monique de demander au gouvernement d'arrêter le processus, de s'asseoir, puis de la rédiger selon ce qu'on suggère dans le processus courant, la consultation, plutôt que d'essayer de passer la lecture de ce bill-là avec plein d'amendements qui sont contestés.

Les principes du préambule sont bons, mais c'est loin d'être acceptable dans le reste du texte.

The Chair: Thank you.

ST JOSEPH'S HEALTH CENTRE SUDBURY

The Chair: Now we've got St Joseph's Health Centre Sudbury. Come on forward. Welcome, Ms Ashcroft. You've got 30 minutes to make your presentation. You can use that time as you choose. Any time that is left over after the presentation will be shared among the three parties equally. This time around we'll be starting with Ms Martel and the New Democrats asking the first question.

If I can get the members' attention, the floor is yours.

Ms Margaret Ashcroft: Good afternoon, ladies and gentlemen of the standing committee on justice and social policy on Bill 8, the Commitment to the Future of Medicare Act, 2003. St Joseph's Health Centre Sudbury is honoured to have this opportunity to provide you with our comments and concerns around Bill 8.

To begin, as the current past-chair of St Joseph's Health Centre Sudbury I would like to take a few moments to provide you with a brief history of our organization. As I am certain you are aware, the St Joseph's Health Centre was created as a result of the Health Services Restructuring Commission in 1997, when they announced the creation of l'Hôpital régional de Sudbury Regional Hospital that has as its goal to move from three current acute sites to one acute site.

At that time, St Joseph's Health Centre was created in order to ensure that the tradition of the Sisters of St Joseph of Sault Ste Marie of providing high standards of health care was continued through the creation of a lay community, a lay community board that now oversees the day-to-day operations of the St Joseph's Health Centre, which is the previous Sudbury General Hospital here in Sudbury. This is done in partnership with the l'Hôpital régional de Sudbury Regional Hospital through a legal contract.

As part of the contract, St Joseph's Health Centre also ensures that our ethics, mission and spiritual and religious care components as a Catholic organization are lived out on a daily basis. In addition, as part of the contract, the long-term agreement is that St Joseph's Health Centre

will manage and oversee the complex continuing care beds currently situated at the Laurentian site. The government recently announced in August 2003 that these beds will be transferred to the new St Joseph's Villa Sudbury site situated at Laurentian University, one kilometre down the road, in order to provide a more appropriate setting for these chronic patients. We look forward to fulfilling our long-term role. Actually, at St Joseph's Villa we had our official opening last Friday, so we were very proud of that.

St Joseph's Health Centre Sudbury supports the overall theme and intention of the Ontario government's Bill 8, the proposed Commitment to the Future of Medicare Act, 2003, the preservation of a universal public health care system in Ontario for the future. Like your government, we too are committed to the five principles of the Canada Health Act: public administration, comprehensiveness, universality, portability, and accessibility. The fundamental values of accountability and improvements to the system are important elements of the philosophy of Catholic health care.

St Joseph's Health Centre aims to provide the highest quality care with respect and compassion to all in need regardless of religion, socio-economic status or culture. We collaborate in open partnerships with other members of the Sudbury community's health care system and are dedicated to voluntary community governance to ensure accountability to the government and to those we serve.

Our organization has more than 50 years of health care history, providing exemplary care for all Sudburians. We have an outstanding record of good stewardship and have taken leadership roles in many areas of need. For your information, it was the sisters who actually built the first hospital in Sudbury more than 100 years ago, and then the second hospital almost 50 years later. We have set high standards in providing palliative and pastoral care, as well as in clinical and organizational ethics that are emulated by other providers. Most recently we identified the need for and we accepted responsibility for building a new long-term-care facility in order to meet the needs of seniors in our community. We are pleased to indicate that this project was completed under budget.

As a Catholic facility we reflect a proven, community-based, voluntary approach to governance. Our board of directors is representative of the cultural, linguistic, socio-economic and religious composition of our community. Throughout Sudbury's history we have clearly stated the intent of the board in Catholic health care to remain an active participant in all sectors of Sudbury's health care system into the future and to work collaboratively for positive change and progress.

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As active participants, we recognize and applaud the government's desire to preserve medicare for the future well-being of all Ontario residents and to a system where public accountability and the shared responsibility of consumers, health service providers and governments are important and fundamental components. Our board also supports the concept of a health quality council.

Catholic health institutions, including St Joseph's Health Centre, are leaders in accountability. We are mindful of the responsibility to ensure that taxpayers' dollars are spent wisely while ensuring that the community has access to the quality health care services required. In fact, in our previous history as the Sudbury General Hospital we always had a balanced budget and did not have a need to request additional operating dollars to fund deficits. Currently, we are participating with the l'Hôpital régional de Sudbury Regional Hospital in their recovery plan efforts to reduce its operating deficit by also reducing our overall operating budget. We feel that, dollar by dollar, this goal can be accomplished. We strongly feel that Catholic health care organizations should be accountable to the taxpayers of Ontario, and we feel it necessary to do our part to ensure this happens.

Having stated our support for Bill 8, we would now like to take the opportunity to address where we believe the bill might be improved in order for it to meet its intent. We are thankful that the minister and staff are open to hearing from their partners in health care such as ourselves in order to try to ensure that Bill 8 is able to meet its goal of a stronger Commitment to the Future of Medicare Act. I will speak according to the way in which the bill is laid out.

Part I, Ontario Health Quality Council: The formation of a new overarching health council provides an excellent opportunity for an unbiased body of experts to review all aspects of the health care system. However, as it is described in Bill 8, hospital board members and hospital executives are currently excluded from representation on this council. Bill 8 states that the Lieutenant Governor in Council is to have regard for the desirability of appointing experts in the health system to the council. According to Bill 8, these people would be experts in areas of patient and consumer issues, health service provision, governance, accountability and public finance, and there should also be persons from the community with a demonstrated interest or experience in health service as members.

All hospitals and long-term care facilities and services within Ontario have community members who have been elected from local residents to serve on their boards of directors. We would therefore recommend that we, as members of boards of health care facilities, be considered for inclusion on this council.

Part II, health services accessibility: St. Joseph's Health Centre Sudbury commends the government on its commitment to prevent two-tier medicine, extra-billing and user fees. However, part II of Bill 8 appears to jeopardize arrangements between hospitals and some of the physicians that hospitals currently pay directly, such as pathologists, hospitalists and on-call physicians.

This is inconsistent with the Health Insurance Act of Ontario as it exists today and it could create a problem in hospitals if physicians are not paid their salaries. It is important to change these portions of the act since it is already difficult for many hospitals to obtain the services of physicians. We therefore recommend that parts of Bill

8 be clarified in terms of how it interacts with the Health Insurance Act.

Part III, accountability: St. Joseph's Health Centre Sudbury supports the underlying principles of sections 19 and 20 of part III of Bill 8, which set the foundations and definitions for accountability within Ontario's health care system. We applaud the government for its leadership in this area. We note and support especially "that accountability is fundamental to a sound health system" and that accountability should consist of: clear roles and responsibilities; shared and collective responsibilities; transparency; quality improvement; fiscal responsibility; value for money; public reporting; consistency; trust; reliance on evidence and a focus on outcomes.

However, we have difficulty with part III of Bill 8, where it outlines methods for achieving this most important goal of accountability. Rather than facilitating accountability, we believe that Bill 8, as drafted, gives the Minister of Health and Long-Term Care direct and strict controls over health care providers and powers that may substantially interfere with the governance of health care organizations. These provisions make the existence of voluntary hospital boards irrelevant and effectively eliminate Catholic health care in Ontario. For Catholic health care organizations, a major role of our board is to ensure that not only are the legal and professional standards of care upheld but also that the values and mission of our institution are lived out on a daily basis.

More specifically, our areas of concern are as follows. First, part III represents a significant and fundamental shift in direction for the health care system in Ontario from one of non-profit, charitable organizations with accountable voluntary boards that are created from elected community members to a system of government agencies. As a voluntary board, we work hard on behalf of the Sudbury community we serve and we do not welcome the possible takeover by the provincial government of our work. We feel that changes are necessary to Bill 8 that would not negatively impact on volunteerism and the fundraising efforts of our board.

In addition, the wording of the bill indicates that the health care sector would become accountable only to the Minister of Health and negates the need for community boards. This does not ensure openness nor accountability to the community we serve. While Bill 8 has very serious implications for the governance of all hospitals and many other health care facilities, if passed as currently drafted, we feel it would eliminate Catholic health care in the province of Ontario. The voluntary nature of governance and our sponsors' responsibilities for that governance is a fundamental tenet of Catholic health care and, without it, all Catholic hospitals, long-term care and mental health services would cease to exist.

We wish to remind this government of the ongoing commitment from all three provincial parties to the mission of Catholic health care and our governance structures. These commitments have been reaffirmed frequently throughout Ontario's history, including most recently from our Premier, Mr McGuinty.

Second, this bill would require organizations to sign accountability agreements. This would seem to be contrary to the principle of limited liability that excludes personal liability for signing officers of corporations. Rather, according to the Public Hospitals Act of Ontario, volunteer board members should not be held liable if they act "in good faith." Our fear is that many strong and dedicated community volunteers would resign from our hospital boards for fear of personal liability, including fines upwards of $100,000.

In addition, by having the accountability agreement signed by the institutional CEO, the bill would have the CEO report to both the board and the minister. The bill also would have the minister able to unilaterally change the terms of the CEO's employment contract. This is in direct interference with the governance process through the board's dealings with our only employee, the CEO. In our experience, the term "agreement" does not mean that one party can unilaterally impose terms on another party. Rather, in our experience, entering into a contract mutually agreeable to both parties is not only sound business but is also in accordance with contract law that stipulates that parties must enter into a contract freely.

Third, regarding privacy, there are several provisions within Bill 8 that allow for disclosure of personal information that is contrary to existing privacy legislation as well as to Bill 31, the Health Information Protection Act, 2003. We would recommend that these be clarified, amended and harmonized with other privacy legislation.

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Accordingly, we believe that many portions and provisions in part III need to be considered for refinement to ensure continuing progress and improvement in the health care system and healthy and co-operative collaboration among all parties. We also believe that a series of incentives for boards and hospitals to meet mutually agreed-upon goals and objectives will serve to encourage improvements to the system in all areas, including accountability, accessibility and quality patient care, compared to imposing punitive fines.

On behalf of St Joseph's Health Centre Sudbury, I would ask the members of the standing committee on justice and social policy to give serious consideration to our recommendations and comments.

We support the government's priority and commitment to ensuring that medicare is protected for now and for the future. We are concerned, however, that the rights and responsibilities of local communities, as demonstrated in the role and nature of voluntary boards, may be removed or vastly changed if sections of Bill 8 become law. As we noted early in our submission, removing voluntary boards from responsibility for hospitals and other health care organizations would effectively eliminate Catholic health care and its proven history of commitment to Sudbury and Ontario residents.

We want to make it clear that we are prepared to continue to work with the government and our local community partners to ensure that we remain true to our dedication to accountability, accessibility, integration and

system improvement, and the preservation of a universal public health care system in Ontario. We urge that Bill 8 be amended to allow us to continue to provide high quality health care to Sudbury's residents.

In closing, congratulations on your efforts for drafting a bill that is committed to the future of medicare for our community and province. We thank you again for this opportunity to provide input. I welcome any questions you may have at this time.

The Chair: Wonderful job. Thank you. You used up about 18 minutes, which means we've got 12 minutes left to ask you questions, which gives four minutes to each party, starting with Ms Martel.

Ms Martel: Let me start on the conclusions. You've referenced this throughout the text. The end of paragraph two: "Removing voluntary boards from responsibility for hospitals and other health care organizations would effectively eliminate Catholic health care." If I go to the bill, and I just want to be sure that I clearly understand this, this is because in your view the accountability agreements that would be set up would effectively have your volunteers just leave. They would not want to be party to liability that might come if they can't meet the terms and conditions in the contract stipulated by the minister. Is that part of the concern?

Ms Ashcroft: Yes, that's part. The other part too, Ms Martel, is that when the boards are appointed to Catholic health care hospitals/institutions, we do have a policy of having the proposed community members look at our values and our mission and everything else. If that is not in agreement with their values and missions, then obviously it is negative on ours; therefore we do have a choice of who we have on our boards. Obviously if it's a Catholic health care system, it doesn't necessarily have to be Catholics who are on the board, and in our case we do have people who are not Catholics on the board. That's not the issue. The issue is that it's people who we can appoint who have our vision and values and mission.

The other area with them would be that if there was a liability issue, then those of us—we're all volunteer members. We're all community members on that board. We have the insurance that covers us, but we're not personally liable. Therefore, if you think that for any decision that's been made you're going to be personally liable, then who would really want to sit on a board under those circumstances?

So there are two parts to that, Shelley, and I hope I answered them.

Ms Martel: I suppose a third one could be that—and this may appear to be extreme, and I'm not trying to up the ante here—you could have a minister putting a provision in an accountability agreement that would either violate or not be in keeping with the principles under which you operate. So that would be a third area where in fact some of the conditions outlined in the agreement would be ones that you just couldn't live with.

Ms Ashcroft: That's a possibility.

Ms Martel: OK. So in terms of the changes, there are a number of changes that we understand the minister is going to propose. We're not sure what they are yet. That's coming, and we hope that comes sooner than later so we can deal with that. Do you have some suggested changes through that section that would make you more comfortable, or do you really think that the whole section perhaps needs to be done again from scratch so that we address some of these concerns?

Ms Ashcroft: I think, and as we showed in our presentation, that we can take what is proposed and we can sort of enlarge it or remove some of the things that are in there. For example, it's very important in communities that community members be on the board and not just appointed. People could just apply. You see an advert, "Please send in an application to sit on this board." Well, there are people in our community who will go on boards because they truly, truly believe in what they're doing. There is a possibility that if it's left wide open, people would just go on the board to say, "Oh, I'm on such a board. I'm on such a board. I'm on such a board." In our case, we truly believe in Catholic health care in Ontario, and as a result, that is our underlying reason for being on the board of, for example, St Joseph's Health Centre.

The Chair: Thank you, Ms Ashcroft.

Ms Smith: Thank you, Mrs Ashcroft. I really appreciate your presentation today. It was a great presentation. I'd just like to address some of your concerns.

Yesterday when we started these hearings, the minister appeared before the committee and gave his views on how he hoped that this would move forward. He also stated that he in fact was apologetic about the tone of the bill and that it may not reflect exactly what we're striving for. So we appreciate your input. I'd like to give you a copy of his statement before you leave so that you can see what proposals he's talking about that we will be bringing forward.

One of them has to do with—and I'm just going to go really quickly through your presentation. You spoke of the representation on the Ontario health council and recommending the inclusion of boards of health care facilities. In fact, in subsection 2(7) of the act, we talk about "A person who is a member of the board or a senior staff member of a health system organization...." That will be further defined in amendments. The "health system organization" is actually stakeholder groups or the colleges. So what we're looking at is precluding representatives of the stakeholder groups from being on the council, because we don't want it to just be a council of vested interests, so to speak. We would prefer to have a much broader representation on the board and, as I've been saying all along, certainly representation from regions in the province so that our northern communities are represented as well as a number of various types of stakeholders generally—users of the system, people who have worked in the system, board members. I think we are looking at all of that.

With respect to your part II, where you talk about the arrangements between hospitals and some physicians, we've heard those messages as well, from the OHA and the OMA. We're looking at section 9, and we're looking at language to address that.

With respect to page 6 of your presentation, you say, "Bill 8, as drafted, gives the Minister of Health and Long-Term Care direct and strict controls over health care providers and powers that may substantially interfere with the governance of health care organizations." And then you go into some detail.

In his statement yesterday, the minister did specify that the accountability agreements will be between hospitals, long-term-care facilities, CCACs and independent health institutions and that the agreements will actually be between the boards and the ministry. That again is where I think the tone rang through. There was in no way an intention of this government to usurp the authority of boards in administering the hospitals. I think that too will hopefully address your concern on governance issues. The boards will be asked to enter into negotiations and discussions on accountability agreements, but we won't be pushing the boards aside or anything like that. We're not dealing with governance issues at all, so your governance structure will remain in place. You'll be expected to enter into negotiations on these agreements. As a corollary, there'll be a performance agreement between the CEO and your board that would hopefully reflect the accountability agreement that is entered into between the board and the ministry.

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I think I've dealt with most of that. We do hope to elaborate on the process for reaching these accountability agreements. You did raise some concerns about the process. We hope to have some elaboration of that in the amendments.

Again, you touch on a series of incentives for boards and hospitals to meet their goals. Certainly that's part of the process that we hope to be looking at; not just accountability but also incentives, so we can use the limited resources we have to their best possible outcomes.

I thank you very much. I hope that addresses some of your concerns. I'm sure I've run out of my four minutes.

The Chair: You did, by eight seconds. Mr Wilson and Mr Klees, four minutes and eight seconds.

Mr Klees: Thank you, Ms Ashcroft, for your presentation. I want to congratulate you on how effectively you have couched your presentation. You have made the point of where you disagree with the government, but you were so very careful to compliment them on their attempt. I'm sure that was appreciated by members of the government here.

Ms Ashcroft: Thank you, but universal health care is something we all want, right?

Mr Klees: Absolutely.

Ms Ashcroft: There are lots of parts of the bill—

Interjection.

The Chair: You have the floor, Ms Ashcroft. Go ahead.

Ms Ashcroft: Why would we come here and say all the negatives things? My cup is usually half full.

Mr Klees: The spirit certainly was appreciated, I'm sure.

I would like to speak to something specific. At the top of page 7, you refer to your concern about the effect this bill would have on voluntary boards and volunteerism, the implication for liability, and that effectively there would be a very negative signal to people who work and take very seriously, as you say, their dedication to this.

I'd like to take this one step further, because not much has been mentioned around the table here about the impact on foundations and the good work that foundations do in the province. With the signal here in this bill that effectively the minister is now going to take over the board and the very strong signal that the volunteerism here really is not being appreciated, that there are serious liability issues, what impact do you think this bill might have on the work of foundations around the province, and specifically in your case?

Ms Ashcroft: I can just refer to Sudbury. We have just set up a new foundation for the Sisters of St Joseph and also for the villa. The foundation is composed of, I'll use the word "prominent," members of the community in Sudbury—prominent in that they are involved in so many different aspects of our community, and as a result they can bring to that foundation their expertise. Basically, the foundation's job is to raise money. These people know who they can approach.

I'm actually delighted that Monique Smith mentioned that this is going to be relooked at and revisited, so some of those concerns I hope will be eliminated. But if you take it to the nth degree, they would be appointing people to foundations who probably do not know the area and do not know whom to connect with, whom to network with. We've been quite successful in that because of the people we've put on our boards.

Mr Wilson: Could I just make one quick comment?

The Chair: Very briefly.

Ms Smith: If he does, I want to, too.

Mr Wilson: Both of my great-aunts were Sisters of St Joseph: St Frances Regis—Sister Frances Regis; she might be a saint by now, although if God looks at me, I think she'd have a hard time getting there—and Sister Mary Ellis. I just want to say that since you did point out that the Liberals are in favour of Catholic governance, so are we, and we'll stick by you on that. You're right; all three parties have been through this. It seems to cycle itself about every seven years or so. Good luck to you.

Ms Ashcroft: Thank you.

Ms Smith: I just want to clarify—and I had it in my notes—that section 30 addresses some of the issues around liability of board members. If you want to take a look at that, we're happy to hear more submissions on that if you don't feel it goes far enough. As well, after the session, I think we can talk to you a little bit about Bill 8 and Bill 31, the interchange on privacy. I'm sorry I didn't give my colleague time to respond.

The Chair: Thank you, Ms Ashcroft, for coming today.

DAVE WILEY

The Chair: Our next delegation is Dave Wiley. Good morning—good afternoon, Mr Wiley.

Mr Dave Wiley: It's afternoon already.

The Chair: We haven't seen outside in a few hours, so we don't know what's going on out there.

Mr Wiley, are you here on behalf of yourself, as an individual citizen?

Mr Wiley: Yes, I am. I'm here on behalf of myself.

The Chair: Wonderful. I think you're the first citizen we've had today. Everybody else has belonged to something.

Mr Wiley: We're all citizens, in one way or another, aren't we?

The Chair: That's right.

You've got 30 minutes. You can use that time any way you like. At the end of your presentation, we'll share the remaining time among the three parties to ask you questions. It's 3:39, and the floor is yours.

Mr Wiley: It's a real pleasure as a citizen and, I will say, a retired member of the health care community, to be able to present before you today on Bill 8. It was very difficult trying to decide where to go and what to say. I had so many thoughts. I'm going back and revisiting my 30-plus years of experience as a clinician in the mental health system. I've tried to keep things short and fairly pointed. It won't be couched necessarily in nice, warm fuzzies, but some of my comments will be very clear.

This experience gave me the opportunity to start looking a little bit at the Romanow report, which I never had time to do. Now that I'm retired, I do have time to do some of these things. I looked at the three principles in the preamble of Bill 8: universality, comprehensiveness and accessibility. We've all had our own particular understanding of what we thought those terms meant. I discovered that those terms are not quite as specific as I would like to have thought. We look at universality, and one of the things Romanow referred to is that it isn't necessarily achieved through public funding. I always really expected that universality of access to the health care system in Ontario and throughout Canada would be through publicly funded services, and I think the public generally believes that too.

In terms of comprehensiveness, some of the words in there that really bothered me tremendously were "medical necessity." I think there was acknowledgement that how to determine medical necessity was a difficult task. Each of the provinces and territories make their own determinations on what they see as medically necessary. Those decisions usually are made between governments and medical associations, without a lot of input from target populations, that is, citizens.

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It also reminded me that back in, I think, the early 1990s, Dr Dorothy Pringle, from faculty of the school of nursing, started what I think may have been the first delisting committee. I searched feverishly for my address to that committee many years ago. I thought it would be someplace in my archives of information, but I could not find it. I do recall sort of questioning and challenging: "What is the journey you're about to embark on? Where is it you're going with this? How far do you want to go, and what are the rules along the way?" The one example I do remember commenting on was the notion or idea of delisting port wine stain after a certain age. I don't know what happened with that, but I really felt that some of the northern folks with young children with that particular condition may not have real accessibility to those specialists in the health care system within a timely manner. I thought, "If we delist, maybe it's fine. It sounds good. Maybe it's good down in the Toronto area. But what about northern Ontario and other people who have certain issues with accessibility?" I don't know if anyone has come to terms with what provides a clear definition of "reasonable access." The real issue here seems to be timely access, and that's a very difficult situation. Things have slowly eroded over time.

I can give you a local example, a personal example, which I don't mind giving at all. Last September, I asked my family physician about an arthritic knee. Being a competitive soccer coach, it's somewhat problematic for me to be out in the field with young kids, training them with an arthritic knee. I said, "I think I need to see an orthopaedic fellow," and he said, "Sure, no problem. We'll refer." He referred in September. A few months went by, and I didn't hear anything. I made a phone call and they said, "We won't call you for at least a year to 14 months." I said, "I didn't know that. That's awful." I made a few calls, looked around and found an orthopaedic surgeon within three weeks in another city, made the trip to the other city and got the consultation. He gave me a recommendation of physiotherapy—that was one recommendation among a few others. I said, "It sounds good to me," and went back to my family physician, who gave me a referral for physiotherapy. He contacted the local hospital-based physiotherapy service. They assessed the condition as being a chronic arthritic condition. They said, "Maybe six months, maybe a year; it's hard to say. We're still dealing with the wait-list from 2003."

How did this all come about? It came about by a reduction of staff. They don't have the physios any more in the public hospital-based system that they had a few years ago. If you have insurance benefits, you get physiotherapy within a matter of days. So, timely accessibility certainly has to be on the agenda. I know this bill talks about those three principles, but in some way it needs to be a little clearer as to what the direction is and where things are going.

I had a question at the very beginning, in terms of trying to put together this presentation, and that is, what path or direction are we taking in health care policy? That doesn't speak directly to Bill 8—Bill 8 is a part of the puzzle; I understand that. If we ever arrive at where we're going with this, what's it going to look like? I don't have a vision of where health care is going to be down the road, and I think that's important. I think where

we're going and what it will look like is also important to all Ontarians. What appears to be the case is that health policy direction in Ontario is following a US model of managed care, with government dictating or controlling what services are to be provided, who will provide them and where it will happen. To date, citizens have had little input or say on these matters, and I think it's important that they do.

That raises the question of why we're chasing a system that's fraught with problems of cost, inaccessibility, accountability and no real solutions, because that's what's happening south of the border. As soon as you draw a line in the sand and say, "This is what we do and this is what we don't do," then you open the door to the private sector of managed care.

Ontario health benefits plans, if one is fortunate enough to have one, have increased 20% to 28% annually over the past years, a tremendous cost increase. How does that work with benefit providers? It's very simple. In the previous year, if a company pays out a million dollars, they take their 8% to 12% or 13%, add that on, divide by the number of plan members and that's the new premium for the following year. Costs are recovered very quickly. For me it's important to understand that shifting costs from publicly funded systems to the private system does not—I repeat, does not—reduce the cost for the citizens of Ontario; in fact, it adds through duplication of services. Citizens pay for those services that one cannot access in a timely fashion, and then they have an option of being able to additionally pay more money for services they can pay for or pay for through a benefit plan if they contribute to that.

I'll give you an example of a non-profit managed care provider. I had this absolutely phenomenal experience. It was something where you kind of think you know what it's about, but you don't until you're right there. It was with Kaiser Permanente, one of the largest, if not the largest, providers of managed care in the US. It was a very revealing experience that was conducted in a workshop a number of years ago. We got to role-play, and I jumped right in there. I wanted to role-play this so bad, because I wanted that experience. I got to be the clinician—I was a clinician, and I thought I was a good one.

It was a situation with a single mom with three kids. She was working but struggling. She lacked energy, and it was hurting her work performance. There was a history of specific trauma. She was anxious, fatigued, had difficulty getting the kids organized, off to school etc, was receiving pressure from the educational system, was receiving pressure from the employer etc to produce, produce, produce. In role-playing this, I thought I came up with a great proposed treatment plan that included a nice assessment protocol, very simple: a request for six sessions to be paid. I thought we could do some good work in a short period of time. Cost-effective, efficient, effective etc—sounds good. Well it was flatly turned down. I was kind of left speechless in front of this huge audience as I'm trying to show my stuff. What happened over the phone is that this individual, who didn't have any contact with the client, just through me, the clinician, said what we will approve is five sessions where she goes on a parenting course. Well, the arbitrariness of those decisions, when you get into controlling what services are being provided and what aren't, has its problems.

I think my point is clear: We need to be clear about who's making decisions regarding the delivery of services. I personally don't support any plan that allows an increase in private sector opportunities into the publicly funded provincial plans. I just think we can't afford it, simple and clear.

Let me move on to the Ontario Health Quality Council. My understanding is that the proposal in the legislation as it is written now is that there be nine to 12 members with (1) experts within the health care system, (2) experts in governance, accountability and public finance, and (3) persons from the community with a demonstrated interest etc. The word "expert" kind of scares me. As a clinician, I've always prided myself on never, ever being the expert. Experts in people's problems are usually the ones who come to you looking for some assistance.

Around this table you could probably find more examples than I could ever begin to find about experts, expert advice and expert direction. But two come to mind: One is the corporate directors and board members from Ontario Hydro who are experts in business and, more specifically, the utility sector, who plunged the citizens of Ontario into extreme debt. Those experts dropped the ball big time.

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Another example from a few years ago is with the introduction of the EQAO testing in the school systems. I remember being on the phone I don't know how many hours, saying to people, "Three hours of testing for eight-year-old kids, 10 straight days in a row is wrong. Common sense says it's wrong." I don't think I could do it. I don't think any adult could do it. I think it was wrong. The testing protocol was wrong; the experts should have known better. So "expert" never leaves me with a good feeling.

Experts have their place, but so do the citizens of Ontario, because they're the experts in what they need and what they want and how it ought to be delivered. Obviously, the EQAO testing protocol was a recipe for reduced performance by those eight-year-old kids. Later, when the protocol was improved, there where claims that the new curriculum was working with the rise in the test scores. The better scores were probably reflective of the changed protocol and, most likely, the teachers' familiarity with the new curriculum.

So what do we have now in terms of quality out there, in terms of need for a quality council? We have our district health councils and their advisory functions. They do an admirable job. There's the Canadian Institute for Health Information—I've looked at some of the work that they have put out; they do an excellent job. The Canadian Council on Hospital Accreditation, I think it's

every three years, looks at the quality and accredits hospitals as to whether they are doing a good job. In the last number of years they have included a very clear protocol around quality assurance issues and how to organize the hospital community into one that's constantly and vigilantly reviewing how it does business.

Then there's the Institute for Clinical Evaluative Sciences who, along with the University of Western Ontario, the Centre for Addictions and Mental Health, the University of Toronto grad studies in rehab science, the faculty of nursing, the University of North Carolina, and Wilfrid Laurier, who all collaborated to produce The Hospital Report. I'm not sure what it would have cost for all those people to collaborate and bring some of this stuff forward, but in looking at the paper the other day, when I see that the ice machine breaks down and the kidney dialysis unit can't even provide ice and juice any more and we've got this kind of stuff going on, I'm saying, "Where's the money going? To the wrong place. To the wrong people." Get it back to the direct services, the people in the province of Ontario.

Then we can go to the OHA. They talk about believers in timely access, one of the fundamental principles in the preamble and in the Canada Health Act. That's not happening. They see themselves as leaders in accountability and quality care in our hospitals. It doesn't seem to be happening. Recently in the Sudbury Star, February 11, the president and CEO of the OHA announced warnings of bed closures as hospitals are facing a $420-million deficit.

So how did these services really occur within our system? It's been a very simple matter. Year after year there's underfunding to that system. There are increased costs, whether it be for drugs et cetera. It puts tremendous pressure on the system. In order to balance the books services are cut. Front line health care professionals are laid off. That's why there's not as many physios in our hospital here in Sudbury today as there were a few years ago. That's how services in remote communities in northern Ontario will be reduced in terms of the services available.

Quality, for me, has always been the responsibility of that individual service provider right up front. I took that very seriously in my 30-plus years. It doesn't matter if it's a physician, physio, speech and language pathologist, but the regulated professionals pay hundreds of dollars annually to practise in Ontario and fall under the scrutiny of their regulatory colleges. I had an experience recently—in fact I've had a few since my retirement, running into people who I saw, families in therapy, many years ago. The operative words here are "many years ago," because they say, "Do you remember me?" I say, "Yes, I do." He says, "I have to tell you, my son is a graduate of York University," or Trent University or the University of Western Ontario. "He's done this and than. Everything has worked out so well; I'm so grateful to you and the services you provided." The services I provided at that point in my life were very clear. They were very patient-focused, very patient-directed. I met with their needs at that time. It wasn't somebody telling me what their needs were. It wasn't somebody telling me how to provide service to those people. I took the responsibility seriously and I'm very concerned that, with more control of the issues, more accountability factors built in, that less vigilance by individual clinicians will take place in the future.

I probably could go on for another 30 minutes; I'm not sure how my time is right now. Let me say in summary that I want to return to my original question and ask this government, including all parties, to come to a clear consensus as to the direction of health care policy in Ontario and outline the specific incremental steps that are necessary to get the citizens of Ontario to where we need to be. That seems to be the real task here. I guess I'm also saying I'm not so sure that a health care quality council with experts and a few citizens is necessarily where we go. I think we have the infrastructure, but I think we need to start moving away from some of these structures and organizations in and around health care and get more of the dollars back into those direct services to be able to provide to the people of Ontario. Thank you very much.

The Chair: Thank you, Mr Wiley. You used up about 20 minutes. That leaves us with about 12, so we'll go with four each. Mr Delaney, from the Liberals, first.

Mr Delaney: Thank you very much, Mr Wiley, for your very interesting presentation. It brought to mind something one of my professors once said in class while I was learning physics as an undergrad. He too talked about the definition of expert and, very much like you, was a little sceptical about experts. He said, "You know what an expert is? X is an unknown quantity and spurt is just a little drip under pressure."

I think it's in that vein that the minister has struck the council. It allows him to gain access to a broader spectrum of input than he would otherwise gain from his staff and the people to whom he normally reports. Of course, the idea of having the membership change and revolve allows that representation to be refreshed. I think the idea here is that the council reports annually through the Legislature, which allows those of us who are in the Legislature to see the reports, to debate it within the Legislature and, of course, the report becomes a public document. The council reports, I think, are intended to encourage continuous improvement in the quality of Ontario's health system.

Among the areas that it might report on would be access to publicly available services, which would include the waiting times that you mentioned, the availability of health care professionals—something which we acknowledged through the election we have got to spend a lot of time working on. There just aren't enough professionals in the system to deliver the care. This is a long-term problem. We'd love to be able to turn it on and off like a tap, but I don't have to explain to you, with your background, what a long-term problem it is. If there are any other of my colleagues with a comment, over to you.

The Chair: Kathleen, you've got about a minute.

Ms Wynne: OK, just a quick question. Thank you for your presentation Mr Wylie. I wanted to ask you to explore for a second—you made a statement that more accountability factors built in will mean less vigilance on the part of individuals. Now, you understand that the accountability agreements would be between the minister and a board of a hospital, not an individual. Can you just talk to me about how you see that working, that more accountability leads to less vigilance? Because obviously the intent would be the opposite, right?

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Mr Wiley: I'm not sure I fully understand exactly what the minister means in terms of the accountability agreements and what those things would look like.

Ms Wynne: So they need to be laid out.

Mr Wiley: It does need to be laid out. But I guess my only concern is that when you start holding people accountable and saying, "This is what you do: (a), (b), (c), (d)," they're not open to doing (e), (f) and (g). If that's the kind of accountability that gets passed on down to the front-line regulated professional, that becomes problematic.

On the other hand—I'm going to be fairly blunt—if accountability agreements are tied to performance, those are obviously problematic for me because I'm not so sure that as an individual front-line clinician I would want to take full accountability for my performance constantly when I am working in an environment that has no controls over socio-economic policies and their effects on health care and a lot of other government policies. But I get to hold the bag at the end of the day.

If those accountability agreements are such that when the dollars don't seem to be there, instead of cutting services perhaps there are other options so services aren't cut or the front-line people aren't laid off—perhaps some of the salaries and remuneration of other people within the health care system, that is, managers, CEOs and other directors, are going to need to be pared back and they carry some of the burden and the responsibility within that system to be able to provide services to the people, but not cutting back on services. I'm not sure if that really is helpful at all.

Ms Wynne: That's helpful. Thanks.

The Chair: We'll go to the PCs.

Mr Wilson: Mr Wiley, your comments are much appreciated, with 30-plus years' service. It reminds me of a story a paramedic told me when I was going with him as my mother was going to Newmarket hospital last Tuesday. Anyone can check the records if they want. She just had to go to the fracture clinic, so it's not terribly bad.

Casino Rama in Orillia is just next to my riding. This paramedic came down from Collingwood. He said, "Our number one call at Rama is not with the patrons at the casino; it's the dealers, because of the stress." Their accountability environment is they have a camera above them on their 12-hour shifts and they have nervous breakdowns—what I would call nervous breakdowns. You, in the mental health area, would understand that. We've heard some things about that. We've heard CUPE people today say, "If our people are so worried about their contracts or they're so worried about Big Brother, they can't do their jobs."

We all agree with accountability and it sounds great in an election. Over your 30 years, you've seen all three stripes of government try to bring in new visions, new bells and whistles for accountability. This is the first time the minister has decided that he's going to go into a volunteer board and at least give himself the power to do anything that board can do under law, including hiring and firing the executive director.

If you had your druthers, what would you rather we concentrate on? I think you said front-line services versus accountability and paperwork. I think people might want to take the paramedic's story into account, in that if you're really going to micromanage the system, you're going to drive the front-line workers batty.

Mr Wiley: Absolutely. I couldn't agree more. I would think there's tons of stress within that system, and being held more accountable all the time—it's not just being held accountable. There's nothing wrong with being held accountable. The one thing that got me through 30 years of that pressure cabin you work within, with very difficult decisions—and life-and-death decisions too, in the mental health area—is that I was accountable to the people who sat in the room with me. That was my number one prime accountability.

I had to turn my back on others. There was probably more than one occasion when I told senior types within the organization, "Just don't mess up. Just don't make things more difficult for me. Help make things easier or simpler." But my accountability has always been to clients. That's got to be number one. I think you'll find in Ontario most of the regulated professionals by far are very skilled practitioners who are accountable and believe the same as I do, that their number one and prime accountability is to the clients. That should never be put in a controversial position with accountability to an organization and the organization's vitality. It needs to be clearly going to the clients themselves. I'm not sure if that answers the question.

Mr Wilson: We're not quite sure what "accountability" means here, so your answer is as welcome as the government's.

The Chair: Thank you.

Ms Martel: Thank you, Mr Chair. Congratulations on your retirement, Dave.

Let me just focus on the council. I had a discussion with the minister about this yesterday, and I've heard some government members say this is key in terms of how the government is going to be accountable for improvements to the health care system. You rightly pointed out that there are a number of organizations that are already producing reports about the state of health care in the province now and have been doing so for a long time: DHCs, ICES. The public health unit here produces a report called PHRED that looks at indicators of obesity and heart problems etc. Cancer Care Ontario—

I've used this example a couple of times—produces reports on waiting lists in the province. Hospitals produce reports and report cards.

But that doesn't mean that anything is done to address the concerns that they raise. For Cancer Care Ontario, for example, the auditor's report in 1990 made it really clear that Cancer Care Ontario was not meeting waiting times for getting timely cancer treatment; that the standard is four weeks, and most people were waiting 12 weeks at the time. I don't know what it is now, but I'm assuming most people still aren't getting cancer treatment in four weeks.

The concern I have is that while the government's rhetoric has been that this council is somehow going to improve health care, there is nothing here that forces the minister to respond to whatever they produce. There is not even anything here that says there is going to be one single second of debate about this report when it's actually introduced in the Legislature. The Environmental Commissioner now produces an annual report, and the Legislature doesn't debate it for one second. So I've got some real difficulty looking at this health council and saying to myself, "This is something that's going to produce some accountability," especially on the part of the government to respond to waiting lists, to respond to whatever comes forward in terms of what the council actually looks at.

Tell me again, as you read this, do you think there is anything here with respect to the work that these fine people are going to do? I don't want to knock the people who are going to come forward, but what is it that they're going to do that's going to make the government accountable for improving the state of health care?

Mr Wiley: Well, those are very good questions. My first thought, as you were asking the question, was that I think a representative from the Liberals, Conservatives and NDP should all sit in a room with a facilitator. I think you guys should really come together very clearly for the citizens of the province of Ontario and come up with how we are going to deal with this kind of an issue. That's non-partisan, and I think that serves the people, and serves them correctly.

If there is an opportunity for a health care quality council to do something that's worthwhile, I'd be the first one to back it, not a problem. I'll submit my name as one of those citizens, non-experts, to contribute to it, and I would be proud to do that.

But there are so many organizations right now. There are literally hundreds of thousands of dollars—actually, I'm going to say millions of dollars—of clinicians' time being spent right now in just that hospital accreditation process with the Canadian Council on Hospital Accreditation. It's huge the amount of time that goes in that, just to be able to get a certificate at the end of the day every three years that says you're an accredited hospital in terms of quality.

There are structures in place. If this is something new, and it can be devised that it can be additive, that there's added value to this, I don't see it as a problem. I don't even see it as a big expense necessarily, but there are some tremendously expensive structures in place in organizations right now. I think they need to be cut and slashed, not the front-line services to the people of Ontario. I guess that's what I'm trying to say.

The Chair: Thank you, Mr Wiley. We do appreciate your coming.

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RURAL AND NORTHERN NETWORK, NETWORK 11

The Chair: Our final presentation of the day is from the hospital network—that's either 11 or 2.

Mr Joe Pilon: It's 11.

The Chair: The spokesperson for that group is Joe Pilon. Mr Pilon, welcome. You have somebody else with you, obviously; if that person would introduce themselves for Hansard when you start. You have 30 minutes. You can use that time any way you like. Any time that is left over after the presentation will be divided amongst the three parties in equal amounts. It will be the Progressive Conservatives' turn to start the questioning. The floor is yours. It's 4:14.

Mr Pilon: Thank you very much. Good afternoon, ladies and gentlemen, and thank you for this opportunity to address you today. My name is Joe Pilon. I'm the CEO of the Espanola General Hospital and the Blind River District Health Centre, two hospitals in small communities west of here. This is Tom Querney, who is the chair of the board of the Sudbury Regional Hospital. He will be helping with this address as well.

I am here today as the spokesperson for network 11 of the Rural and Northern Network. I'd like to just tell you what that network is about. It includes six hospitals and two CCACs: the Sudbury Regional Hospital, the West Parry Sound Health Centre, the Espanola General Hospital, St Joseph's General Hospital in Elliot Lake, the Blind River District Health Centre and the Manitoulin Health Centre, which has two sites, one in Little Current and one in Mindemoya. The two CCACs that are members of our network are the Manitoulin-Sudbury Community Care Access Centre and the Algoma Community Care Access Centre. Many of the hospital CEOs and board chairs are with us in the audience today.

That network was formed in 1999. It was part of the rural and northern health care framework, which was recommended by the health services restructuring committee and endorsed by the Ministry of Health and Long-Term Care. Our mission is to explore operational efficiencies and coordinate patient flow before, during and after hospitalization.

Today I really just want to focus on two areas in part III, the accountability part of Bill 8. I'd like to talk about the alternatives to accountability agreements, and then Tom will talk about the impact on the independence of voluntary hospital boards.

The members of network 11 support the government's attempt to provide accountability in the health service

sector. We are mindful of our responsibility to ensure the taxpayers' dollars are spent wisely while ensuring that our communities have access to the quality health care they need. However, we believe that the accountability agreements and compliance directives, as proposed in the current bill, are not appropriate ways to achieve these goals.

Firstly, the members of network 11 are concerned that the proposed legislation does not define the parameters within which the Minister of Health can force a hospital to sign an accountability agreement. According to section 21, entering into the agreement is done by direction and not by mutual purpose or negotiation. As well, there is no appeal process for a hospital that feels it does not deserve to be party to such an agreement.

In his speech to the standing committee yesterday, the Minister of Health outlined the goals of Bill 8. Minister Smitherman stated that the bill will protect essential health care services and preserve the sacred principle that Ontarians should have access to medically necessary health care services based on need. Our commitment in our communities and our responsibility as board members and CEOs has always been to protect essential health care services for our communities and to ensure access to care based on need. We believe that negotiation of the accountability agreement is essential to capture the diversity of our communities and the uniqueness of their individual health care needs.

For most hospitals in Ontario, there are many factors beyond their control that impact the provision and delivery of health care. For example, expenses are outpacing revenues due to the following key cost drivers, and I'm sure you're aware of them: growth of an aging population, cost of new drugs, cost of new technology and diagnostic equipment, recruitment and retention cost pressures.

The wage increases and inflationary pressures currently represent 60% of all of our expenses. In 2002-03 alone, those expenses increased by 14% due to salary increases in union wage settlements. In many cases, these were settled by the courts. Hospitals have no choice but to pay them.

It is not clear with the current wording of the bill what weight will be given to these factors or what obligation the government has to fund these costs. As board members and CEOs, we are guardians of the public trust, and we take that obligation very seriously. The minister and the government have that same obligation, the obligation to act in the public interest. That obligation is set out in section 9.1 of the Public Hospitals Act. We're concerned that that's not in Bill 8, and we think this requirement must not be set aside by that bill. Therefore, the members of network 11 believe that Bill 8 should be amended to enhance the accountability of the government to the citizens of Ontario and more clearly define those situations that will warrant its intervention.

Protecting essential health care services and ensuring access requires adequate resources. The obligation of the government to resource the system as appropriate to the needs of the system is not set out in Bill 8; it should be. It should be set out to ensure shared responsibility and accountability.

Secondly, it will take a complex infrastructure and bureaucracy to implement these agreements, one that the Ministry of Health and Long-Term Care currently does not have. This added cost to the currently financially pressured system will take resources away from direct patient care, away from the patient and into added bureaucracy.

Thirdly, the bill makes reference to individuals in executive functions. Presumably, this means the hospital CEOs.

Today's modern hospital boards operate under the principle that board members establish corporate policy and set the strategic direction for the institution. They have one employee and one employee only. That's the CEO. To him or her, the hospital board members delegate the good management of the hospital's day-to-day operations. All other positions within the hospital corporation fall under the CEO's leadership and direction. In this way, the hospital CEO has only one master, the board.

The accountability agreements proposed in Bill 8 would change this relationship by introducing the possibility of placing the CEO under ministerial control. While we hope that the government will strive to maintain a collaborative approach when dealing with hospital governance issues, it is very possible that the CEO could find him or herself receiving conflicting direction from two masters: one from the community board and another from the Minister of Health in the form of a compliance direction. This would completely undermine the important principle of local input and involvement.

In addition, it appears as though the intent of the bill is to make hospital administrators personally responsible for their institution's performance. In sections 26 and 27, the minister has been given the power to modify and even nullify a pre-existing employment contract negotiated between the hospital board and the CEO. We think this provision will render recruitment of senior managers even more difficult in northern communities.

It has been shown that small and remote hospitals have a difficult time achieving provincial benchmarks due to their inability to consistently maintain the critical mass that creates efficiencies and the isolated nature of their practice. The challenges in a northern community can be daunting to a CEO, and to assign personal responsibility to the CEO and punitive action would make recruitment and retention even harder.

The members of network 11 strongly believe that hospital boards must be free to include in the CEO's employment contract whatever recruitment incentive will work. Furthermore, they must be able to rely upon these negotiated terms. In addition, the members of network 11 believe that any reference that assigns personal accountability to a person in an executive function should be removed from the bill.

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Fourth, the Public Hospitals Act sets out powers for the Ministry of Health to intervene. Section 9 gives the

minister a clear and absolute right to assume and exercise all of the powers of the board and members of the corporation. We believe that this gives the government adequate power and authority to address any governance or management issues of public and government concern.

Finally, it appears as though most of the system reforms proposed in Bill 8 are already being analyzed by the multi-year funding and performance agreement task force of the joint policy and planning committee. This is a partnership between the Ministry of Health and Ontario hospitals through the Ontario Hospital Association. This partnership has been forged to recommend and facilitate the implementation of hospital reform within the broader context of the health care reform agenda in Ontario. One of the deliverables of that group is to discuss and evaluate the face validity of performance agreement templates and the mediation strategies therein, which would be presented by the Ministry of Health. What is different from Bill 8 is that the terms in the multi-year performance agreements would be based on measurable indicators. There would be incentives in place to encourage and reward good performance, along with mechanisms of resolution for bad performance.

Another fundamental difference is that the working group will be making recommendations on relief for hospitals when the Ministry of Health fails to deliver on its obligations.

Myself and other CEOs in the audience are actively participating in these working groups. We believe in and are committed to this process. We recognize the need for system transformation and we want to achieve it. However, the success of this transformation will only be through a mutual belief in and a commitment to the process.

This brings us to our second section, and Tom.

Mr Tom Querney: I will begin by stating that the members of network 11 agree with the government's statement found in the preamble to Bill 8 that a strong health system depends on collaboration between consumers, health service providers and governments, and a common vision of shared responsibility. That is why we are disappointed to discover that the current wording in Bill 8 does not adequately address this direction.

In the first place, section 22 gives unilateral power to the Minister of Health to issue a compliance directive for health providers to change their operations. There is no explicit provision for consultation. The members of network 11 are concerned that this section could be used to undermine the accountabilities undertaken by voluntary hospital boards with their communities.

In his December 17, 2003, address to hospital board chairs and CEOs at an OHA meeting, Health Minister Smitherman valued the significant contribution volunteers make to hospital governance. He further suggested that hospitals need to remain connected with their local communities. We agree with Minister Smitherman's advice. Network 11 hospitals are already responsive to community needs, and we are accountable for our performance.

Community board members have a governance responsibility to plan and direct the delivery of programs based on local need and within the funding envelope provided by the Ministry of Health. But it should be recognized that our northeastern Ontario communities are unique with their needs and challenges. For example, board members in network 11 know that local residents have historically reported higher rates of smoking and obesity, and this translates into higher morbidity and mortality rates than the rest of the province. We also know that our geography, climate and physician shortages restrict access to primary care services, more so than in the rest of the province. We keep these factors in mind when setting the strategic direction for our hospitals. We are accountable to our communities because we live and work there.

The members of network 11 are concerned that a ministerial compliance directive under section 22 may not fully take these factors into consideration. We believe that section 22 should be amended to be better aligned with the principles of shared and collective responsibility, transparency and trust that are identified in section 20 of the bill.

The government should recognize the contribution that voluntary hospital boards make to the health care system. The men and women who sit on network 11 hospital boards are dedicated individuals who devote many hours of personal time and many of whom drive long distances to attend board meetings, to participate in committee work and to further their trustee education, all without remuneration.

The members of network 11 believe that it is only through the involvement of local stakeholders that hospitals can be truly responsive to their community. If the ministry wants to proceed with accountability agreements and directives, then the unilateral powers found in part III should be tempered by adding a mandatory consultation phase. They should be negotiated to achieve buy-in, and the agreements should be balanced by articulating exactly how the ministry will fulfill its accountability for funding the programs and services needed to ensure quality outcomes and achieve better accessibility.

Network 11 board members are also committed to the efficient operation of their hospitals. We all participate in the acute care hospital report card, the largest patient satisfaction survey in North America. We do this because our boards believe in being accountable to the communities they serve and to constantly improve by comparing performance against that of peers. The geographic realities of northeastern Ontario, however, do not always make these goals achievable.

Hospitals in network 11 face a unique set of challenges. These include service delivery issues that arise as a result of travel distances, isolation, inclement weather and transportation difficulties. In addition, our hospitals provide much more than acute care therapeutic services. In some communities, we dispense primary care, long-term care and respite care, and coordinate post-acute community-based services. We are also the source for

diagnostic services, rehabilitation and mental health. We must staff and resource essential services such as critical care, emergency and obstetrics, even when patient volumes are not high enough to achieve economies of scale.

In addition, the lack of post-acute services in some areas delays a patient's discharge from hospital and increases the hospital's proportion of alternate level-of-care days. This adds to system cost and reduces hospital-length-of-stay efficiency measures.

For these reasons, the members of network 11 believe that when hospitals do not meet their performance expectations, they should work collaboratively with the Ministry of Health to determine the cause. We should not be punished, as is contemplated in Bill 8, but encouraged and supported by the ministry to find a solution.

In closing, I simply want to stress the importance and added value of the voluntary nature of hospital boards. The ability to advocate and seek resources to provide quality health care based on local needs is important to network 11 hospitals, and this role supports the government's commitment to the Canada Health Act and ensuring accessibility.

We urge the government to proceed in a more collaborative fashion when trying to achieve greater accountability. Accountability agreements, if they are judged to be a necessary tool, should be negotiated between the parties and not imposed unilaterally. Hospitals are prepared to work with the ministry to set clear performance measures and targets, but they must be bilateral. They should foster the interdependent nature of the relationship between health care providers and government, one that should be characterized by trust, mutual respect and collaboration.

Bill 8 provides a tremendous opportunity to facilitate meaningful transformation of the health system in Ontario. We support the general principles enunciated by the government and believe that success in system change will be through a mutual belief in and commitment to the process. That concludes our remarks.

Mr Pilon: I was remiss, if I could, in describing network 11. I forgot to acknowledge all of the support we get from the district health council here, the Algoma, Cochrane, Manitoulin and Sudbury District Health Council.

The Chair: Each party has five minutes to ask you a question, starting with the PCs.

Mr Wilson: Thank you, gentlemen, for your presentation, and I guess, wearing my old hat, thank you for eventually coming together in network 11, since I was the minister who sponsored the authorship of the rural and northern health care framework. I take credit for the good parts and I blame the bureaucrats in the Ministry of Health for the bad parts. What else is new in politics?

Joe, I just want to ask, the only example the minister gave in his remarks to the committee yesterday as to why he needs a performance agreement—and it's one that's sexy for the public—is, "Hey, PCs, you really tried to get the ratio of full-time versus part-time nurses up." He said that's why he needs it, so he can compel hospital boards to correct that, for example. I would think it's more a function of the budget that he gives those hospitals, rather than whether they want to have full-time or part-time nurses, or it may be—and the reason I triggered it was the volumes you mentioned. You have such a diverse region and probably unpredictable volumes throughout the members of the network. Can you see a reason in your area, in all honesty, why the minister would want a compliance agreement there or an accountability agreement or whatever? Is there a problem that really needs to be fixed that you guys have been hiding from the ministry or that you're not playing ball with the ministry on that he as a new minister would within his first four months—within his first three months, actually, was when he first thought of this idea—say, "I have to go after those hospitals. I have to take over their boards"?

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Mr Pilon: I can't come up with a situation in my hospitals that needs that attention.

Mr Wilson: As northern minister for four years, I can tell you that I never read anything on your network that was that bad.

Can you just comment on the nursing thing, though? I know that's maybe more a Toronto-based one because of the volumes of nurses they're dealing with. But that was the only example he has given us to date of why he needs these extraordinary powers. Of course, that sounds good to the public, but, as I said, I think it has more to do with financing.

Mr Pilon: The nursing one can be a challenge in northern and rural hospitals in trying to maintain a baseline of service for volumes that are somewhat inconsistent. To maintain cost controls and flexibility sometimes you need more part-time staff than full-time staff. On the other hand, that creates a recruitment challenge. To try to draw people into the field when there are no full-time jobs is not a great strategy. You have to balance that with your requirement to have a balanced budget and operate within that budget.

Mr Klees: I'd like to just follow up on the issue of the control that the Ministry of Health wants to have and effectively take the control away from the local board. In York region, which I'm most familiar with, we have three hospitals, and there have been numerous times when, due to local stresses and local situations, we've had to effectively do battle with the Ministry of Health to get them to understand the local issue. Being so close to the centre, to Queen's Park, we have a hard enough time trying to get Ministry of Health staff to understand why there should be some latitude in one particular budget envelope and why we need certain accommodations.

I can't imagine what it would be like, for example, for northern Ontario to get the Ministry of Health officials, as well-meaning as they might be, to understand the nuances of the pressures that you have. I'd be interested in your comment on what the impact would be on you as a local hospital being able to manage those local issues if in fact the Minister of Health effectively is saying to you,

"We'll look after it. You comply with our direction." What would the implication be to your organization?

Mr Pilon: It would obviously depend on what that agreement looked like. In my organizations, if I think about Espanola and Blind River, we have created some integrated models that allow a lot of flexibility in addressing the community needs, that allow us to move resources into Meals on Wheels, supportive housing and those kinds of things, because we have long-term care, we have supportive housing and we have other programs that help serve the community.

That flexibility and that ability to meet the community need would be important to maintain. Having said that, that may be recognized in an accountability agreement. I don't know. We would certainly hope that that would be recognized and we would seek to see that if it becomes a negotiated process, which is what we believe needs to happen.

Ms Martel: Thank you to both of you and to your colleagues, some of whom have come a long way today to be part of this process.

I want to focus on where the minister might be coming from with respect to part III in particular. You said in your remarks that the minister addressed hospital board chairs and CEOs on December 17. I don't want to put either of you on the spot, but were either of you there?

Mr Querney: Yes, I was.

Mr Pilon: Yes.

Ms Martel: Did he talk about the bill at all, because the bill would have been introduced by then? Did he make reference to it?

Mr Querney: I don't recall that, but I certainly recall that he was indicating that there would be changes afoot in the ministry and with the hospitals in particular.

Ms Martel: Did he give you any indication at the time, during that presentation, what would be driving those changes? What was driving his need to bring forward changes with respect to boards and hospital operations?

Mr Querney: The OHA has telegraphed repeatedly the growing deficits that hospitals are facing, so the cost pressures on the operating side as well as it relates to capital projects. So I believe the minister is responding to some of those pressures, those cost pressures in particular.

Ms Martel: Deficit pressures.

Mr Querney: Possibly.

Ms Martel: All right. If the minister had a concern about a deficit in a hospital—maybe he thought it was completely out of control, the incompetence of the board, fraud, whatever you want to deal with—surely under the Public Hospitals Act—and you would know this better than I; I apologize, because I don't know all of the criteria—he could intervene in one specific hospital if he thought there was a serious problem around deficits and why those deficits were growing. Am I correct?

Mr Pilon: That's correct.

Mr Querney: I was just going to say that we actually lived that at the Sudbury Regional Hospital. We underwent an operational review and then the appointment of a supervisor.

Ms Martel: Yes, well, we won't go there, will we? That mess is not sorted out yet, despite all the promises made by the local member. We hope they will be.

What then would drive the minister to have a more blanket approach? Because that is what this bill entails. Now we're going to have a bill that essentially allows him a broad range of powers that are quite sweeping in a number of areas to ostensibly, in terms of what you heard, try and deal with a deficit problem. If you want to do that, if you think there's a problem, then you use the Public Hospitals Act and address it that way.

The method here is really broad. I think it's really draconian. I think it's going to force board members to flee en masse, especially when they look at the liability sections of this bill, if something isn't done to address this. Is that your read of where we're heading here?

Mr Querney: Certainly that's one perception. I think it all revolves around exactly what is entailed in those accountability agreements.

Ms Martel: Do you see that there is even a need for them, though? That's my other question. Is this really a broad, draconian response to a concern that may be actually more readily got at by using the Public Hospitals Act in those hospitals where you think there's a problem around finances?

Mr Pilon: My assumption is that they believe this is a better way than having to put the supervisor in. Our position is it's not a better way. It's not a way to achieve the goals. It is just new legislation that creates the same old directives, and that's not how you reach mutual belief in a process or commitment to a process.

Ms Martel: I've assumed that the powers here are even more sweeping than contained in the Public Hospitals Act.

Mr Pilon: And they take away the responsibility to act in the public interest, which is something of grave concern for us in the north, I think.

Ms Martel: Right, because that at least is in the Public Hospitals Act—it hasn't been transferred to this bill—that there had to be some action that's in the "public interest." That doesn't appear here.

Mr Pilon: No.

Ms Martel: In terms of how we respond to this, you have said part of this has to be amended. I'm not sure you can amend some of this, because some of the provisions are just so broad in terms of what the minister is allowed to do in any number of sections: 22(1), 22(2), 26, 24. At any time, anywhere, any place, the minister is going to be able to do whatever he or she wants. I don't know that you can really amend this unless you remove most of this and start again.

Would your view be that if the minister really wants to get at some issues in some hospitals, do that under the Public Hospitals Act and don't move forward with provisions which appear here, which really are very sweeping in the powers that he or she would now be allowed to have? Do you have a recommendation on

what's the better way to try to achieve what allegedly is a deficit problem here?

Mr Pilon: My view is—

The Chair: It will have to be a 12-second recommendation.

Mr Pilon: My view is the powers are there under the Public Hospitals Act if there is a need to intervene with direction. There may be, and should be—I recognize the need to increase accountability. I think that's a good a goal, and we should do that. This doesn't seem to achieve it in its current form. In an amended form, it may.

Ms Smith: Mr Pilon and Mr Querney, thank you very much for appearing before us today. I appreciate you recognizing that you're also affiliated with your district health councils I met with last week. They would be happy to know that they're being acknowledged as well.

I'm sure that through your association you have heard that there have been ongoing discussions between the minister himself, the ministry staff and your association, among other stakeholders, on possible amendments to this legislation. I'm hoping some of that will have calmed some of your fears with respect to the legislation, although I appreciate that you have come forward with a number of those again today.

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I'd just like to go through your presentation, and I'm going to talk really fast because I've only got four minutes. I'm happy to discuss with you afterwards any other questions you have.

You were concerned that "the proposed legislation does not define parameters within which the minister ... can force the hospital to sign an accountability agreement." That's one of the issues that I think has been addressed with the OHA, and we are looking at proposed amendments that will include language around the negotiation of the accountability agreements. I think you're also aware that the accountability agreements that the ministry is looking at will be between the ministry and the board and not the CEO and that there will be an expectation there will be a performance agreement between the CEO and the board. I think that has gone some way to calming some of the concerns out there.

You talked about Bill 8 being "amended to enhance the accountability of the government to the citizens of Ontario and more clearly define those situations that will warrant ... intervention." Again, I think you'll hear through the discussions that have been held that there will be amendments put forward around sections 21 and 22 around process before directives are issued within an accountability agreement framework.

You raised a concern about resources, and particularly the bureaucracy required to implement these agreements. As I understand it, there are presently funding agreements in place with health care providers. I think those resources that are in place to negotiate those funding agreements will also be there to negotiate accountability agreements, and it's our hope that those things will start to mesh together into some kind of framework.

I think I've already addressed your issues about the CEOs not being part of an accountability agreement. Therefore, your CEOs will not be receiving conflicting direction, which you raised.

Again, you raised concern about the ministry taking action against a CEO or against a board. I think you'll see in the proposed amendments that we'll be looking at a very specific framework within which action would be taken. It would only be in extreme circumstances where the minister would intervene in a board or in a CEO's activities.

You talked about the joint policy and planning committee. I think they're doing some fabulous work and it's certainly the expectation that that work would continue and that the accountability agreements that we're looking at would work within that framework, that they would blend together. So the work that's being done there would not be lost in any respect but would form some of the work into accountability agreements.

There was one other thing. I think I'll let Ms Wynne speak, because my head is a little muddied at this point. If I figure something else out that I want to raise, I'll bring it up to you later. Thanks.

Ms Wynne: I just had a very quick question of clarification: You talk about the particular issues in the north and the accountability agreements. As Ms Smith has said, there are going to be amendments around that, but I just wanted to get at whether in principle you object to the accountability agreements. With the appropriate structure and clarity around them, can you support that idea?

Mr Pilon: Yes. I have no objections to an accountability agreement. I understand the reason for that; it's the way it seems to be unfettered in this bill that gives us concern as a network.

Ms Wynne: Great. I just wanted to get that clear.

Ms Smith: Sorry, I remembered my last point, which Ms Wynne actually just raised. You discussed the particular needs in the north, and I just wanted to note that we have two northern members on this committee, so your concerns are well attended to in this committee. I think that those concerns will be addressed in negotiations and discussions leading up to an accountability agreement. There will be plenty of opportunity for the health care providers to make their submissions or input into the process so that the particularities of the north or of any specific region or any specific health care provider will be taken into account when developing these accountability agreements.

The Chair: Final question of the day goes to Mr Duguid.

Mr Duguid: Thank you. I noticed in your presentation you talked about the powers the ministry has under the Public Hospitals Act to take over a board. I should probably know this, but I don't: What is the difference between those powers and the powers being proposed under Bill 8? If they already have the powers to take over a board, then how does Bill 8 change those powers?

Mr Pilon: I think the point is why does Bill 8 need to create these powers if they're already there?

Mr Duguid: I guess my question—and I say this constructively—if those powers have always existed, and I know the previous government did use them on a couple of occasions, probably under extreme circumstances—

Mr Pilon: But the powers under the Public Hospitals Act also qualify that the minister has to act in the public interest. It clearly sets out how that public interest is there and the use of cabinet, those kinds of things. That's not in Bill 8.

Mr Duguid: So the public interest aspect is the difference between the two pieces of legislation?

Mr Pilon: Correct.

Mr Duguid: OK, thanks.

The Chair: Thank you, Mr Querney. Thank you, Mr Pilon. We are adjourned to Ottawa. We all need to be at the front doors for the bus at 5:20; planes leave at 6.

The committee adjourned at 1647.

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Tuesday 17 February 2004