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Wednesday 18 February 2004

Journal des débats (Hansard)

Mercredi 18 février 2004

Standing committee on justice and social policy

Commitment to the Future of Medicare Act, 2003

Comité permanent de la justice et des affaires sociales

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

Chair: Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

Wednesday 18 February 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE ET DES AFFAIRES SOCIALES

Mercredi 18 février 2004

The committee met at 0903 in the Courtyard Marriott Hotel, Ottawa.

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): Good morning, ladies and gentlemen. I call this committee to order. I would ask people to take their seats. For those members of the committee who are here, checkout time is 12:30, so judge your time and your packing accordingly.

HÔPITAL MONTFORT

MONTFORT HOSPITAL

The Chair: Our first presentation this morning is from l'Hôpital Montfort. We have four people with us: Gisèle Lalonde, president; Marcel-Guy Bélanger; Michelle de Courville Nicol; and Bernard Grandmaître. Would you come forward, please.

Welcome and thank you for coming. If I can explain the rules to you a little bit, you've got 30 minutes. You can use that time any way you choose. At the end of the presentation, we'll split the remaining time among the three parties to ask you any questions they may have as a result of the presentation. The sequence of questioning will begin in the first round with the official opposition, the Progressive Conservatives.

Having said that, the floor is yours, and I've got 9:06.

M^me^ Gisèle Lalonde: Monsieur le Président, membres du comité, permettez-moi d'abord de vous remercier de nous donner l'occasion d'exprimer notre point de vue sur le projet de loi 8, une mesure législative qui aura un impact majeur sur le système hospitalier de la province, et un impact que nous devons qualifier de dévastateur sur l'Hôpital Montfort, une institution essentielle à la survie de la communauté franco-ontarienne, et sur la communauté franco-ontarienne dans son ensemble.

Our views can be summed up in two words: Not again. It is extremely difficult for Franco-Ontarians to fathom how a Liberal government could even propose to pass a law so draconian, so totalitarian, that it brings us back to the sad days of the ill-advised and unconstitutional proposed closure of our hospital by the Ontario Health Services Restructuring Commission.

Bill 8 is nothing less than a blatant and dangerous attack on what Ontario's linguistic minority considers to be a sacred trust: the Franco-Ontarian's ability to make decisions that affect the development and the future of its own institution, the Montfort Hospital.

Cette loi menace en fait de nous soutirer le pouvoir qui nous permet d'assurer la survie de l'Hôpital Montfort, une institution essentielle à la survie de la culture et de la langue de la minorité. À l'heure actuelle, nous avons les outils pour prendre et mettre en vigueur n'importe quelle et toutes les décisions qui permettent à Montfort de continuer à jouer son rôle essentiel.

Il n'y a également aucun doute dans notre esprit que cette loi va à l'encontre du principe constitutionnel fondamental du respect et de la protection des droits des minorités linguistiques, tout comme le faisaient les actions de la Commission de restructuration qui ont été rejetées unanimement par trois juges de la Cour d'appel de l'Ontario et trois juges de la Cour divisionnaire en première instance.

Le pouvoir de prendre des décisions qui ont un impact sur la vie de notre communauté est important pour la société ontarienne dans son ensemble, mais il est absolument vital pour la minorité linguistique d'avoir ce pouvoir au sein de ses propres institutions. C'est une réalité qui a été confirmée par plusieurs jugements de cour, particulièrement dans le secteur de l'éducation, et plus récemment dans la décision Montfort.

The Supreme Court's Mahé decision, which was quoted in the Montfort judgment, is often cited as the cornerstone of all the decisions involving the importance of leaving this decision-making in the hands of the minority. It says: "... minority language groups cannot

always rely upon the majority to take account of all their linguistic and cultural concerns. Such neglect is not necessarily intentional: the majority cannot be expected to understand and appreciate all of the diverse ways in which educational practices may influence the language and culture of the minority."

What the highest tribunal in the land is telling us, in the end, is simply common sense. Cultural decisions taken in the interests of the linguistic and cultural minority have to be taken by people who understand this minority. And as hard as they may try, as empathetic as they may be, members of the majority cannot achieve that.

A francophone institution is more than a service counter where French is spoken. There is also a crucial cultural element involved in decision-making. For the Franco-Ontarian community to receive proper services, it must be able to decide how those services will be provided. Only francophones can make those decisions. In the case of a hospital, these decisions are made by the board of trustees.

Voici ce que disait de l'Hôpital Montfort la Cour d'appel de l'Ontario dans son jugement historique :

« Nous sommes d'accord que Montfort joue un rôle institutionnel plus large que la prestation des services de soins de santé. En plus de remplir la fonction pratique supplémentaire de dispenser la formation médicale, le rôle institutionnel plus large de Montfort comprend notamment celui de maintenir la langue française, de transmettre la culture francophone et de favoriser la solidarité au sein de la minorité franco-ontarienne. »

Le ministre de la Santé croit-il vraiment qu'il peut remplir cette mission mieux que les membres de notre communauté? La communauté franco-ontarienne ne permettra pas au gouvernement de l'Ontario d'empêcher l'Hôpital Montfort de jouer ce rôle essentiel à la survie de la minorité linguistique de l'Ontario.

0910

Our volunteer members from the Montfort board of trustees will address more fully questions that concern them more directly in their depositions, but let me tell you that from the community's vantage point, we see this law as nothing more than a hostile takeover by the minister of an institution that Franco-Ontarians built. We see nothing more than a deliberate attempt to do away with the bothersome intermediaries that are the volunteer board of trustees.

Vous placez une énorme épée au-dessus de nos têtes, et vous dites que vous ne vous en servirez pas. Si c'est vrai, pourquoi sortir l'épée? Pourquoi vous donner et donner à tous les ministres et à tous les gouvernements qui suivront des pouvoirs aussi excessifs? Il n'y a qu'une réponse possible : parce qu'il viendra un jour où vous déciderez de vous en servir.

Plus encore, nous sommes estomaqués de constater que cette loi est l'idée saugrenue du Parti libéral que plusieurs Franco-Ontariens ont fidèlement appuyé au fil des ans, peu importe où le vent soufflait. Notre communauté vous a soutenus lorsque vous couliez, et maintenant que vous voguez allègrement, ce sont les remerciements que nous méritons.

C'est honteux. Et ce l'est pour tous les Ontariens qui s'attendaient à ce que ce gouvernement leur offre un leadership qui encouragerait l'inclusion et la participation des gens, plutôt qu'une plus grande exclusion que même le régime précédent.

Monsieur le Président, c'est une chose pour votre comité de nous entendre aujourd'hui. Nous l'apprécions. Mais c'est une toute autre chose d'inclure les Ontariens, dans un esprit de confiance mutuelle, dans la prise de décisions qui touchent directement leurs vies quotidiennes, telles que l'administration et la gestion des institutions de santé.

On nous demande de vous faire confiance. Franchement, de notre perspective, c'est trop demander. Les Franco-Ontariens ont vécu trop de tristes expériences où leur confiance s'est avérée mal placée.

Our volunteer members from the Montfort board of trustees will address more fully questions that concern them more directly in their depositions, but let me tell you that from the community's vantage point, we see this law as nothing more than a hostile takeover by the minister of an institution that Franco-Ontarians built.

Nous sommes aussi troublés par un autre aspect de cette Loi 8. Les mots de l'ancienne loi précisant que le ministre doit agir « dans l'intérêt public » ont été mystérieusement rayés du nouveau texte. Ce curieux amendement fait sonner toutes sortes d'alarmes à Montfort. Car, coïncidence des coïncidences, lorsque la Cour d'appel a tranché en faveur de Montfort en décembre 2001, l'une des raisons invoquées était que, contrairement à son mandat, la Commission de restructuration n'avait pas agi « dans l'intérêt public ». En effet, l'intérêt public exigeait qu'elle tienne compte du principe constitutionnel du respect et de la protection des droits des minorités linguistiques.

Pourquoi ces mots ont-il été effacés du texte de la nouvelle loi? On nous dit que ça ne veut rien dire, que le ministre doit quand même agir dans l'intérêt public. D'accord. Mais alors, pourquoi ne pas tout simplement laisser ce passage intact?

Le texte entier de cette loi dégage une odeur malfaisante, comme si l'objectif exprimé n'en est pas la véritable intention.

Monsieur le Président, j'ai eu l'honneur de mener une lutte de cinq ans pour sauver l'Hôpital Montfort. Nous y sommes parvenus pour la seule et unique raison que la communauté franco-ontarienne était massivement et activement impliquée dans la cause, comme elle le démontrait le 22 mars 1997, lorsque 10 000 défenseurs de Montfort remplissaient le Centre municipal d'Ottawa à craquer pour le plus grand ralliement de l'histoire franco-ontarienne. Si cette Loi 8 avait été en vigueur, il est difficile de m'imaginer comment cette communauté aurait senti le besoin de se rallier pour défendre un hôpital contrôlé par le ministre. La décision inconstitutionnelle de la Commission de restructuration aurait bien pu être incontestée. L'Ontario serait privé aujourd'hui de

son unique hôpital d'enseignement francophone, et la communauté franco-ontarienne aurait subi un tort irréparable.

As president of the SOS Montfort movement, I said I would remain at Montfort as long as the hospital's survival was threatened in one form or another. With this bill today, it is.

Merci. Thank you.

The Chair: Thank you, Ms Lalonde. Are you ready to receive questions now, or will there be further presenters?

Ms Lalonde: We thought maybe at the end you could ask any of us to answer your questions.

The Chair: OK. Mr Grandmaître, then?

Mr Bernard Grandmaître: Am I next?

The Chair: That's what I'm asking.

Mr Grandmaître: That's good. Excuse my gravel voice.

Monsieur le Président, membres du comité, permettez-moi d'abord de vous dire que je ne suis pas ici de gaieté de coeur aujourd'hui. En fait, ceux qui me connaissent seront passablement surpris de me voir ici. Ils sauront qu'il a fallu quelque chose de très important pour que je me déplace pour venir devant vous.

I am a Liberal—I don't need to hide it, Jim or Frank; they all know it—fast and true. I always was a Liberal and always will be. I am sitting here today as a Liberal, a former member of the Legislature like yourselves, and one who has had the honour of being a minister in the David Peterson government. But as a Liberal, I have seen better days. This law, Bill 8, is not the product of the Liberal Party that I know. In fact, it is in flagrant contradiction to some of the most basic principles that inspire and have always inspired my party.

While claiming that it will make hospitals more accountable to the people, Bill 8 is disenfranchising the people from the decision-making process by rendering insignificant the boards of trustees of hospitals. In doing so, it is dealing a devastating blow to the future of Montfort Hospital, a major and crucial Franco-Ontarian institution which the community has just waged a bitter five-year fight to preserve.

Cette loi n'est rien de moins qu'un bris de confiance et des principes démocratiques. Comme le disait M^me^ Lalonde, il est difficile pour moi de croire que c'est un gouvernement libéral qui la propose. De toute évidence, aucune considération n'a été donnée quant à l'impact qu'aurait cette loi sur la communauté franco-ontarienne. Et cela, même si, depuis le jugement de la cause Montfort, le gouvernement de l'Ontario, particulièrement le ministère de la Santé et des Soins de longue durée, devrait savoir que toutes les décisions et les politiques gouvernementales doivent être considérées en fonction du principe constitutionnel du respect et de la protection des droits des minorités. Car cette loi signifie que la communauté ne sera plus en mesure de prendre les décisions nécessaires à la survie de son institution, l'Hôpital Montfort, une institution essentielle à la survie de la minorité franco-ontarienne. Le ministre de la Santé est incapable d'assumer pleinement cette responsabilité.

Mr Chairman, members of the committee, let me underline a rather embarrassing coincidence. As minister responsible for francophone affairs in 1986, I too fathered a Bill 8. Exceptionally, it was approved by all three parties of the Legislature. It was a momentous day, an historic day, one that is fondly remembered by all Franco-Ontarians. My Bill 8 was in fact the French Language Services Act. When Franco-Ontarians speak of "la Loi 8," cruel irony, isn't it? Less than 20 years later, here we are, here I am, fighting "la Loi 8" that poses a clear and present danger to the Franco-Ontarian community.

0920

Just to remind the members of the committee what spirit guided members of the Legislature in approving the French Language Services Act two decades ago, let me read part of its preamble:

"Whereas the French language is an historic and honoured language in Ontario and recognized in the Constitution as an official language in Canada;… and whereas the Legislative Assembly recognizes the contribution of the cultural heritage of the French-speaking population and wishes to preserve it for … generations...."

Strong enough for you?

Mr Chairman, members of the committee, there is a lot more to recognizing the cultural heritage, and especially preserving it for generations, than providing translation at these meetings. Only strong francophone institutions can achieve the goal set out by the legislators in this act. Francophone governance is an integral part of the francophone institution. To do anything else is not only bound to fail; it is absurd.

Let me add to this that Ontario's Court of Appeal stated in the Montfort judgment that the province's French Language Services Act is a quasi-constitutional law, which gives it legally more weight than this Bill 8.

Les temps changent. Comme politicien, je le reconnais. Mais des principes aussi fondamentaux que les droits d'un des peuples fondateurs de ce pays ne changent pas. Le jugement de Montfort est fondé sur la constitution qui créait le Canada en 1867, légalement, en grande partie sur les principes et les clauses contenus dans la Loi sur les services en français de l'Ontario.

La Commission de restructuration l'a fait au nom de l'efficacité. Aujourd'hui, ce gouvernement le fait au nom de l'imputabilité. Ça recommence. Les prétextes changent, mais nous connaissons la méthode. Passez le rouleau compresseur sur tout le paysage et ne dérangez surtout pas ce ministère avec des réalités sociales ou des faits constitutionnels. Et nous voici donc à nouveau, là où aucun d'entre nous ne veut être : à défendre nos droits d'exister et de prospérer dans cette province. Nous devons en remercier, une fois de plus, le ministre de la Santé.

At this time, I'd like to céder la parole à M^me^ Michelle de Courville Nicol, présidente sortante de l'administration de l'hôpital Montfort.

M^me^ Michelle de Courville Nichol: Monsieur le Président, membres du comité, en tant que présidente sortante du conseil d'administration de l'Hôpital Montfort, je suis offusquée par cette loi. Je suis offusquée comme membre du conseil, je suis offusquée comme bénévole, je suis offusquée comme représentante de ma communauté et je suis offusquée comme Franco-Ontarienne.

Je passe droit au but.

This law is apparently being proposed in the name of "accountability." Over the years, especially the last decade, we have heard many key phrases of this kind being used by governments to explain their actions. As Mr Grandmaître pointed out, sometimes it's "efficiency." Sometimes it's "better access." Sometimes it's "rationalization." Very often it's imposed by governments, usually in what seems like a desperate rush, and rarely does it live up to its own grand promises. Does the party now in power at Queen's Park tell us that health services restructuring was a great success? I doubt it. Yet that commission, created by the government, had all the right key phrases too.

We change governments; we change the flavour of the month. Now it's accountability. And it is imposed with a law so drastic, so totalitarian, that it rivals in scope the powers that were ceded to the restructuring commission by the previous regime, except this time it's the minister who seeks to increase his own power over hospitals and over the communities they serve.

But we will deal with this question of accountability, because Montfort Hospital is not afraid of accountability. We, as members of the board of trustees of the only francophone teaching hospital in Ontario, as well as our management, have always been accountable to our community. We have to be accountable. We can't afford not to be accountable. We are the beginning and the end of the health care stakes for Franco-Ontarians. Every decision Montfort makes has a direct impact on the future of the Franco-Ontarian community and its self-sufficiency in health care. Francophones look to us for more than French-language services. They look to us for francophone doctors and health professionals in Ontario in the future. They look to us as a vital part of their network of institutions. They look to us as a beacon that tells them they belong in Ontarian society.

We have inherited a noble but onerous responsibility. We are condemned to excellence, and thus to accountability. Montfort has always been accountable. While we were for years the most underfinanced hospital in Ontario—a situation that was recently redressed—we were accountable. In fact, we were at that time and still are today one of the most efficient hospitals in the province, with one of the lowest costs per weighted case. Our track record of the last eight years speaks for itself. As our community has often done, we did a lot with very little. Franco-Ontarians do not take money for granted, whether it comes from the government or elsewhere.

Montfort ne s'est pas opposé à la signature d'un contrat d'imputabilité ou d'un rendement de compte. Il s'agit en fait de contrats de services qui vont au coeur du mandat et de l'avenir d'un hôpital, puisqu'ils déterminent les volumes de services alloués et le financement qui y est rattaché. En fait, l'Hôpital Montfort a signé le tout premier accord de rendement de compte avec le ministère de la Santé et des Soins de longue durée en octobre 2003. Mais il s'agissait d'un accord négocié, le fruit d'un processus équitable.

Bill 8 is totally unacceptable to us in its current form because it imposes unilateral, non-negotiated accountability agreements on hospitals by the minister. Minister Smitherman's soothing words before this committee on Monday in Toronto indicated the law could be changed to include negotiated rather than unilaterally imposed accountability agreements. But the way we understand it, the minister still reserves the power to impose accountability agreements at the end of the day. It is still not an even playing field. And let's make no mistake about it: That power is immense. The minister stated Monday, "In the end, only if all recourse fails and only in exceptional circumstances can the ministry impose penalties directly on the CEO." What are those exceptional circumstances? Will the next minister, the next government, stand by the same statement, or will the law be interpreted to achieve one's goals? We suspect the latter.

The Ontario Public Hospitals Act already gives the minister the power to take over a hospital after due inquiry and justification, and the previous minister has already done so in our community, among others. But this new law gives the minister the power to take over the entire management of a hospital for no other reason than the fact that he wishes to do so. It is a measure that goes against what has been the cornerstone principle under which our hospital system has functioned throughout our history: voluntary governance.

When one takes into consideration Montfort's essential role in preserving the language and culture of the Franco-Ontarian community, the minister's proposed powers will cause irreparable harm to that community. At Montfort, we respect the principle of accountability, but I would like to ask the minister and his bureaucrats, where is your accountability when it comes to the Franco-Ontarian community? The Ministry of Health is not accountable to the Franco-Ontarian community, yet the minister wants to take the responsibility to adequately respond to the health needs of the Franco-Ontarian community away from us and take it upon himself. You will forgive us if we greatly fear the results. To strip us of governance in such a way for no reason at all and with predictably disastrous results is a major affront. We hope the wisdom that escaped others who came before you will be brought to bear to help find a solution that is agreeable, fair and just to all Ontarians.

Now I'd like to introduce Mr Marcel-Guy Bélanger, who is treasurer of the Montfort board of trustees.

The Chair: Just so you know, Mr Bélanger, we've got about five minutes left in your time.

Mr Marcel-Guy Bélanger: Thank you very much, and I'll respect that.

Mr Chairman, members of the committee, for weeks now, ever since I became aware of this bill, I have been

asking myself one question: Why is this Minister of Health attacking me?

What have I done that is so bad that all of a sudden this Minister of Health finds it necessary to threaten me, my fellow members of the board of trustees and the hospital's CEO with a $100,000 fine? On ne m'a jamais dit qu'être bénévole était un crime.

Le ministre déclarait lundi que les amendes imposées par la loi étaient, et je cite, « trop sévères ». Eh bien, laissez-moi dire d'abord que c'est lui qui les a proposées au départ. Et permettez-moi de poser cette question : après avoir suggéré des amendes de 100,000 $ qu'est-ce qu'il considère comme étant moins sévère? Est-ce que cela signifie qu'il y aura toujours des amendes?

0930

Mr Chairman, members of the committee, has anyone stopped to realize the full implication of what this law says about the voluntary board of trustees? It implies nothing less than that we are not honest people, that we are not trustworthy, or, at best, that we are totally irresponsible. At the same time, he tells us and our CEO that we hold positions of "great honour and responsibility." Pardon me if I don't feel that honoured right now. In fact, I feel downright bullied and belittled.

Pardonnez-moi si je ne me sens pas très honoré présentement. En fait, je me sens carrément bousculé et diminué.

Bien sûr, on nous dira que la Loi 8 ne vise qu'à traiter des cas « exceptionnels ». Peut-être. Mais nul doute que son effet est de peindre tout le monde avec le même pinceau : tous les membres de conseil et tous les PDG. Nous sommes maintenant tous des transgresseurs potentiels de la loi du ministre. Et c'est une loi hautement subjective, à être interprétée selon la compréhension et les intentions du ministre du moment.

As if fines aren't enough, Bill 8 gives the minister unprecedented power to shove us aside and take over the entire management of the hospital if he simply wishes to do so. So this law is basically asking me and all my fellow members of the Montfort Hospital board of trustees, "Why would you bother being a volunteer?"

And let me ask, does anybody stop and think who these volunteers are who serve on the board of trustees? They are responsible people who have achieved responsible positions in their lives, who are respected members and representatives of their community. They are dedicated to their task, yet this bill treats them like children who have no idea what they are involved in.

There is no doubt in my mind that with this kind of law, the quality of the people who will accept to sit on boards of trustees will greatly diminish. So will their dedication, so will the service to the community, and, I dare say, so will the accountability to the community. It's telling my CEO, "Stop mustering all your energy to make Montfort one of the best and most efficient hospitals in the province. It's too dangerous. Become a consultant or something."

La Loi 8 dit à notre communauté, « Votre hôpital ne vous appartient plus. Pourquoi donner votre argent à la Fondation Montfort quand vous savez que le ministre pourrait prendre le contrôle à n'importe quel moment? »

Il n'y a qu'un seul hôpital d'enseignement francophone en Ontario. C'est une fière et forte institution franco-ontarienne. Elle est essentielle à la survie de la minorité linguistique de l'Ontario. Mais elle doit reposer sur une fondation solide, et ce que fait cette loi, c'est détruire cette fondation. Elle mine la participation active de la communauté dans la vie et le développement de son institution.

It is undermining our ability to retain and recruit competent francophone administrators. Personnel retention and recruitment is already a major challenge for Montfort, given essential bilingual requirements. We are presently blessed with a CEO and a management team that we consider to be above the norm, and they are accountable. But we seriously wonder how this law will affect that situation.

We wonder what will happen the day the minister decides to impose an accountability agreement, which will cause irreparable harm to the Franco-Ontarian community. We will then, no doubt, be told that all the hospitals are being targeted. We have heard that one before, but yet again, that is totally missing the point of the impact such policies have on the minority. Especially when all it can count is one hospital, this impact is much greater. With Bill 8 we are left with no defence. Worse, we will be punished if we defend ourselves and do what we think is right.

For all these reasons we present to you today we firmly and deeply believe that this is a bad law. It must be changed extensively. We, in our management, are honourable and responsible people; we do an honourable and responsible job. We neither deserve this, nor can we accept it. Thank you for listening.

The Chair: Thank you very much, ladies and gentlemen. Your presentation was very clear, very direct and a little bit over 30 minutes so unfortunately we have no time for questions, but I do thank you for coming today. Thank you for your input.

OTTAWA ACADEMY OF MEDICINE
ACADÉMIE DE MÉDECINE D'OTTAWA

The Chair: Our next delegation this morning is from the Ottawa Academy of Medicine. Gail Beck, the president, is with us. Ms Beck, make yourself comfortable. As with all delegations, you have 30 minutes to use as you please. Any time that is left over at the end of the presentation will be used by the three parties to ask you any questions of clarification. We'll be starting with the PCs again, seeing as we didn't have any questions last time, going to the NDP and then to the Liberals. Having said that, it's 9:39 and the floor is all yours.

Dr Gail Beck: Thank you very much. Mr Chair and members of the committee, I bring greetings to you from the physicians of Ottawa.

The Chair: Ms Beck, could you stop? Excuse me, if there are any conversations to take place, could they take

place in the hallway, please. I'd like to give our delegations our full attention. I'll even re-start your clock.

Dr Beck: Thank you. Je m'appelle Gail Beck. Je suis la présidente de l'Académie de médecine d'Ottawa. En tant que médecin, je peux vous dire que le projet de loi 8 peut garantir l'accessibilité aux services de santé pour mes patients à long terme.

As a patient, and as a woman of my age likely to use the health care system more and more over the next 20 years, I must say that Bill 8 may not guarantee the commitment to medicare that I would like.

My family doctor has cared for all of the members of my family—three generations—for almost 20 years. He sees us annually for our physicals, in a timely manner for our illnesses, and has provided care before my children were born, after my children were born, and attended their deliveries. He visited my mother the several times she was in hospital. Like most family physicians in this community, he works a 60- to 80-hour week and is at a greater risk for health problems himself because of his stressful lifestyle and schedule. Like the vast majority of physicians in this community, and in all communities across Ontario, my family physician provides the best health care my tax dollars could buy.

0940

One of the members of your committee whom I don't see here today, Mr Patten, in another life had been well acquainted with this city's paediatric specialists at the Children's Hospital of Eastern Ontario. The specialist physicians at that hospital and in all the hospitals of this region and in our community also work an average of a 60- to 80-hour week, twice the usual work week in many cases, to provide care to the people of this community. The patients of this community are committed to the spirit of the Canada Health Act, and with the hours the work and the dedication they provide, the physicians of this community have also proven their commitment to the Canada Health Act. Where in Bill 8 is the portion that spells out the government of Ontario's commitment to sustainable funding, to guaranteed wait-times, to ensuring sufficient health care providers for the people of Ontario? Where is their commitment to the spirit of the Canada Health Act?

Le projet de loi 8 édicte un Conseil ontarien de la qualité des services de santé. Les médecins d'Ottawa supportent cet « edict ». Will the government of Ontario not just commit to tabling the reports of an Ontario health council but commit to following such a council's recommendations?

As a former member of the Expert Panel on Health Human Resources in Ontario, I know that councils and panels of this type, making recommendations to governments, take particular care to provide the best, the most timely and accurate information possible. An Ontario health council's recommendation will be taken very seriously by the people of Ontario and by their doctors. Can we not have that same commitment in Bill 8 from government?

Part II of Bill 8 outlines, first of all, a number of measures, apparently to ensure accessibility. Unfortunately, accessibility is not one of the terms defined in part II. Part II seems to cover a number of measures to be taken in order to recover "unauthorized" payments to physicians. I find this to be a misleading portion of the bill. I feel that part II implies that my colleagues and I spend more time billing our patients than we do treating them. Part II implies that we are stealing. Why else would there be a reference to jail terms in subsection 17(2) of part II? I'm not saying there are no dishonest doctors, but I am saying the evidence would show you that there are no more dishonest doctors than there are dishonest lawyers or dishonest accountants or dishonest politicians.

It also upsets me that this section of Bill 8, apparently devoted to accessibility, does not at all mention wait-times. If you ask my patients or the doctors of this community what concerns them the most about health care today, in 2004, most of them will say, "How long must one wait for essential diagnostic treatments or tests?" We now have in Canada several excellent wait-time studies—for example, the western wait-list study or the MRI study produced by the Institute for Clinical Evaluative Sciences. Will the government of Ontario truly commit to accessibility and look at such things as wait-times for diagnostic tests and treatments for Ontarians?

In this regard, I would like to mention one initiative of the academy of medicine that did address wait-times, specifically the wait-time for a psychiatric referral. The academy of medicine, under the direction of Dr Keith Anderson, a local psychiatrist, set up a psychiatric referral service for family physicians in Ottawa. This service provides family doctors with access to a psychiatric consultation, and usually follow-up, for a patient within one month of the date of referral. Such an initiative really does address accessibility in this community, and yet we have struggled to get from the provincial government the funding necessary to cover the costs of administering this program.

I would now like to move to part III of Bill 8, accountability—also not defined. In January 2004, I became the acting clinical director of one of the Royal Ottawa's clinical units. Like most of my colleagues in such positions, I was honoured to have the opportunity to serve my community and my patients more effectively in this way. Having said this, like most of my colleagues, I enjoyed a pay increase of approximately zero dollars. I realize that good patient care is the result of strong clinical teams and I'm very pleased that my colleagues afford me such confidence. However, if I review part III of Bill 8, I discover that the Minister of Health has even less confidence in health professionals in "executive functions" than he does in health professionals in general.

I'm just going to read from subsection 29(1): "For the purposes of carrying out the provisions of this part, the minister may require any person, entity or agency to provide the minister with any information that the minister considers necessary, including personal information other than personal health information within the mean-

ing of the Remedies for Organized Crime and Other Unlawful Activities Act, 2001."

There must be something about this clinical director's job that no one has told me for the Minister of Health to have to have such sweeping powers over volunteer health professionals in Ontario's health facilities. I do understand that the minister yesterday indicated to you that there was a need to amend this bill and I am glad to hear it. This bill makes me feel as though I'm either a thief or a gangster and, as the representative of this region's 2,500 physicians, I assure this committee that my colleagues are devoted to the health care of the people of this region, that we welcome innovation and that we expect to be accountable in our daily work.

The work of the doctors of this city, this province and this country is second to none, and we work with the best nurses, the best pharmacists, the best social workers—in fact, the best health care providers in the world. The health professionals of Canada have delivered to the people of Canada the promise of the Canada Health Act.

Surely the government of Ontario could commit to the people of Ontario around the Canada Health Act. Will the government of Ontario hold the government of Canada responsible to the recommendations of Commissioner Romanow? That's not indicated in this bill. Will they say to the people of Ontario, and hold themselves to account, that they will do their utmost as government to fund, support, research and sustain the health care of the people of Ontario? Will they be accountable for their leadership in health care reform, as the physicians of this community have shown their responsibility?

The Chair: That's wonderful. Thank you very much. That took about 10 minutes, so that leaves each party with seven minutes to ask questions, starting with Mr Wilson.

Mr Jim Wilson (Simcoe-Grey): Thank you, Dr Beck, for taking the time to present before us today. Certainly, we should thank you for taking on the added responsibilities with no pay that you have done. When you point out section 29 in particular, where it makes a reference to the remedies of organized crime and other unlawful activities, it goes on in part II, actually, to make it clear that the minister doesn't need the patient information. He or she can get that without names through the Ministry of Health.

But it has another personal attack on what one has to presume is physicians, because it says that the minister may order the compliance directive or the accountability agreement—let's just read it exactly—to be put "in a conspicuous place when ordered to do so by the minister"; in other words, to be put up on a bulletin board in the institution or hospital, "even if this results in the disclosure of personal information."

We don't know what that means, and I'm the former Minister of Health. I have no idea what that means in terms of why the minister, for the first time that I'm aware of, would need the personal information of a physician. I assume that's your financial information or something, because we're dealing in here with probably what the minister would think is fraud or something. Without any recourse at this point to courts or anything, I assume your billing information—I'm the minister who had to step aside for 10 weeks because one of my assistants said to Globe and Mail reporter Jane Coutts that so-and-so is a top biller. He was dismissed, but it turned out after the Privacy Commissioner's investigation that personal information hadn't been disclosed and this guy was just guessing that this particular cardiologist, who everyone in the province seemed to know was a top biller—he was relaying third-party information or, at the very best, third-hand information.

But this actually lets the minister do something that I had to sit in the penalty box for, even though I had nothing to do with it. He can actually ask you, I guess, for your personal information. Can you just tell us how you feel about that?

Dr Beck: Certainly I feel that physicians have the same rights to privacy that most other people do in our community. The other thing, I guess, from my perspective, is that if you were to look at physicians, on average, much of their income is pretty much an open book. That's why the piece about the unlawful billing is very puzzling to me. On average, the vast majority of family physicians bill the same amount of money because, on average, they all practise in the same way. The vast numbers of child psychiatrists like me have very similar billings.

The College of Physicians and Surgeons of Ontario has the capacity to investigate physicians' billings. Certainly the doctors of Ontario are not happy with how the medical review committee has conducted some of its hearings. We have reason to believe that one of our members, a pediatrician in Windsor, actually took his life because of the way he was treated by a medical review committee.

We don't dispute that those among us who may be unlawfully billing, who are very few, need to be investigated. We know that the vast majority of us are not billing any more than our neighbours next to us with exactly the same practice. It's just that easy for the Ministry of Health and Long-Term Care to examine it.

0950

Mr Wilson: On another train of thought here, psychiatrists, particularly pediatric psychiatrists, are a fairly rare breed in this province. I have one in my entire riding. In fact, she is only able to run a clinic there once a week. She is running clinics throughout the province, trying to patch up parts of the province where there are literally no services, especially for children.

Among your members, whether pediatric or otherwise, are there not a number of arrangements in place between physicians and hospitals or physicians and other medical or public institutions that are incentives to try and keep those physicians retained and attracted to those institutions?

Dr Beck: The government of Ontario is setting up alternate funding plans with a number of specialist phys-

icians or physicians of larger teaching hospital institutions. It was the view that those were to help to offset some of the disadvantages of being in academic teaching centres.

Mr Wilson: Is there any apprehension among your members that, outside of an APP or AFP, as you call it, alternate funding plan—for instance, I can think of ER. Take Collingwood, in my riding. With the ER doctors, the one psychiatrist we have who does everybody, children right through, the different specialists, outside of AFPs or APPs—alternative payment plans—the board or the foundation has had to make arrangements, with the consent of the public, to try to attract and retain those physicians.

There's a section in this bill that says that the minister now will try to get them to—first of all, the minister must approve every one of those arrangements. There are 22,000 physicians in the province and there are probably, I'm told, close to 14,000 different arrangements out there. We were in northern Ontario yesterday, for example, and here in eastern Ontario with shortages. Outside of alternative plans—you told us you get nothing to be president—do you have colleagues who are in any way aware of this? Secondly, if they are aware, are they apprehensive about it?

Dr Beck: I think that all of my colleagues are apprehensive. This is certainly not the first government to suggest that doctors ought to be forced to practise in certain parts of the province. Our medical students and our medical graduates are the best in the world. They can travel anywhere on the credentials they earn in this country.

In many cases, what we know about medical students is that if you have enough medical students from a community like yours or smaller communities in any part of rural Canada, the students from those communities are more likely to return to those communities. The recommendations of medical schools have been that you have to recruit medical students from all parts of the country in order that they'll return.

When I sat on the committee on health human resources several years ago, what we learned was that 50% of the medical students in Ontario, no matter where they went to school, were from metro Toronto. It's no wonder that's where they want to practise; that's where they're from. If we want physicians to practise across Ontario, we have to go to Sault Ste Marie and Thunder Bay and recruit physicians there. Then they'll return to where they are from or to very similar communities, because that's where they grew up.

The Chair: Ms Martel, you have seven minutes.

Ms Shelley Martel (Nickel Belt): Thank you, Dr Beck, for being here this morning. You mentioned in your remarks that you heard the minister say there were going to be amendments, and you're pleased about that. Given all we've heard to date, I do wonder how we even got here with the particular bill we've got before us right now, because with the exception probably of one presentation yesterday that was fairly supportive, the rest have been fairly to very unsupportive. I'm not sure that amendments can fix this. I'm starting to wonder whether or not the whole thing doesn't have to be withdrawn and the minister start again.

Let me focus on the council. Before that, let me say that I appreciated your remarks that said, "Where is the accountability for the government with respect to the health care system?" and ensuring that people have access and that waiting times, for example, are dealt with.

This brings me to the function of the council. On Monday the minister suggested that one of the mechanisms that makes him accountable with respect to health care will be the council. I differ with him on that, because frankly I don't see that the council has much of any responsibility that the minister will have to be accountable for.

In the bill as it's presented, the group doesn't even make recommendations about the health care system; they can only make recommendations about what they report on. Right now their functions are to monitor and to report; nothing about making a recommendation with respect to what they found. That concerns me, because what will then force the minister to respond?

You mentioned wait times. The example I've been using is that Cancer Care Ontario, as early as 1999, was suggesting that optimal waiting time, the benchmark they're trying to work toward, is four weeks for someone to start cancer treatment, and they're not meeting that. They're not the only group that is not meeting wait times. Even if the council was to report on that, they can't make recommendations about what the minister can do or should do about that with respect to funding etc, nor can they make recommendations about changes to health policy, health laws etc.

You sat on a group that made recommendations. I don't know where they went. My concern is, we're going to have yet another group that gives a report about the state of health and nothing happens from there.

Dr Beck: It would be difficult to know what happens with some of these reports. Certainly the Ontario health council is very similar to a recommendation made by the George report for a body to oversee some of the things this council is going to see. As a citizen of Canada, you do see that there are lots of reports requested. As well as the George panel, I'm also presently involved in the technical advisory committee on the disability tax credit.

One of the things you see is that ministers themselves become, I guess you could say, attached to their committees. They pick people who they think can do a reasonable job, they see the work they do, they see that they're trying to work very hard to get good, timely recommendations, and they know themselves that there are political pressures on recommendations that may not be in keeping with what their government wants. But I genuinely think that when ministers look for recommendations from committees, for the most part they want to be able to put in place the recommendations of those committees.

This seems to be, in many respects, an entirely cynical bill. When you read through it, there is phrasing and tone that really suggests there isn't a lot of goodwill between the government of Ontario and the people of Ontario and between the government of Ontario and the physicians and health care providers of Ontario. I don't believe that to be the case. I have worked very closely at times with Richard Patten. I know who he is. I know what he believes in. It doesn't seem to be reflected in this kind of bill. It's very hard to believe that this bill actually passed through the minister's office, in my view, because it's so cynical in the way it looks at relationships that we know have been reasonably strong. Hopefully it's something that will be remedied.

1000

Ms Martel: I know you're very busy, so I'm not sure how much time you had to do all this. If you look at the preamble, it has really glowing statements about medicare, which are motherhood statements. For goodness' sake, of course we support medicare, in this of all countries. If you look at the statements, that this bill is going to essentially confirm Ontario's commitment to the principles of public administration, comprehensiveness, universality, portability, accessibility, that we're going to prohibit two-tier medicine, and then you look at the details of the bill with respect to where the funding is for home care, where the funding is for pharmacare, do you see provisions in the bill that actually support the preamble, that actually are going to enhance medicare in the province?

Dr Beck: This government right now has a unique opportunity to do something to ensure the sustainability of the health care system in this country. Our health care system has been the envy of the world. Commissioner Romanow, Senator Kirby—we have reports coming out our ears with suggestions for how the system can be changed. The physicians of Canada themselves and the physicians of this community support those views and are ready to work toward a sustainable health care system in this country. The physicians of Ontario are prepared to work with our government, with the council of federations, in order to ensure sustainability of this health care system. We're committed to it. We've been working in it for a number of years. We work extra hours in it.

We would like to see in this bill some statements by the government of Ontario of how it's going to work with the Romanow report, with other provinces, with the people of Ontario to set up care guarantees; how it's going to work with different communities to recruit young physicians, to ensure that they have the residency spots they need to train when they're finished medical school. There is nothing about any of these things in this bill.

The Chair: I'm going to the Liberals now.

Ms Kathleen O. Wynne (Don Valley West): Thank you very much for being here today. I just wanted to make a couple of comments and then I think some of my other colleagues have questions. I don't know if you had a chance to get a copy of the minister's remarks from yesterday.

Dr Beck: I did not.

Ms Wynne: OK, we will get a copy of those for you. You talked about the tone of the bill, and I think it's important that we acknowledge that we think we got the tone wrong. The minister has said that. There are definitely changes that need to come and we need to address that tone. When I hear you speak, it sounds as though you're seeing this bill as an attack on individual physicians, and that is certainly not the intention in any way. So I'll make sure you get a copy of the remarks.

I wanted to address a couple of your other concerns. You talked about subsection 17(2) in the accessibility section. The minister has talked about adjustments needed there, so there will be amendments coming forward to address that concern.

You also talked about concerns in the accountability section. I guess I wanted to ask you whether you have a concern that the accountability measures put in place—and they're not very specific. They need to be more specific, and they will be, as the bill evolves. One of the things we need to remember is that this bill is out after first reading, so there are a number of other opportunities to work on it. That's also part of our strategy, to do consultation early on in these pieces of legislation so that we get them right.

Around the accountability issues, is it your fear that individual physicians are going to be held to account in a way that they're not now? The intention of the bill is that the accountability provisions will apply to a broad range of publicly funded organizations. We understand that doctors are already accountable for their clinical standards and the OHIP requirements. Can you just talk about your concern there a bit more?

Dr Beck: I do have concerns when I go through it that physicians in this community, and other health care professionals as well as non-professionals, contribute in a number of ways to health care through their volunteer work. We're dependent on that volunteer work. In addition to that, because that work is voluntary, in a way, we know that some of the people who step up to do it want to do it for the kinds of reasons that come from our best inclinations and not from those that are influenced by financial gain.

I don't understand why the accountability section of that, when there are concerns about accountability in other ways that we're worried about, is emerging in this bill. I guess I could say that maybe it goes back to the tone. I don't know why, coming right out of the gate, when you look at the relationship that most people in this province have with their physicians, with the nurses who treat them, even in their communities if they feel they have to present to the boards of their hospitals—we have good working relationships. There's no need for this tone in this bill.

Ms Wynne: Right. If we can find a way to address the tone, I think what this comes out of is a general sense that we're putting millions and millions of dollars—when I say "we" I mean the whole society—into health care and there's a sense that we don't really know where it's going

and we don't really know what the practices are. What we're trying to do is to bring some clarity to that. In talking about these accountability agreements, if the government has some standards, some goals in place, and builds a framework around what health care should be delivering and then enters into these agreements with organizations and there's a discussion that goes on, I guess that's part of what needs to be laid out in the bill: What's the process whereby the accountability agreements are put in place? Would you agree with that, if there was more clarity there?

Dr Beck: I would agree with that. I would also agree that those things have to be a little bit of a two-way street. It's one thing to say—because some of this stuff is best guesses. We have some good evidence-based wait times. We have some idea of how long is too long to wait for a hip replacement, how long is too long to wait for a psychiatric consultation. We have that kind of evidence. Even physicians don't agree that the only way to solve a problem is to throw money at it. You have to consider not only the investment, but which are the parts of the investment that are going to pay back what you really want.

Ms Wynne: So in putting those agreements in place there has to be a solid discussion between the government and the—

Dr Beck: Yes, and an ongoing dialogue. If I see someone in my office and they're not well and I say, "I think maybe you should have some psychotherapy from a social worker; I think maybe your family ought to do this or that," I don't make that recommendation and say, "Come back in three months to see what's happening." There's an ongoing dialogue about whether or not they feel that's needed. That's how health care works. There are ongoing dialogues between health care providers and their patients. This bill looks as though, all of a sudden, we'll just throw in some government here and see if that works. There is evidence in this country for how government best works in the system.

Ms Wynne: Am I out of time?

The Chair: Yes, you are.

Ms Wynne: OK. I just want to reassure you that a number of the things we've talked about are going to come forward in amendments. If we don't get the tone right, this won't work. It is certainly our intention to do that.

Dr Beck: It's not only the tone; it's what behind the tone and why that tone emerges, but I thank you for that reassurance.

Ms Wynne: We'll get the copy of—there it is.

The Chair: Thank you, Dr Beck, for coming today. We certainly do appreciate your input. Thank you for taking the time.

1010

DENNIS PITT

The Chair: If I can now call forward the representative from the Ontario Medical Association, the Ottawa chapter, Dennis Pitt.

Dr Pitt, same rules as I outlined before. You've got 30 minutes. You can use that any way you choose. At the end of your presentation we'll share the remaining time amongst the three parties.

Dr Dennis Pitt: It's a pleasure to be here, ladies and gentlemen, and to have the opportunity to make some comments about this bill. I'm a general surgeon. I have practised in Ottawa for more than 20 years. Currently, I practise at the Ottawa Hospital. I'm an assistant professor of surgery at the University of Ottawa. I'm a member of the academic alternate funding plan at the Ottawa Hospital, which currently is in phase one.

I serve some executive functions at the Ottawa Hospital: I'm vice-president of the medical staff association, a member of the board of governors of the hospital and a member of the medical advisory committee and several other committees at the hospital. I receive no payment from the hospital or from the ministry for those executive tasks. I get a small stipend from dues that my colleagues, other doctors, pay. Almost all my income comes from clinical care, looking after patients. I make those remarks so you'll understand my concerns about the accountability provisions of this bill with respect to executive functions in the hospital.

I firmly believe the system of medical care we have here in Ontario is the best in the world. If I got sick in any other country besides Canada, my first concern would be getting back to Ontario. If I got sick in any province other than Ontario, my first concern would be getting back to Ontario. I think we have the best there is.

That's not to say there's no room for improvement. There certainly are areas that are not perfect that I would have liked to see Bill 8 address: the shortage of physicians; doctors leaving the hospital, not infrequently, because of a lack of resources to look after their patients; as a surgeon, the long waiting lists are a day-to-day concern that I have to face; on the hospital board, I hear at least every month about funding that's unpredictable and difficulties knowing what our budget is.

I'm speaking to you today not as a board member from the Ottawa Hospital, not on behalf of any medical organization or the university; I'm speaking to you as a practising surgeon in private practice here at the Ottawa Hospital. So my remarks are not the official party line from any organization.

When I read this bill, the preamble was wonderful. It's great. I support it entirely. Obviously, whoever drew up this bill, the people behind it, the minister, have good intentions. Their heart is in the right place. They mean well. However, there are some things in the bill that obviously have not come out right. They mean well, but the effect will not be what they intend. I'll comment mostly about accountability, and I'll make a brief comment about annual fees for uninsured services.

Sections 21, 22, 24 and 27 concern accountability. I have no legal background, so I don't pretend to have expertise in reading this type of bill. However, I read these sections several times, and what they mean to me is that health care providers such as myself can be forced

by the minister to sign an accountability agreement for their executive duties and the minister can change it unilaterally or terminate it, and the health care provider is deemed to agree.

I read that several times, and to me this doesn't talk about an agreement. This is not an agreement. The word that comes to mind is "dictator." I can't imagine that I would ever enter into an agreement where somebody can dictate those types of terms to me and I have no say in the matter. As I said, in my positions I'm not employed by the ministry and I'm not employed by the hospital. I do what I do because I want to do it. I think I'm making a significant contribution. My colleagues elect me to the medical staff executive, and certainly the money is not a factor. So why I would enter into an agreement where I can be dictated to on these terms is unimaginable to me.

The second problem with these sections, as I read them, is that the minister can deem that I agree to any changes in the accountability agreements. When I read that, the word that comes to mind is "perjury." The minister can force me to perjure myself, saying that I agree to something when I don't. Obviously, I would never put myself in the type of position where anybody, including the Minister of Health, could have that power over me.

In section 31, under accountability, if I fail to comply with the accountability agreements that I'm forced to sign, I put myself at risk of a $100,000 fine. I have a wife and four daughters. They're all in school. I haven't paid for their education yet; I haven't paid for any weddings yet. For me to submit to a situation where I'm at risk of financial bankruptcy is just impossible. These provisions read more like a master-slave relationship. I know it's a very serious thing here this morning and I don't mean to be flippant, but it's almost slapstick humour when you think I would voluntarily get myself into that situation.

I don't want you to get the impression that I don't support accountability. Surgeons in Ontario probably have more accountability provisions than anybody else in this province. I'm accountable to my patients; to the royal college to maintain my specialist certification; to the Ontario college for my licence, standards of practice, discipline and quality audits; to the Ministry of Health medical review committee; to the legal system, lawsuits, coroners; to the hospital practice peer review. I'm surrounded by accountability, and I think it's a very good thing.

Unfortunately, the effect of the accountability provisions in this bill is not to increase accountability for physicians in executive functions; what they do is stop all physician participation on hospital committees, as heads of departments, heads of divisions, chiefs of staff, presidents of medical staff. No physician would ever put himself in this type of liability to carry out those functions. They'll cease all those activities. Physicians will continue to look after their patients, but that's all. They'll contribute nothing else to the hospital.

The final thing I want to comment on—and I'll be very brief—is section 16, about annual fees for uninsured services. As a surgeon, I don't have long-term patients. I see patients on referral only. So when there's an uninsured service to perform, such as signing a sick note or filling out an insurance form, the patient pays me $10 or whatever and I sign the form. And if they don't pay me, I don't sign the form. Granted, if I perceive they have financial difficulties—they're indigent or something like that—I don't charge them. But by and large they just pay me when I perform the service. I don't give them the option of paying annually for uninsured services, as some family doctors work out with their patients. It's not clear to me why the minister is interested in uninsured services that are provided.

When I read section 16, there's the threat of a jail term for physicians. Threatening my profession, threatening me with a jail term, is very offensive. It implies that we're part of a criminal class—motorcycle gang members or something. We have a problem with doctors leaving Ontario, and this provision will certainly encourage a lot of doctors that Ontario is not a very friendly place to practise.

Most of my remarks have been critical, but I have recently been told that Mr Smitherman and the Liberal government are looking at revisions to this bill. I hope these remarks and criticisms can be taken as constructive. I look forward to seeing a bill that follows through on the provisions in the preamble, and that the mechanics match the good intentions.

Thank you very much for listening and for the opportunity of speaking with you.

1020

The Chair: That took 11 minutes, which leaves 19, so we'll go with six minutes each and start with Ms Martel.

Ms Martel: Thank you for coming to speak to us today. You said the effect of the provisions will be to stop all physicians from being involved in executive positions in hospitals. Yesterday we heard very strongly from a number of board members that none of them would be around either, so we're going to have a lot of people fleeing the health care system before this is finished.

I ask you this question not to try to put you on notice or to undermine you in any way—and I asked it of the last group of presenters we had yesterday, who were a number of CEOs and volunteers: In all your capacities, although I appreciate the one in which you're speaking today, can you see any reason why the Ministry of Health and the minister would put this kind of bill with this kind of tone and language on the table? Do you see anything in the hospital, anything among your colleagues, anything in the work you do that would encourage a bill that has such draconian provisions for the minister and a tone that would just promote confrontation?

Dr Pitt: The simple answer is no. I don't think there is anything we've done to provoke it. My own view is that the minister's intentions were good; it's just lack of information about what actually happens in the hospitals and how we interact that has led to this bill, and it certainly needs to be corrected.

Ms Martel: I appreciate that you say "lack of information," maybe on his part or a lack of information being

transmitted to him about the workings of the system. But you don't have to know too much about the workings of the system to know that a response, in terms of the minister's powers here, which are really overwhelming, is like taking a sledgehammer to some kind of problem that you perceive to be in the system, and we haven't figured out yet what problem the minister perceives.

If I just look at some of the powers—it's probably worth reading a few of them into the record. If you look at the compliance directives, for example, in 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."

If you look at section 24: "The minister may at any time terminate an accountability agreement or a compliance directive, and may at any time vary a compliance directive or issue a new compliance directive."

Section 26, consequences: "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."

The powers of the minister are overwhelming in this bill. "Draconian" is probably the appropriate word to use. I just can't see how a lack of information transmitted to him about how the system works could have resulted in the kinds of measures we see outlined here.

Dr Pitt: I don't know why these measures have been brought forth either. I certainly can't answer that.

Ms Martel: If you look at the penalty provisions—and earlier you used your own personal situation in terms of four daughters at home and none of them married yet and no weddings paid for. That's your particular situation, and I'm going to assume that's the situation of most other physicians or surgeons who would be having some kind of executive position. No one is going to want to have that liability hanging around their neck.

Dr Pitt: That's correct. That's too big a risk to run financially for what we do.

Ms Martel: So unless this is dramatically changed, you would see a number of people just resigning outright from the important positions and the important work they're doing on hospital committees now.

Dr Pitt: Correct.

Ms Martel: You talked about the preamble, and I just want to go back to that for a moment. I'll ask you a question that I also asked your colleague who came before you. Who could not support the provisions in the preamble? Who could not support the statement of Ontarians' support for medicare? I look at the preamble, and then I go to the bill and see a lot of talk about accountability. I see nothing, though, that says what the government's role and accountability will be in terms of ensuring, for example, that funding is in place to support what we want in medicare or that, as Romanow suggested, we're going to have pharmacare in the province or, as even the preamble suggests, we're going to do something about home care to ensure that that's covered under the Canada Health Act.

Do you see, as you move from the preamble—which is a great statement—to the guts of the bill, anything in the bill that is actually there to either support or enhance medicare?

Dr Pitt: No, I didn't see anything positive about this. Accountability in this bill is entirely on the backs of the health care providers. I would certainly like to see something about government accountability in here as far as referring to waiting times or hospital resources or any number of things that they could have taken on as a responsibility for themselves.

Ms Monique Smith (Nipissing): Thank you, Dr Pitt, for joining us today. I really appreciate your comments and the concerns that you've raised. I think some of them have been addressed by the minister in his opening statement. I don't know that you've had a chance to see it, but I'll make sure that you have a copy before you go today.

In his opening statement before this committee on Monday, he did state that he felt he had the tone wrong in this bill and that we are working toward improving that and certainly improving the entire bill.

As my colleague noted in the previous presentation, this bill is being brought forward after first reading, which is an unusual step. We're looking for a lot of public input, so we appreciate your coming forward with your concerns. We hope to be able to calm some of those concerns and also get some more information from you so that the amendments we bring forward will make this a better bill and will really fulfill the intentions of the act.

You had concerns about accountability with respect to the executive function. Let me just say that the health care providers that are intended to enter into accountability agreements in this legislation were designated or listed by the minister in his statement as hospitals, CCACs, long-term-care facilities and independent health facilities. He went on to state, "The bill does not apply to solo physicians, group practices or labour unions. We will offer amendments that make that abundantly clear." That's just to calm your fears that the accountability agreements will not apply to practitioners like yourself.

I recognize your concerns about the shortage of doctors in our communities. I'm from northern Ontario so I'm fully aware of that need and, of course, of long waiting lists. That's another concern that we as a government hope to address over the next four years. The unpredictability of funding is a concern that I think is being addressed as we negotiate multi-year funding agreements between our hospitals and the ministry. I know that that work is ongoing. I appreciate your raising those and I want you to know that we're also very cognizant that those issues are outstanding.

You raised a number of specific concerns. One was with respect to leadership in the hospitals and those who would be part of performance agreements. I think the intention of this legislation is to designate those

performance agreements specifically between a CEO and a board. The accountability agreement would be between the board and the ministry, and then there would be a subsequent performance agreement between the ministry and the CEO that would reflect that accountability agreement. I don't think the roles that you're playing, and that we appreciate that you play in your hospital, will be affected in any way by this legislation.

You talked a little bit about section 31 and the fines there as being harsh. I had to chuckle when you talked about your four daughters and their weddings. My brother is getting married this weekend so a wedding is very much top of mind, as my colleagues have heard me talk about this week. So I appreciate that. We have heard that message.

As you no doubt are aware, the ministry and the minister himself have been in discussions with a number of stakeholders from the first reading of this bill up until these hearings started. Certainly in our discussions with the OMA we've heard about the concerns surrounding that. I think you'll see amendments around the fines, the penalties, the harshness and the incarceration. That was part of what the minister was trying to address in his "tone" comments and I think you'll see some amendments there that will satisfy you in that regard.

I was pleased to hear that you support the notion of accountability. I'd just like to expand on that for a moment and ask you, are you supportive of the notion of accountability agreements between hospitals as we foresee it now through boards and the ministry? Do you think that's generally a good idea?

Dr Pitt: Yes, I do support that. In our alternate funding plan for the academic centre, there are accountability clauses, for primary care reform there are accountability clauses, and I am fully supportive of that.

1030

Ms Smith: Great. I also just wanted to ask you briefly about your comments on block fees. I understand that you don't have that experience in your practice and you've raised a question as to why that would be raised in this legislation.

I think one of the concerns out there is that while we hate to, in effect, legitimize block fees, they are in fact in place in a number of practices and we are hearing of situations that we are very concerned about where block fees are being charged, $2,500 a year, and are seen as kind of key money in order to secure a family physician. Because of the shortage, there's some jockeying. So we're concerned about that and we want to make sure that, within the framework, health care is accessible to everyone and that these fees aren't prohibiting someone from accessing health care.

I just wondered if you had any other thoughts or ideas. We're really looking for direction on this one as to how we could structure something that would allow physicians the flexibility they need but also address our concerns about accessibility.

Dr Pitt: Excessive fees charged annually for non-insured services are wrong and I would not support that. The College of Physicians and Surgeons of Ontario currently regulates block fees. They have a number of provisions for it. I'm not familiar with them, because I don't charge them. The college, in my view, does a very good job of regulating physicians in Ontario and I think working with them and making the provisions adequate to handle the concerns that you have representing the public would be the process of solving this problem.

Ms Smith: Oh, I'm out of time.

The Chair: You are. Mr Klees.

Mr Frank Klees (Oak Ridges): Thank you, Dr Pitt, for your presentation. I think you are joined by probably everyone in the health care sector across this province in your consternation about this bill. The encouraging thing, or discouraging thing, is that you're joined by the Minister of Health himself. In his opening statement to this committee he seemed to reveal that either he had not read the bill before he came to committee or he read it and didn't understand it, because he was clearly embarrassed at what he was reading. He was clearly embarrassed at not only the tone—he referred to the tone—but clearly was embarrassed by the structure as well, because he gave directions to his parliamentary assistant to assure everyone that there would be wholesale changes to this bill.

I think one of the key issues that we have heard time and again, regardless of who the stakeholders were—we've heard from medical doctors, nurses, labour groups, the volunteer sector—whether they be boards of trustees or others, there's a consistent theme here. Never before have I been in a committee where everyone condemns the bill.

So from that standpoint, we have a problem as a committee. We should be hearing recommendations in terms of how to make it better, but the underlying theme is that really this is so bad that there's not much left to breathe life into it.

A fundamental concern is the absolute disregard for contract law that I think reflects not only on this bill but on this government. In your particular case, you refer to it. Sections 27 and 28 concern many people, whether they're medical doctors who have entered into agreements—and there are many agreements that physicians enter into with hospitals and various other organizations—or whether it's an association, but the issue is of the Minister of Health having the absolute authority to set aside those agreements and, according to sections 27 and 28, you as the recipient not being entitled to any compensation for a setting aside of that agreement. It goes for you as a medical doctor; it goes for a CEO who may have an agreement.

Certainly on this side of the House we feel very strongly that there are some fundamental principles here that have to be addressed, or, as was said previously, we won't have anyone in health care in this province at the table.

I'd be interested to know how you feel about this. Our recommendation is that, given the preamble and all of the good things that are said there and the absolute dis-

connect between the preamble and what the bill says—it must have been two different sets of people drafting, because the one obviously didn't know what the other was doing—the best thing to do is to scrap this bill, set it aside, and go back to the Minister of Health and say, "You had the preamble right. Now, would you please draft a bill that's consistent with that, that sets aside all of these other concerns?" How would you feel about that?

Dr Pitt: That sounds reasonable to me. I think the important thing is that some health care providers who are what we call "on the front lines" have some input here, and that specifically doctors should be consulted and involved in the drafting of these types of bills before they come to first reading.

Mr Klees: On that note, Chair, I do have a motion that I'd like to put forward for consideration by the committee. I can do that now or I can wait until after this deputation.

The Chair: This deputation is over in 10 seconds. Dr Pitt, I want to thank you for your time.

Mr Klees: In that case, I'd like to do it now.

The Chair: And you have it in writing for us, Mr Klees?

Mr Klees: I do.

The Chair: Very good. You're going to read it into the record, then, Mr Klees? After that, can we get it to one of the clerks to get it copied so that all members have a copy?

Mr Klees: I'm happy to do that. I move that whereas the committee has heard from stakeholders representing the broadest possible scope of health care professionals and volunteers engaged in the governance structure of health care delivery in the province; and

Whereas deputations to the committee have been heard from stakeholder groups representing medical doctors, nurses, social workers, representatives of boards of trustees, hospital CEOs, labour councils, as well as consumer representatives, all having unanimously condemned not only the tone but the fundamental premise of this bill; and

Whereas the minister himself has conceded that the bill is flawed, and the repetitive insistence on the part of the parliamentary assistant to the Minister of Health that wholesale changes will in fact be made to the bill; and

Whereas those amendments will in fact result in such substantive change to the bill that the very basis of the bill may well be overturned and therefore be found not to meet the requirements of the Legislature's standing orders;

The committee recommend the immediate withdrawal of Bill 8.

The Chair: If we can call a brief recess, we can get that photocopied. We'll recess for 10 minutes.

The committee recessed from 1040 to 1050.

The Chair: Mr Klees, as the clerk was photocopying your motion, they reviewed it and have informed me that it is out of order. The proper procedure would be to either vote for or against the bill. That's within our powers, obviously. We don't have the option to withdraw the bill as a committee or as individual committee members. We can vote for or against the bill, and that obviously takes place during clause-by-clause, which starts on March 9.

Mr John R. Baird (Nepean-Carleton): On a point of order, Mr Chair: Thank you very much for the opportunity to make a point of order. The motion itself doesn't call—I recognize you're very correct in your decision—for the committee to withdraw the bill. The motion simply is a statement of the wishes, the desires of the committee to the government, to the minister, that we are recommending. You're very right, we can't withdraw it ourselves, but the motion drafted by my colleague Mr Klees merely makes a recommendation to the minister.

I think procedurally doing that, the minister himself in his statement the other day and then the parliamentary assistant and other members of the government have indicated that substantial motions will be coming forward. I know, in addition to the reasons outlined by my colleague from York region, the deputants who are coming before us won't have the opportunity to give public comment on those amendments.

Simply put, I recognize we can't withdraw it, the committee doesn't have that power to withdraw it, but we could certainly recommend that the minister and the government—the executive council, the executive branch of government—take the advice of this committee. That's their decision.

The Chair: The advice I'm receiving is that the bill cannot be withdrawn. We'd be recommending something that could—

Mr Baird: I realize we can't withdraw it. We would just simply make a recommendation to the executive branch.

The Chair: But the bill cannot be withdrawn in any event. It's got to be voted for or against.

Mr Baird: No, if we made a recommendation to the minister, he could talk to his colleagues and say, "You know what? You're right. It's unfair to the presenters to come forward and make presentations any more in the absence of the amendments with which we're going to deal with all of their concerns. Gee, I appreciate the advice of the committee, and I'm going to recommend to the committee that they cease their hearings, and when the House comes back on March 22, that we would withdraw it." It's a recommendation. Obviously, we can't withdraw it in this committee. I recognize that. We can't vote to withdraw it, but we can just give a recommendation as a legislative committee to the executive branch.

The Chair: OK, the advice I'm receiving from the clerk is that that is out of order and cannot be done.

Mr Baird: Why? I don't mean to challenge your—you're just passing along—

The Chair: No, no, I appreciate this, because I do want to do this correctly.

Mr Baird: I appreciate your willingness to entertain the discussion. We can hear from the clerk, it's fine.

Ms Smith: Just make up the rules as you go along.

Mr Baird: Oh, you're an expert in the rules three months into the job, are you?

The Chair: I'm trying to listen with one ear.

OK, I've conferred with the clerk again. We have a few alternatives. One of those is not to recommend the withdrawal of the bill. We can report back to the House, obviously. We can choose to not report back to the House. We can report the bill back, as amended. We can report the bill back with no amendments, or we can not report at all. But we could not make a recommendation that the bill be withdrawn.

Mr Baird: I agree with you. I accept that. I accept your ruling. Could Mr Klees move a motion requesting that the committee halt its hearings and report the bill without amendment back to the House?

The Chair: During clause-by-clause, but by then, obviously, the hearings would be over.

Mr Baird: We couldn't report it back now, seeking to amend the subcommittee's report? I just think it's unfair to the people who are making presentations to offer—

The Chair: OK. I think there's a way of achieving what you would want to achieve. If the committee was prepared to go into clause-by-clause right now, it could do that.

Mr Baird: Thank you.

Mr Klees: I think it's important that the intent of this motion is fully understood by the committee. I wouldn't challenge the ruling relative to the point that has been made; however, I do believe there may be another alternative here, and that is that the committee communicate with the minister that this motion has been made and to allow the minister then to make a decision, based on what the committee has found, to act on it or not to act on it. I would ask that at least we consider doing that. I think it's important, Chair, that we, at the earliest possible opportunity, communicate with the minister the gravity of this situation.

I'm the first one to say, yes, let's consult. But we have had a very clear expression so far that this committee is effectively wasting taxpayers' dollars by taking a bill across the province that is so fundamentally flawed. Let's conduct hearings on the basis of a bill that at least is substantive and that people can embrace. That's my intent. So if we can at least agree—

The Chair: I think that will probably happen as a matter of course. I've ruled the motion out of order. It's not debatable, but I did want to explain the reason for that. I think the fact that you have made the motion is probably on the news. It definitely will be getting back to the minister in some form. To ask for the committee to report to the minister on a motion that was ruled out of order I think procedurally would be incorrect. I haven't been here a long time, but news seems to travel pretty quickly from building to building. I suspect that's going to happen in this case. So on that, unless you've got another point of order—

Mr Klees: I do. I would ask, then, not necessarily that you do, but I certainly would ask that the clerk ensure that the minister is apprised and receives communication of this—let me put it this way, because I see you getting some advice and some shaking of the head. Let me preempt that.

Ms Smith: Mr Chair, maybe I can pre-empt this by saying that I will undertake to advise the minister of Mr Klees's concerns and of the fact that he brought this motion. Would that satisfy you and can we return to the presentations?

Mr Klees: Would you be willing to do that in writing and present me with a copy of that?

Ms Smith: Of a letter that I write to the minister, or of my undertaking?

Mr Klees: No, of a letter that you write to the minister advising him of this motion.

The Chair: There we go.

Ms Smith: I can call him.

Mr Klees: Would you be willing to do that in writing?

Ms Smith: Mr Klees, if it will allow the presenters who are waiting to present, yes, I will put it in writing.

Mr Klees: Thank you very much. I appreciate that.

The Chair: Everybody's happy again—I thought. Mr Baird.

Mr Baird: I appreciate that you're doing an excellent job. These issues are very complex.

I have a question for the parliamentary assistant. Would she be willing to table the amendments to this bill for 30 days just to allow all these presenters to see the amendments rather than—we'll be back in Toronto—

Mr Khalil Ramal (London-Fanshawe): Point of order, Mr Chair: We are here to listen to different presentations. We have a busy list. We're not here to debate. I would rather listen to the people and then take their consultation instead of debating among us.

The Chair: I tend to agree with you, Mr Ramal.

Could you summarize in 20 seconds what—

Mr Baird: Sure. I just want to know—there are a lot of apologies to the presenters that the bill is terrible and we're going to fix it. Would the presenters all have an opportunity to see the amendments to fix it before we vote on it? We're basically going to gut the bill, and I want these folks who have come here to be able to see the fix-it before we vote on it.

The Chair: We'll get you an answer on that before the end of the day, Mr Baird.

Mr Wilson: Just a quick point of order that I believe is a point of order: The minister made a commitment on Monday to present within 72 hours a draft outline of the amendments that he was considering, and we haven't been presented that today.

Ms Smith: It's only 48 hours now; 72 hours would be tomorrow morning.

Mr Wilson: Today is Wednesday, isn't it?

Ms Smith: We started on Monday.

Interjection.

Mr Wilson: OK, "within." So is it coming tomorrow?

Ms Smith: You'll have it within 72 hours of when the minister made the commitment, which was 1 o'clock on Monday.

Mr Wilson: OK. It's appreciated.

The Chair: Thank you all for your patience and cooperation. I believe we're back on track—not that we were ever off track.

1100

CAPITAL HEALTH ALLIANCE

The Chair: Now we are going on to the Capital Health Alliance, who are represented by Tom Schonberg from Queensway-Carleton Hospital and Jeff Polowin. Alasdair Smith is not here today; is that correct?

Mr Tom Schonberg: That's correct.

The Chair: Very good. I'm not sure if you were here at the start of the day. You've got 30 minutes to use as you see fit. At the end of your presentation we'll split that time amongst the three parties equally.

Mr Schonberg: Sounds good. Thank you very much. Obviously, we have heard a number of the presentations. You will hear a lot of the same information. But first of all, I'm here representing the Capital Health Alliance, which is essentially a voluntary amalgam or association. All the health care providers in this region are represented, so it's the hospitals, the community care access centre, public health, the district health council, etc.

We support, basically, the government's commitment to medicare and the key aspects of the bill, the adoption of the five principles as well as the inclusion of accountability. As has been said many times, the preamble in the bill is good. The rest of the bill, though, does not fit.

Specifically, what doesn't fit? When the bill talks about accountability, the way it's drafted, it will undermine community involvement and certainly the involvement of local voluntary governance for public hospitals across this province. Revisions don't provide for shared accountability, and by any definition of accountability by any management guru or practising management authority, it has to be shared. In other words, providers and government have to have a dual accountability framework or agreement. It has to be negotiated. Otherwise it's a directive and nothing else.

The bill also speaks to the tenets, if you will, of medicare, but it is silent with respect to accessibility. In other words, this government took power and recognized that we had major issues as far as wait times and there is nothing in the bill that, specifically in the accountability, addresses or makes a commitment by government to address accessibility and wait times.

Being a little bit more specific, and many of you have already mentioned this, in the bill sections in the 20s—they are numerous: 26, 27, all the 20s series, essentially—the way the bill is drafted, it is directive. It is one-way. It really will turn the boards into advisory boards. My board chair is here representing, as an example. Board chairs will speak to that further. Obviously, if you have a bill that enables the minister to change the relationship with a CEO—and the CEO, as well as the board chair, are the only two people the board has the authority to hire and fire. They look to us to run the hospital and to hold us accountable. But when you take that authority potentially away, as this bill would do, it would make someone like myself really like a civil servant, if you will, or a bureaucrat, yet it undermines any protection that I might have as part of the bureaucracy as well. You've heard that before. You will lose a lot of talented people, not only from boards but from management, because really you're in an untenable situation.

The government also was quoted from the Ontario speech from the throne in November saying that "Your new government understands it can only hold others to a higher standard if it subjects itself to the same standard." That's, I think, one of the premises in this bill that is not addressed: about the dual accountability.

One of the other aspects that I think is critical, which I'm not sure you've been made aware of, is that a similar type of arrangement exists in British Columbia. The auditor general very specifically stated that these accountability agreements or performance agreements must be made between hospital boards and the government. It is up to the CEO, the chief of staff and, on the government side, the deputy and the rest of the bureaucracy, to actually implement. I did hear the previous presentation, and I'm very well aware of that. I sit on behalf of the OHA on the provincial task group that is looking at Bill 8 and that is also working with the government to come up with a performance agreement for all hospitals across this province.

Our concern is that it may be said that the minister does not want to undermine voluntary boards, but it has been said before that unless you scrap the major parts of this bill that essentially provide a directive relationship between the minister and the CEO, you will still undermine the board, irrespective that you say the intent is not to do so. My colleague will speak to the fact that in doing that you will undermine a check and balance we've had in existence for many years between community representation on one hand, which looks after community interests, and government interests, which often, realistically, are focused on resource conservation or resource allocation. Jeff?

1110

The Chair: I'm sorry, I didn't ask you gentlemen to identify yourselves. I introduced you, but—

Mr Schonberg: I'm Tom Schonberg, CEO of Queensway-Carleton, and I'm also representing Capital Health Alliance.

The Chair: Just for Hansard, would you identify yourself as well?

Mr Jeff Polowin: My name is Jeff Polowin. I'm the chairman of the board of Queensway-Carleton Hospital. In my 9-to-5 life, or lately it seems like my spare time, I'm the senior vice-president of a major public affairs firm. Since assuming the chair's position at the QCH in June of last year, I've spent more than 400 hours, travelled more than 4,000 kilometres, have been out at umpteen night meetings when I could have been at home with my wife and spent countless hours on the telephone. It's not about me; I'm not alone. There are hundreds of people like me across the province.

Why do we do this? I can only speak for myself. I do it because this community has been good to me and to my family, and I want to put back. I want to play a role in ensuring that people in our community receive the health

care they want and deserve, and I want to know that the hours I'm putting into this make a difference.

I honestly believe that if you pass this bill the way it is written, I will not be making an impact. I believe that I, and people like me, will become figureheads. I believe that the only people who will be board members in the future are those who want to put board membership on their resumés. And believe me, you don't want those people.

I've canvassed the members of my board. They're lawyers, accountants, public servants and consultants—busy people who have made this commitment to their community—and they've all told me that if this bill passes the way it is written, they're gone. They don't want to be figureheads; they don't want to be rubber stamps. They want to make a difference. Those lawyers, accountants, public servants and consultants also derive great pleasure in providing the hospital, free of charge, with the benefits of their expertise, experience and networks. Who knows what extra costs will be incurred by hospitals that are not able to call upon these free services any longer? People often ask me why I got involved with the board. I served as a consultant for them, and then they probably figured, "We can get this guy for free if we put him on the board." It works.

There's a great similarity in all our roles. We are all working hard to provide the people of our communities with the health care they deserve. I do not receive a salary or even expenses. The only remuneration I receive is the feeling I get that I'm making a difference. Don't pass this bill the way it is written and deprive me of that. Thank you very much.

The Chair: Thank you, gentlemen. You started at 11:02 and it's 11:12, so we've got about six minutes per party, starting with the Liberal Party this time.

Ms Smith: Thank you both for your presentation today. We really appreciate it. I do appreciate the time you put in as a volunteer on a board. My mom sat on our hospital board for a number of years when I was a kid, and I remember the time and commitment it took to better the services we're provided with as a community. So we really appreciate and acknowledge that.

I assume, Mr Schonberg, because you've been involved with some of the OHA discussions, you're aware of the minister's statement that was made on Monday. I don't know if you've seen it as well, but I will provide you with a copy if you haven't.

Mr Polowin: Thank you.

Ms Smith: In it, the minister makes very clear that the accountability agreements we are looking to institute through this legislation will be between the boards and the ministry, and not with the CEOs. The boards would then be expected to enter into performance agreements with their CEOs which reflect the accountability agreement. I think that goes some way to calming the fears that have been raised about lack of recognition of boards' existence or undermining their governance authority. Certainly we don't want to do that. We recognize that boards are doing a huge service and governing their institutions well, and we want to make sure that continues.

I want to just make sure you knew that those amendments are coming forward, as I'm sure you know, Mr Schonberg, because we've been in discussions on these with the OHA for some time, as well as with other stakeholder groups. What we've done in this instance is bring forward this legislation after first reading, recognizing there is work to be done and asking for your submissions. That's why we're here, and that's why we appreciate that you're here. Although the members opposite may feel this is not an important exercise, we on this side certainly believe it's an important exercise and we want to get your input. So we appreciate your taking the time out of your busy schedule.

I was interested in your assumption or speculation that the accountability agreements we're looking at in this legislation are similar in type to BC. Where does that assumption come from?

Mr Schonberg: It comes from the joint committee I sit on between Ministry of Health officials and ourselves. In fact, I think it's a wise thing. We're looking at the agreement from BC; we're looking at agreements in Australia. I'd just comment that the common premise in all of them is that the agreements are made between the political head—the minister, if you will—and the board. But certainly BC is our prime example. It has existed for a year or two, so it makes a lot of sense to use that as a guidepost.

Ms Smith: In your discussions, obviously you're using it as a guidepost and not the absolute model. You're using it as a starting point from which to build a type of agreement that would suit the Ontario model.

Mr Schonberg: Yes, absolutely.

Ms Smith: OK. That's great. I know one of my colleagues had a point to raise as well, so perhaps I'll pass it on to Mr Levac.

Mr Dave Levac (Brant): Thank you very much for making your presentation. I also want to make mention of the fact that in your very thorough presentation you have identified the good parts of the bill. We're not going to throw out the baby with the bathwater and you're offering us recommendations. As I had the opportunity to say to the presenters before you this morning from the Ottawa Academy of Medicine, the OMA and the rest of the people on our deputation list, which goes right to 4 o'clock, thank you so much for bringing your concerns forward. They will be listened to.

After a first reading bill, I'm assuming the groups talked about the potential for making amendments and that there were amendments offered on several occasions. I understand you're working with officials to speak specifically to the changes you're proposing and would offer those amendments to us in some form, either in this deputation or in writing, so we could look at how we can improve and make the bill even stronger. Is that a fair assumption?

Mr Schonberg: Yes.

Mr Levac: In a nutshell, we are still going to Windsor, Niagara Falls and Queen's Park to receive more deputations from more people who have issues.

I can say to you that negotiated accountability agreements are a reasonable thing to request, and I thank you for those observations. Also, the dual accountability you spoke of—I think this government has indicated, either through the throne speech or through other actions up to that point, that they believe there is a dual accountability that will be built into this bill or other bills that will be coming forward.

Other deputations made the comment, in general, that they're looking at wait times. Some of the members on both sides have made comments about wait times for psychiatric help, wait times for surgery in the hospitals, wait times, period, and all the other changes. Is it your belief that this bill is the only thing that can encompass those particular concerns that are raised? Would you believe that legislation to follow could take care of some of those issues as well or do you think it needs to be put into Bill 8?

Mr Schonberg: I think Bill 8, as has been said before, is focused on accountability, and really focused to a large extent on ensuring accountability from hospitals in particular and health care providers, back to the government, yet the preamble and even the name of it really speak to ensuring the tenets of medicare. So I guess the supposition to you would be that if I look at the preamble, this bill is probably where accessibility should be covered, as well as accountability as the sixth principle. That would make sense.

Mr Polowin: If I could just make a comment about accountability, as a volunteer board chair, I think it's already there. I know about the discussions that take place in our board. I know of the work my board members do in terms of realizing how important they are to the system, and the thin line that I as a board chair have to walk. On one side, I'm responsible to the community, to the people of our community, to you; on the other side, I'm an advocate for the hospital itself. And all the while I'm aware of how important deficits are, of not being in a deficit position, of how money is spent, how the hospital operates. I think that for anybody to expend the kind of energy we do, we'd have to be aware of accountability; otherwise, why would we do it?

Mr Baird: Thank you for your presentation. The parliamentary assistant said that we on this side of the committee don't think it's important. That's ridiculous. We obviously think this bill is important.

What would happen if the two of you went to the annual meeting of your membership, the people who elect the board, and said, "We've got a big report about the future of the hospital. By the way, we're going to make major changes to it. We think it's terrible. We want to apologize for this report"? Or would the appropriate thing be to simply withdraw the report and get it right the first time? That's our argument, and I want to correct that.

I want to talk about accountability. There's nothing in this bill about the accountability that either the provincial government as an institution or the Ministry of Health or the Minister of Health has to you, as CEO. What do you think of that?

Mr Schonberg: To me, that's why the operative word is "negotiated." That's been mentioned many times. That has to be part of it. What we're talking about is that if we have an obligation to provide a certain quality and a certain amount of service, that can only be done if we know what resources we have; ie, what funding we get from the ministry, that it's guaranteed and that it's early enough so we can plan for it as well. By that nature, it has to be a two-way street. Government has to provide us in advance with what resources it can afford to provide to us, and we, based on standards, can then say, "Yes, based on field standards across this country or internationally, this is what we can give you back."

Mr Baird: But if we're talking about waiting times—everyone wants an accountable system; no one can argue with that. The growth in the population of the folks you serve, the acuity level of care required by the elderly out your back door—you can't control how many people come into your emergency ward; you can't control how many physicians come in to do deliveries in the obstetrics ward.

I appreciate negotiating the accountability agreement; it's fantastic. But nothing I heard in the minister's statement on Monday and nothing I've heard today—they'll negotiate your accountability to them, but I haven't seen anything to say what their accountability will be to you. Getting the budget ahead of time would be fantastic and great, but you and I know there are so many factors totally outside your control, whether it's funding levels for home care, rehabilitation services, supports for other professionals that fall outside of your mandate. They have a huge impact, whether it's an issue like SARS or a flu epidemic. I guess I'm just troubled by that.

1120

Mr Schonberg: Certainly the only way this will work, John, is if it is negotiated. Also, we're developing principles right now. It also has to be flexible, for exactly the reasons that you said. So that's why it cannot be unidirectional if something like SARS happens or there is a group of physicians from a certain speciality that leaves. The whole premise of this accountability has to be that it is on an ongoing, negotiated basis, that it's flexible, that it's revisited. It's a living contract. It has to be. Therefore, that's why it makes no sense whatsoever for it to be unidirectional.

Mr Baird: With respect to the accountability of medical staff, it was reported earlier that there will be amendments specifically saying physicians aren't covered. But if a physician is serving in management, whether it's your chief of staff, whether it's the head of a department—by law you have to have physicians on your board. How many physicians would you have in a quasi-managerial capacity at the hospital?

Mr Schonberg: About 15 in total.

Mr Baird: And you're a community hospital.

Mr Schonberg: Yes.

Mr Baird: Have you ever talked to them? Have they said anything about their concerns with respect to this imposition of accountability?

Mr Schonberg: Certainly they have. To be very fair, I think the clarification has been made that the accountability would be between, minimally, I guess, the hospital, the CEO and the board. So yes, they're concerned. The concern there is mostly to do with the provision that's in the existing bill about not being able to extra bill for specific physician positions that could be on salary or negotiated outside of that arrangement. But their overall concern is that any agreement that we have collectively has to be flexible and negotiated.

Mr Baird: And just finally to you, Mr Polowin: Do you have an accountability mechanism for your CEO?

Mr Polowin: Very much so.

Mr Baird: Is that just something you got last week or last month?

Mr Polowin: No, it's been in operation—I don't know—three, four years.

Mr Schonberg: Four years.

Mr Baird: So it's there.

Mr Polowin: And it's solid, too.

Ms Martel: Thank you to both of you for coming today. I appreciate it. I wanted to look to the slides. If I can deal with page 4 of the document that you gave us, it would be slide number 14, entitled "Ensuring Accessibility." It says:

"What Bill 8 fails to do

"Ironically, Bill 8 abandons a key accessibility criteria under the Canada Health Act, which the bill purports to enshrine.

"Bill 8 excludes any legislative requirements to fund the system adequately, as set out in the accessibility provisions of section 12(d) of the Canada Health Act, which in the case of hospitals stipulates that '...the health insurance plan of a province must provide for the payment of amounts to hospitals ... in respect of the cost of insured health services.'"

That's pretty strong language in terms of what the bill fails to do, particularly with respect to accessibility, which of course is one of the tenets of the Canada Health Act.

Certainly the government talks about accessibility in their preamble and yet, as you've just pointed out, there's a big gap between what's said in the preamble and what actually appears in the provisions of the bill. What do you think about a bill that's got a preamble that of course everyone would support—who doesn't support medicare in this country? Of course, I would expect everyone would support page 1; it's the rest of the document that doesn't support what's on page 1 that concerns me. I'm assuming from your pointing out accessibility, you've got a similar concern.

Mr Schonberg: Yes.

Ms Martel: In terms of the bill itself, then, what should the government do, draft a new bill using page 1 and get rid of the rest of it? It's very clear that part II is essentially another bill, the Health Care Accessibility Act, which was already in place; it has some revisions. Part III is all of the sections that most people have come forward and said are the draconian new measures the minister has which should go right out the window. That essentially leaves part I, referencing a Health Quality Council, which will have some role to survey and provide reports but not make any recommendations to the minister about doing anything. What should we do? Just keep page 1 and start again in order to actually put something in place that's going to be meaningful to people when we talk about medicare? What's your suggestion?

Mr Schonberg: I have to say I'm not a politician—thankfully, I guess—but in answer to your question, certainly the preamble speaks again to the tenets. We're supportive of a negotiated accountability being part of it, but you're absolutely correct. It should, in our opinion, address accessibility; it should address the other parts of the bill.

The other comment I would mention that we have brought forward is that—Shelley, if you don't mind, I will address this. You asked this of the previous speaker: Why do you think it has occurred? Very candidly, I think there are circumstances in our field, as in every field—we see that federally currently, right now, where you can have a runaway hospital, you can have a runaway governing board or CEO in that way as well. It can happen in any private or non-private business.

The fact is that there is existing legislation through the Public Hospitals Act, which has been used right here in Ottawa, to put in place a supervisor with the powers to remove a board and/or CEO if that's deemed appropriate in the public interest. And that's the key issue: It's in the public interest.

That's not something we're saying should not be there. It's already covered. There's a mechanism to do that in another bill, so we honestly have to scratch our heads and say, "Why is it that draconian in this specific bill?" If you want to get at non-performers, there's a way of doing that. There's a way of doing it properly with negotiated agreements where you would recognize that the vast majority are good performers and deal with the non-performance through many other mechanisms. We have recommended, for example, that you can have third-party arbitration, which can be through operational reviews, as our own hospital went through two or three years ago with the previous government. It was relatively fair, I would say.

Those are mechanisms that, I would submit to you, would be fair to do and are appropriate to bring into line. Or if there's a question about the management of a hospital, that's how you can do it most appropriately. It should not be, in our opinion, resting with a select few, the minister—and quite honestly, I don't believe it would be the minister; it would really be with the senior bureaucrats, and that to me is a very dangerous precedent to set.

Ms Martel: I appreciate that you raise the Public Hospitals Act, because we had that suggestion raised with us by the last set of presenters in Sudbury. By the way, our own regional hospital in Sudbury also had an operational review, a capital review and a supervisor as well, so the mechanisms of the Public Hospitals Act were utilized in our hospital as well.

What's interesting is that not only does the government have new mechanisms which take us far beyond the mechanisms in the Public Hospitals Act, they take us about where we were with the hospital restructuring commission, if I might, and some of their powers. But at any rate—

Mr Baird: Don't look at me. Look at him.

Ms Martel: But the words "public interest" don't appear anywhere in this bill. So not only have we moved far beyond, with powers that I think are quite draconian and reflect some of what we saw before, but now don't even reference public interest. How does that make you feel, you as a CEO who's trying to coordinate some of this, and Jeff, as a chair, to see the government move so far? We heard the same thing yesterday, that you can't see any evidence of broad-scale incompetence, money mismanagement across—how many hospitals and chairs do we have? Some 172 or 173? I'm not sure what the number is.

Mr Polowin: As a volunteer, I remember the interviews we did for people who were interested in becoming members of our board when we had some vacancies. Every one of them talked about what had happened at the Ottawa Hospital. So anybody who enters into this type of arrangement as a volunteer is well aware of how accountable you have to be already.

The Chair: Thank you, gentlemen. We appreciate your input this morning.

1130

OTTAWA HOSPITAL

The Chair: The next group, as I understand, is doing a PowerPoint presentation. The screen appears to be almost at our backs. If anybody would like to perhaps change seats, as the presentation is quite necessary, is it?

Ms Peggy Taillon: You actually have handouts of the presentation as well.

The Chair: OK. Ms Taillon and Mr Hession, welcome. You've got 30 minutes.

Mr Raymond Hession: Yes, Mr Chairman, my name is Ray Hession. I'm chair of the board of governors of the Ottawa Hospital. The previous presenters are a great segue for me, I must say. With your indulgence, Mr Chairman, I'm probably going to modify the presentation, although the materials are there for your consumption. But I would, like you, prefer to have more of a dialogue in the course of our interaction. An awful lot of what I would be saying in the presentation you've just heard from the Capital Health Alliance, in which our hospital is a major player. So again, with your indulgence, it's not to de-emphasize the issues that were made; quite the contrary. But with respect to the formal presentation you've just heard from Queensway-Carleton, I would simply say "ditto" vis-à-vis the core issues that were raised by them.

I think it's always helpful to introduce the hospital to you so you have an appreciation of where it fits and what are its essential characteristics, so I am going to cover that part of the presentation and then I'll become a little more extemporaneous in my comments. Then we can get into questions, which is the more important, the meatier, part of the exchange.

I'm joined, as you can see, by my colleague, who is the director of executive services for the hospital. Peggy Taillon is her name. She is one of the very remarkable senior people in the hospital who tries to connect on a day-to-day basis between myself and the CEO as we get on with our respective roles—a truly exceptional person. Peggy is going to help me with the presentation.

Let's get into it, shall we? The first slide, which you have in front of you, is simply asking the question, what is the Ottawa Hospital? Without attaching too much significance to the past, this hospital has undergone probably more degrees of change, I would say, than any other hospital in the province in the last five, now almost six, years. It's the result of the hospital restructuring. The three significant hospitals in the area, not to cast any aspersions on the Grace, which is no longer with us, have been amalgamated, a five-year journey that, upon assuming my office and that of my colleagues the board of governors, essentially was coming to its natural end. But getting there, five years on, was tortuous, without doubt; tortuous financially, tortuous in cultural terms, tortuous in terms of efficiencies and so on, most of which are behind us now. Indeed, we're into a new era where we're starting to see the efficiency gains and other qualitative improvements arising out of the amalgamation.

But do not underestimate the degree of impact of changes of this magnitude. I don't want to liken that to the sorts of impacts that this bill may visit on hospitals, but the sensitivity around my hospital to changes of this nature is very high because we've come through such a tumultuous period. That period, among other things, can be characterized by a particularly strong focus on the very issues that you're now concerned with in this bill.

Accountability has been worn on everybody's sleeves in the Ottawa Hospital for a very long time. I sit here as the chair, surrounded by a management team that I find exemplary—I'm quite prepared to speak further to that—and a board of governors that is equally so. Highly qualified people. I ask myself every day that I encounter either of those two parties accountability-related questions. They're almost all performance-centric—how are we doing on this or that?—that we know to be part of our well-thought-through plans. Accountability, as I say, is on everybody's minds in my hospital.

Let's just bring up the next slide, if you would.

Ms Taillon: It's not working.

Mr Hession: Aha. The tyranny of technology.

Let me tell you, we're a big hospital. In fact, arguably we're the largest in the country. Some hospitals in Toronto might argue that point, but in terms of bed count, physicians, the nursing staff, in terms of the volume of activity that passes through our doors, if we're not number one, we're certainly number two.

Another way of looking at it, in the context of the catchment area we serve, mainly eastern Ontario—not

exactly defined as such but close to that—is that we represent a little over a million people who look to us as the only critical care hospital in the region. Those of you who represent ridings that are in the metropolitan areas of, say, Toronto or the Golden Horseshoe really have to understand this. We're the only game in town, whereas if there's a critical care condition in the metropolitan Toronto area, for example, there are at least six, probably seven, critical care hospitals to which a person can be deployed if indeed there is a problem in an emergency department in any one of the other hospitals. That's not true here. We're it. So the management processes we have to put in place and the extent to which we have to respond are unique.

I dare say there are other such situations. I understand the member from Sudbury might see somewhat the same situation, but it's a very important distinction. With that in mind, let me indicate also that in the context of our accountability mindset, our hospital has excised from our operations $38 million of cost in the last two years. We do that partly as a direct consequence of the supervisor and the operation review that was done, but mainly, interestingly, we do it as a consequence of the attitude of our people.

They were told that we have a sustainability issue in the Ottawa Hospital, which is not unique—it's everywhere in the province—and we have to pull in our horns on any discretionary spending that isn't relevant to our principal mission. So the management, led by an exemplary CEO in the person of Dr Jack Kitts, has by consensus, including the doctors and the nurses, come to a meeting of the minds to say that yes, we can do better and reduce our costs by, as I've said, cumulatively $38 million.

Some of you know that during the last election, out of the most genuine frustration you can imagine, I, on behalf of my board, sent out into the public domain to many of the candidates of all parties a document that said that the financing of our hospitals in this province is broken. It isn't this year, it is a systemic problem and it's one that's got to get fixed regardless of which party would end up governing. I simply wanted to achieve a debate that was meaningful both to you as politicians and to us as honest volunteers and others trying to make this thing work.

So when I attach that act and its significance to your issue today, which is the accountability of the hospitals in this province, it speaks volumes about the misalignment between your role as government and your role as legislators and our role as people who have to make it work within the envelope of resources that we're given. This is critical. We are faced with a serious problem of misalignment, and I would put that problem ahead of the accountability issue with which you're now dealing. I don't want to leave the impression that we're not in agreement on the fundamental principle of accountability in the public sector. We're absolutely in agreement.

Some of you know me well. I've spent 40 years of my life in the public and private sectors and I know a lot about the subject of accountability, both as a public and a private sector board member, a chair of a board responsible for two audit and governance committees and public sector companies traded on the TSE. I understand this stuff.

I sat, as I thought I heard one of the previous speakers say, on the joint planning and policy committee of the OHA, and I have to tell you in all candour that listening to the discussion, including the officials of the ministry, it was amateur hour in terms of the ability of people to articulate what they meant by accountability as expressed in a form of performance agreement, whether between a board or between the government and the CEO. Regardless of that, you've got to get the performance metrics right, and there has to be a structure and logic in that performance agreement that aligns the parties in a way that we're all singing off the same page—I think I just mixed my metaphors there. Singing off the same song sheet is what I really meant.

On that, let me just spend a minute talking about what we would do, given our druthers, in terms of this bill. I'm entirely motivated by a productive outcome. I'm not interested in being critical of the bill. Much has been said about that. I have the impression that members on all sides appreciate that it's significantly flawed. That's fine.

1140

I believe that we need a robust accountability framework. I believe that such frameworks exist today in a great number, if not most, if not all, of the hospitals in our province. We must remind ourselves that the hospitals in Ontario, when you look at CIHI data and talk to persons in Health Canada who have a more national purview, are amongst the best managed and most efficient in the country. Don't forget that. When we talk about accountability, let's contemplate learning from all of what's been done in those very hospitals, drawing the distinction, as is necessary, between teaching hospitals such as my own or the community hospitals that are the majority. They are different in their characteristics, they are different in their performance measures, and so on.

Drawing those obvious distinctions, go into any number of them—you're welcome to come to ours—and have a hard look at exactly how we achieve accountability. I'll spend a minute on that, if I may, Mr Chair. Find out what are the characteristics of the highest-performing hospitals in this province. That's a clue to what should be the accountability framework. It's not a matter of abstract academics. It's a matter of: that's a high-performing hospital; that's their accountability framework; that's a good model that we should consider.

I don't see any sign of that. I'm shocked. I sat in a meeting—I'm going to share this with you; I don't want to offend anybody. I was shocked to hear an official from the ministry, a well-meaning person, talk about the accountability arrangements that are being inculcated into the New York Stock Exchange. I said, "What in hell has that got to do with the hospitals in Ontario?" Interesting question, but it happens to be on the front page of the paper and on everybody's mind. But it's a sign of the

misguided nature of what's actually going on. The real evidence of real capability to achieve the accountability that you quite legitimately seek is in the high-performing hospitals today, right in our province, and we are national leaders in that respect.

In my hospital, with our very fine president, we have delegated authorities to him as a board. The authorities of boards in public hospitals are quite unique and robust, let us not forget. We've delegated these authorities on the condition that he produce for us the evidence of the outcomes that we seek, whether in the area of quality, human resources, business processes, whatever we think is important. He's now busy, for this current round, building those plans. Those plans will come to us. There will be clear performance outcomes contained in each one. In HR, we're looking for productivity gain. In the quality area there's a whole gaggle of things we'd like to see improved, including access. Obviously there are issues around safety and so on and so forth. But it's a very robust document, and by the way, it will be a public document. It will be out on our Web site so the whole community that we serve can see exactly where we're going with their money, which is the money that you have to husband—they being the taxpayers—and that we have to make sure we execute effectively. They have to know what we're doing. We may not always agree; I hope we do.

The outcome is the evidence of alignment between what the current government wants in its health care system, what our hospital is actually doing, and the extent to which that's relevant to what our community wants. We, the board of governors of this hospital, are doing our very best to connect with those two quite relevant constituencies.

If that's a sign of a high-performing hospital, you're all welcome—you, your officials—to come in, have a hard look, figure out what the attributes of a high-performing hospital are and import those attributes into your legislation as attributes—not a whole bunch of dictates which may be irrelevant to some hospitals; the attributes. Then undertake as a government to say, "From year to year, we will take those attributes and specify what it is we seek from you." I tell you, it would be an all-time first if government did that. We'd take that, we'd inculcate that into our plans and we'd generate executable, real, live stuff that would achieve those outcomes. Accountability would be aligned.

We would debate with you if we can in fact afford what it is you're asking us to do. That's a fair debate. Frankly, I've polled our CEO and he's now ruminating on this. I said I don't want to get into this business of speculating with the current government as to what might be the up tick in our budget next year. That's a mug's game. For two years I've done that now and it's never turned out to be right. In fact, I get sandbagged and I get blindsided left, right and centre. I don't want to do that. So we'll say from now on we're going to budget on the basis of exactly what we know, which is our current operating budget. We're not going to make any assumptions about growth. We're going to explain to the government, as an accountable entity, what it means if there is no up tick, what programs will have to be reduced, changed or whatever. Then the accountability connection occurs. You make the funding decision. That will affect my ability to deliver services. It's up to you. If you don't want to fund it, we'll cut the services and we will agree on what those cuts are.

I'd like to conclude with this thought. There was a question that was asked by one member about how many doctors are performing management functions. In our hospital it's about 70. We're a big hospital. We have about 41 programs, I think, something like that. Those people have been sitting in a room, off and on for the last three months, and they will continue to do that through this month, determining the clinical priorities of the Ottawa Hospital. That means there is a hierarchy, an order of precedence, as in acute care hospitals, as to what programs are more significant or important than others. Down at the bottom of that list the lower-priority programs are found. So if there's a funding problem we will know, and our doctors will be in agreement, to focus on those low-priority programs if cuts have to happen. Again, we're going to make this entirely visible to you politicians, to our community. It will be a ready accountability framework if, as in when, we run into a resource constraint. Thank you.

The Chair: Thank you, Mr Hession. You've used up about 18 minutes, which leaves us with 12, starting with the PCs for four minutes.

Mr Baird: I don't have any questions. I just want to thank you for your presentation. I think there is a lot of wisdom in the underlying thought on your summing-up page, on the back page, that it would be a very bad move if we went to a centralized system where boards merely become advisory boards and everything is tried to be run from the Ministry of Health. I think there is always the push for that to come—if you centralize something, it will be better. I think there is probably no greater example of accountability that the ministry can exercise than it has with appointing the supervisor and removing the board. You look at the hospital a few short years later and it's in demonstrably better shape, with a lot of great people and staff morale. Thank you for your presentation.

Mr Hession: It was a pleasure. I would just remind you of the New York Stock Exchange point. You talk about centralizing and trying to figure out the right fit for hospital A, B or C, as the case may be. I was shocked by that, to be perfectly candid. We can't have amateurs at the other end of this transaction. We're serious people and we expect to be treated seriously.

Ms Martel: Thank you, Mr Hession. Mr Baird reminded me of when we last saw each other. It didn't dawn on me until you sat down and he pointed out that you came in to fix the mess with Accenture.

Mr Hession: Yes. I enjoyed our interactions at that time.

Ms Martel: You should know that we talked about Andersen/Accenture at public accounts last week, and I

asked the deputy at that time, who right now is Mr Costante, if he could assure us that Andersen/Accenture will not be allowed to bid on the new computer system at the FRO. He could not provide me with that guarantee, so I hope you're not back in that capacity, cleaning that up.

Mr Hession: You and me both.

Ms Martel: But let me move to the presentation at hand. I'm looking at the second-to-last point on the summary sheet that you provided in the package. Point number one says, "It appears that the government intends to remove accountability from the board and re-establishing them as 'advisory bodies' to government or worse, making hospital boards redundant." We have certainly heard that concern and people's concern that unless there are significant changes, people will not sit on boards.

I find your second point quite interesting: "Given the government's decision in recent years to divest ownership and management of provincial psychiatric hospitals in the province, it is unclear as to why the government would want to move in this direction." I just wanted to know if you could more fully articulate your concern with that.

1150

Mr Hession: We have the great benefit of having on my right-hand side a true authority on the subject, so I'm going to ask Peggy to comment on that.

Ms Taillon: As part of the Health Services Restructuring Commission work when they went around and reviewed hospitals in the province, they did look at the provincial psychiatric system as well and made some recommendations about divesting provincial psychiatric hospitals, which were at that time effectively managed by government, by the Ministry of Health. They divested these programs to the public hospital sector. This was only three to four short years ago that this process took place. You can imagine the wide-sweeping human resource/union implications for the mass move of psychiatric hospital employees from OPSEU to whatever union they were moving into in the public hospital sector. There were huge costs incurred by government and by taxpayers, so the dust is really just settling on this work.

If you look at the provisions in Bill 8, we're almost moving back in that direction. So within three years we're almost moving full circle. We wanted to point that out as an area of concern for us. We really supported the direction the government had taken through the provincial psychiatric hospital divestment, so that was that point.

Ms Martel: The point that follows that is, "We do not believe it is the government's intention to manage every hospital" directly through the bureaucracy "and emphasize that the provisions of the bill that undermine the Public Hospitals Act and the role of voluntary boards should be significantly amended."

There certainly has been a suggestion that the government already has at its disposal any tools it would need to deal with concerns about fiscal mismanagement at an individual hospital and it can do that through the Public Hospitals Act. Do you have a view one way or the other in terms of, should we essentially get rid of the section that we see here and allow the ministry to intervene when it feels it has to via the Public Hospitals Act, which has a clear statement of doing that in the public interest, and that is articulated in the bill? Or do you see some value in trying to reorganize or amend or patch up, or whatever the government chooses to do, in part III of this bill and still retain the accountability sections? Maybe the provision about "in the public interest" has to be added. I'm just not clear what is the best mechanism for the government to follow at this point.

Mr Hession: It's a hard question because it can get us into a discussion of the degree of partisan views on this and I don't want to do that. But I do have a suggestion for you, as legislators, to consider. The province, at least as it is represented by the hospitals and as I see the evidence, more and more getting into my current role of uncertainty—the uncertainty is awful around both the legislative environment and certainly in the hospitals. Uncertainty is, for sure, the first step toward chaos. Be careful. Change is a nice thing, but be careful.

I would ask you to consider this, and I'm getting a little out on a limb here because it's not my business. I would say the greatest thing you could do as a Parliament, as a Legislature, is unanimously pass a resolution. Don't get into legislation quite yet; pass a resolution. As someone said, "We all agree with the preamble." It's good and Ontarians want to hear from their political leaders that "This is unanimously agreed by we, the Legislature of Ontario, at this time."

Then, take a look at the instruments that are available to you, as government in particular. We've been on the receiving end of those instruments in a major way in my hospital. The number one issue that I would say arose in my own mind is the degree of containment on the outcomes the government of the day seeks as a result of the appointment of a supervisor. The one I saw was pretty open-ended and it went on for 14 months. Why, I'll never know, but it did. It could have been done far faster with very clear outcomes expected by the government. It makes the provision in the act perfectly OK, but in its administration I would ask you to consider things of that kind, very practical things.

My hospital was in the financial dumpster. We spent a ton of money on a supervisor whose work could have been done in half the time that it actually took, for example. It didn't look right to me, for obvious reasons. I don't know what your experience was in Sudbury.

The Chair: Thank you. Could you summarize?

Mr Hession: I just did.

The Chair: Thank you.

Mr Hession: Sorry, Mr Chair.

The Chair: You're right. Some things can take shorter.

Mr Hession: Yes, they can. Sorry about that.

The Chair: No, I was enjoying the answer. It was just going over time.

Ms Smith: Thank you, Mr Hession. We really appreciate your presentation today. It was far-ranging. I just wanted to touch on a couple of things, and some of my colleagues have some comments as well. I will try to do the best I can in less than four minutes.

You talked a bit about the funding issues, and certainly we hear that loud and clear. We hear that from most of your colleagues across the province. We are, as you know, working with various stakeholder groups on multi-year funding agreements and arrangements, and I understand that's ongoing.

I appreciated your suggestion about best practices, looking at those facilities that are performing at the highest level and using those as examples or models for building our accountability agreement. I'm presently undergoing a review of long-term care facilities across the province. Certainly that's been my modus operandi, to go in and look at the ones that are run well and see why, and then use that as a tool for improving the others and making sure that the standards are set across the province.

Before I pass it on to one of my colleagues, I want to ensure that you did receive or have received a copy of the minister's statements on Monday, where he outlined some of the possible amendments that we'll be bringing forward in the future, talking about the fact that the boards will be in place, will continue to be in place—the agreements will be between the boards and the ministry—and then looking at performance agreements between the board and the CEO. Just in your summing up section, I just wanted to address some of that.

Certainly I, having one of the last three psychiatric hospitals in the province that's still run by the province in my riding, am totally aware of all the issues surrounding that divestiture. Certainly that is not, I think, the model that we're working toward. We respect the boards in place; we respect the work that they do. The accountability that we're looking for is simply to add transparency and a sense of comfort for the people of Ontario that their money is being well spent in the health care field.

I'm going to pass it on now to my colleague Mr Brownell, who has a couple of comments.

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh): Just a couple of comments. As an MPP from eastern Ontario, it's a delight to have had the opportunity—we almost got bogged down here—to have you speak to us. It was refreshing; great ideas. I had picked up on the best practices ideas, and Monique, my colleague, made comment on that. I think it's very important that we look at those. I'm very familiar with your sites, being from eastern Ontario and with that relationship with Cornwall. It's so important that we understand what's best in our hospitals and whether we can build on that.

I do want to say, there is language in the bill that has to be looked at. The tone, the language, some concepts—we really have to look at that. We have to look at what the presenters are doing here. You are presenting ideas to us that we will be able to take in the clause-by-clause and work with in building something that's going to be a model. I know that I appreciate, as my colleagues do, what you've presented here.

Mr Hession: Thank you very much. Mr Chair, there is one point that arises out of Ms Smith's comments: multi-year funding. Not to sound abusive, it's nonsense. Why are we talking about it? You can't do it as a Legislature. You approve supply annually. To take away that privilege from a Legislature has never happened, to my knowledge, in a British parliamentary system. I've said this time and again to the OHA. The issue isn't multi-year funding; the issue is stable funding, which is exactly the language that I saw while you were on the hustings, which I thought was great.

The problems are now. We need to fix the way in which we allocate resources now. If there be multiyear funding, I want to say again, it's not the health minister that I'd worry about in that respect, it's the finance minister. What's he going to say? What's the Premier going to say? If you're going to lock me into a future without reference to the Legislature, there's no jurisdiction in the Western industrialized world that has achieved multi-year funding. So why we think we're going to miraculously do it is beyond me.

I just say that in good faith. If you could just fix the way we do it annually, we'd be happy as clams.

The Chair: Thank you very much for that closing, Mr Hession.

Mr Baird: Other than that, you're undecided.

Mr Hession: Other than that, I'm absolutely vacillating, Mr Baird.

The Chair: Thank you very much for joining us today. We did appreciate your presentation.

Mr Hession: It's a pleasure. Thank you for coming to Ottawa. We're delighted.

The Chair: Our pleasure.

1200

OTTAWA AND DISTRICT LABOUR COUNCIL
CITIZENS FOR A PUBLIC HOSPITAL

The Chair: We can move on then to the Ottawa and District Labour Council, represented today, I understand, by two people, Sean McKenny, the executive secretary, and Caitlin Kealey from Citizens for a Public Hospital. Please be seated. Make yourselves comfortable. You have half an hour to make your presentation.

Mr Sean McKenny: I'll go first and then Caitlin will follow with the Citizens for a Public Hospital.

Just before I start, one thing I noticed with some of the presentations earlier this morning and specifically the one just before this, is that it to me says what this whole issue is about. We had an attempt at a PowerPoint presentation, certainly a reference to those who have—we have scrap pieces of paper here. The technology didn't work. Again, to me it's representative of those that have. This whole issue in regard to health care is about the average individual who lives in our province. I really do believe that's

lost on so many, and, I think, lost around some of those around the table, and that's unfortunate. When I hear things like the New York Stock Exchange referred to when we're talking about health care, it certainly causes me very deep concern and, I would suggest to you, a lot of people concern.

In any case, good morning. The Ottawa and District Labour Council comprises 90 different local unions representing approximately 40,000 working men and women in the Ottawa area. Those individuals come from a variety of workplaces, inclusive of our hospitals and other health care areas.

We thank the committee for being here today and listening. We truly hope that this process of hearing from the community as it relates to health care is one that provides the listening on your part—somebody over on this side mentioned that just earlier on—and the realization that those making presentations do so because they have a deep, embedded concern about Canada's health care system, a concern that wants to ensure that our system is strengthened and made better. To be made better is not defined as a mechanism for those whose only interest is to make profit. Clearly, Bill 8, the Commitment to the Future of Medicare Act, introduced by the newly elected Ontario Liberal government back in November 2003, is an attempt at that and certainly an admission that the system needs some fixing. However, from my seat, several areas of the bill fail on that level and instead offer weaknesses.

I find it fascinating how certain issues, certain policies, certain legislation, can garner so much interest from some, yet absolutely no interest from others. Assumptions are made that those elected to office, be it at a local, provincial or federal level, or anybody for that matter, make decisions in the best interests of the people they are purported to be representing. If we were to go outside the hotel right now—John, you and I could go out—and ask those walking by if they knew what Bill 8 was, if they knew what was going on inside here, I would strongly suggest, and perhaps some of you would agree, that very few have any idea what Bill 8 is or what's going on inside this hotel today.

I've been working at the Ottawa and District Labour Council for about 12 years now and, not unlike you, numerous papers dealing with a variety of issues cross my desk. Some I have a better handle on than others; for others I rely on others. Not unlike you, who rely on assistants to provide information to you—the labour council here doesn't have much money, so I don't have assistants, but that information does get to me. At the same time, most are able to combine all of that information to form an opinion.

Despite my involvement in a full-time capacity, I still have difficulty. There's confusion. Certainly with some of the previous speakers, I was confused. I don't think I'm a stupid guy; I may be, but I was still confused. If I'm confused, the average person out there in our community, you can be assured, is confused.

Does it have to be confusing? I guess so, because it's so broad and attempts to be all-encompassing. But if it's that complex, again, to me—I've read Bill 8 twice—no wonder that those outside the building have absolutely no idea what's going on inside here today. Absolutely no disrespect intended, but I would strongly suggest that some of you here don't have as much of a grasp as you think you might surrounding the government's Commitment to the Future of Medicare Act or the Canada Health Act. We get into a game of politics, and that truly is unfortunate.

I'm going to read from a couple of documents that I have from the Ontario Federation of Labour and the Ontario Health Coalition, two organizations that I know you all are aware of, whose work around health care has been incredibly persistent with respect to promoting a health care system that indeed conforms to the five principles of medicare: public administration, comprehensiveness, universality, portability and accessibility.

Before I do that, I'm just going to go back to the Ontario Health Coalition's paper. Again, I think it's important, and I'll say this: It's confusing to me, so I rely on some of this documentation. I've read it from different sources as well, and not solely the Ontario Health Coalition and the Ontario Federation of Labour. In this paper, and I'm sure that some of you have heard it, it's talking about Bill 8 and the Commitment to the Future of Medicare bottom line.

The Commitment to the Future of Medicare Act should include these items:

—Concrete initiative to rebuild comprehensiveness and stop delisting. Are these items present in the bill, yes or no? It's got "no."

—Concrete initiative to protect and rebuild universality, yes or no? It's got "no."

—Concrete initiative to rebuild accessibility to publicly funded services, yes or no? No.

—Improved public access to information, including financial information, about health care institutions and sectors? No.

—Public control, public governance, democratically elected boards? No.

—Restoration of access to home care, including home nursing, homemaking, personal support? No.

—Concrete initiative to improve access to primary care? No.

—Concrete initiative to improve access to assistive devices, treatment and drugs? No.

—A stop to the creeping privatization and Americanization of health care, as promised in the election campaign, big part of the election campaign? No.

—A democratic health council that reports on how the health care system conforms to the principles of the Canada Health Act? Again, no.

—A democratic health council that reports on extra-billing, user fees and two-tier health care? No.

—Prohibition of block fees charged by physicians? No. However, the bill does move control over block fees to the government. We applaud this part.

—A stop to delisting medically necessary services? No.

—Restoration of access of previously delisted services? No.

—Prohibition of two-tier access for delisted services? No.

—Prohibition of queue-jumping for so-called medically unnecessary services? No.

—Increased public input and democratic control? No.

—Whistle-blower protection for those who complain about poor practices by managers and company owners? No.

—Stop to P3 hospitals? No.

—Stop to private MRI-CT clinics? No.

—Stop to defunding unilateral orders for restructuring, reductions in services? No.

—Full public disclosure of OHIP delistings, physicians' out-of-pocket fee list, other charges? No.

—Input of health care workers and patients? No.

—Prohibition of extra-billing? No. However, the bill does ban opting out of OHIP, which we applaud, but leaves potential for extra-billing to the regulations.

I said at the very onset that I don't have a whole bunch of knowledge and certainly none at the same level as some of those presenters before me. But why not? Why not? These things, to me, an individual who has difficulty getting his head around them because of the complex nature of our health care system, make sense to me. The fact that it's not a part of that bill makes absolutely no sense. For there to be excuses as to why it's not there, I don't get that.

I'll go the Ontario Federation of Labour paper and read some of their—not the whole submission, but parts of it. Again, I'm sure that you've heard a number of these concerns before. We'll start with the preamble.

1210

Let me be very clear: There are a lot of good things with respect to the bill. The bill is a valid attempt; there's no question about that. I go back to the comment that was made on this side of the room earlier on to the last speaker, and that is that you're going to take what you hear and you're going to put all of that together and hopefully work on that bill and make it better—make it better for the community, not make it better for those who are really worried about the New York Stock Exchange.

In any case, the preamble to Bill 8 recognizes that "our system of publicly funded health services reflects fundamental Canadian values and that its preservation is essential for the health of Ontarians now and in the future." It confirms an enduring commitment to the five principles of medicare—public administration, comprehensiveness, universality, portability and accessibility—as currently codified in the Canada Health Act. Unfortunately, there is little in the actual legislation that provides any significant new initiative on these principles. Again I'm thinking, why?

Although the preamble commits the government to support the prohibition of two-tier medicine, extra-billing and user fees, a closer examination of the legislation shows it fails to entirely close such options. While the preamble recognizes that pharmacare for drug costs and primary health care based on assessed needs are essential to the future of the health care system, there is nothing in the draft legislation which directly addresses either of these concerns.

The Ontario Health Quality Council, outlined in part I, sections 1 to 6 of Bill 8, is supposed to monitor and report to the public on "access to publicly funded health services, health human resources in publicly funded health services, consumer and population health status and health system outcomes, and to support continuous quality improvement." It's our belief that this section is, to say the least, poorly drafted. Given the preamble's commitment to principles of the Canada Health Act, it is disturbing to find that the Ontario Health Quality Council does not include reporting on the extent or otherwise to which the Ontario health care system complies with the principles of public administration, comprehensiveness, universality and portability contained in the Canada Health Act. Further, it is not required to report on issues relating to two-tier medicine, extra-billing and user fees. Each one of these issues is fundamental to the health care system and of primary importance to the public.

The council is to be composed of between nine and 12 members, all of whom are to be appointed by the cabinet. What's with that? Really, in all seriousness, what is with that? We are compelled to ask, where is the democracy in this process? Where is the transparency? For all the public knows, representatives from the private, for-profit sector could be appointed as a major step toward eroding our public, not-for-profit system. It is our strong view that for-profit providers, given their blatant conflict of interest, should be excluded from the council.

We believe it is essential that the people of Ontario exercise democratic control over their health care system through democratically elected boards, reflecting and inclusive of various community constituencies, service users, patient advocates and health care staff. Decision-making should be open and transparent.

Should the council have representative and inclusive criteria and elections for its makeup, there is a further issue that should be dealt with. While the council is required to deliver a report on the health care system on an annual basis to the public and to the minister, it is specifically prohibited from making recommendations as to the future courses of action to be undertaken. Again, I don't get it. A good deal of the value of each council is thereby thwarted by its inability to make recommendations.

We support an elected, inclusive and representative council that is free to make recommendations on the steps to be taken to ensure the future of Ontario's medicare system.

I'll skip forward a few pages, then Caitlin can pick up.

Accountability agreements and compliance directives: The most important, controversial and potentially dangerous sections of Bill 8 are contained in part III, sections 19 to 32. They cover the powers of the Minister of Health to compel persons to enter into accountability agreements or

compliance directives. These provisions have been drafted in such a broad manner as to give the minister unprecedented power to require organizations and individuals to comply with whatever the minister desires, potentially including the overriding of legal collective agreements and other negotiated agreements. This constitutes a fundamental affront to the people's rights in a democratic society—again that play with democracy, or the lack of it.

Under the provisions as currently drafted, the minister can direct any health care provider or any other agency or person to enter into an accountability agreement with the minister and any one or more agencies, persons or entities. Even a trade union, under the broad definition of a health care provider, could qualify to enter into such an accountability agreement.

We are opposed to sweeping powers being given to the minister in such ill-defined accountability agreements. Indeed, throughout the bill the powers granted to the minister are too broad, too open-ended. It is often unclear as to specifically what the directives are about; that is, their content and to whom they will be directed. As a person proceeds through the bill, one increasingly gains the impression that the directives of the minister can be to anyone for virtually any reason.

I'll skip another few pages again and go to the conclusion, and Caitlin can jump in.

One would have hoped—and this makes sense to me, again an individual who doesn't have a broad knowledge of the issue, but I do live here—that this bill would have explicitly prohibited two-tiering for so-called medically unnecessary procedures. Accessibility would have been strengthened and ensured, with special attention to marginalized and equity-seeking communities and those communities that are geographically remote, and there would have been some recognition that for-profit provision is a giant step back from accessibility, as can be clearly seen in an American context, where millions of people—millions of people—have no medical coverage whatsoever and millions more are inadequately covered.

One might also have expected provisions on portability to have been included. Currently, Ontario is not covering services for people from other provinces, yet virtually all Canadians travel to different parts of the country at some point and should enjoy the full coverage of that province.

Given the preamble, one could also reasonably have expected to find provisions on pharmacare and home care.

With regard to public administration, we can only once again raise our concerns about the lack of democratic participation and transparency as opposed to open-ended, top-down, sweeping powers to the minister. This is particularly troubling in the context of the province's debt and the consequent cries for restructuring and efficiencies.

Let's be clear. Moving to sell assets such as TVOntario or the liquor board won't solve the problem of a structural deficit; more revenue will. It's a one-shot deal, postponing the problem until next year. Privatization—and this is big here in Ottawa, where I'm from, with our Royal Ottawa Hospital—in the form of P3 hospitals or whatever is not reinventing government. It's the path rejected by the voters of Ontario, and all the evidence from other jurisdictions tells us it will lead to worse public services.

We urge the Ontario government, in light of our comments, to reconsider some of the components of the bill.

Ms Caitlin Kealey: I want to thank you all for allowing me time to speak and the labour council for giving me some of their time. This is the first time I've ever done anything like this, so I'm a little nervous. My name's Caitlin Kealey, and I'm speaking on behalf of Citizens for a Public Hospital. It's a community-based group dedicated to ensuring a fully public Royal Ottawa Hospital. We are a newly formed group that has joined in the struggle against the looming threat of private-public partnerships. We feel these P3s threaten the core of the Canada Health Act. If I'm not mistaken, the goal of Bill 8 is to try and protect the values and principles of the act. While Bill 8 incorporates the principles in its preamble, it provides no concrete initiatives either to ensure access to services that have already been cut or to implement the sentiments outlined in the CHA.

Home care and pharmacare are the key components of rebuilding an accessible, comprehensive, universal public health care system. So too are homemaking and support services, access to primary care, access to drugs and devices and a comprehensive OHIP list covering the services that people need. The intent of the Canada Health Act is to ensure that Canadians have access to a comprehensive range of medically necessary health services. Real, concrete steps are needed to fulfill this vision of a truly universal, accessible public health care system. This universality will most likely come under fire if this bill does not explicitly protect our public system from for-profit and private companies.

The threat of the two-tier health care system has grown significantly with the continued privatization of our health system. For-profit health corporations see user fees, service charges and two-tier access as potential new revenue and are therefore approaching these ideas in a more aggressive way than their non-profit and public counterparts. An easy example of this are the private MRI and CT clinics. This trend of for-profit clinics being allowed to deliver hospital services poses serious threats to the sustainability of medicare. Access to diagnostics is limited by the supply of equipment such as scanners and trained personnel like radiologists and technicians.

1220

While private clinics provide machines for which we, the taxpayer, ultimately pay, they do not increase the number of health professionals. The private clinics find their staff by poaching them out of the public hospital system, leading to staff shortages in public facilities. In addition, they seek new revenue streams, including out-of-pocket payments for so-called medically unnecessary scans, a trick to get around the Canada Health Act. A

person who pays for a medically unnecessary scan therefore is allowed to jump the line, using up scarce resources for no reason and pushing back those with medical needs on long waiting lists.

In addition, the private clinics take the less risky and less costly scans, leaving the heavier-burden scans to the public system, which has been deprived of personnel. They also take the third-party-billing patients and those on WSIB, depriving hospitals of this revenue. These clinics make profits at the expense of the public health system.

With the onset of more and more pressure due to financial considerations and private interests in delisting services, the fact that section 15 only prevents line jumping for insured services limits the scope of the bill. The major threat is not really the occasional queue-jumping abuse, but rather from the ongoing shift from public to private for-profit health care service. We believe this shift must be stopped and then reversed.

In October, Ontario elected a Liberal government on a platform of change. In November, Mr McGuinty went to the ROH to announce a fully public hospital. Unfortunately, this announcement offered very little change from the original deal. I have heard from many Liberal supporters who are very upset about these P3 deals. The newly elected government campaigned against the privatization of our health care system, and they should continue their commitment to the people of Ontario.

Clearly, this is not what the residents of Ottawa or Ontario want to see happen in their communities. The suggestion that for-profit companies can build a hospital and run it in a more efficient manner for less money than the government is false. This has been proven time and again through the British experience with their P3s, which are called private finance initiatives. There is much documentation about the disasters that have followed the British move to privatization. In fact, the global evidence is that the more privatized the health system, the more costly it becomes. Look at the results of the massive privatization in the United States over the last 10 to 15 years to see the impact.

In their endless search for profits, corporations seek new sources of revenue, imposing fees and service charges wherever they can. The motivation and means for increasing two-tier health care systems are increased. The result is that the scope of services offered under the public system is reduced. As was the experience in Britain, beds and staff are cut; patients face a barrage of new fees; two-tiering increases; public accountability and access to information are reduced; democratic control is reduced; advertising, consulting and legal fees go up; fraud goes up; executive remuneration goes up; more and more of the health system is governed by a bottom line of profit margins and rates of return for investors.

Further, the trend toward sectioning off the so-called non-clinical services and privatizing them in facilities must be stopped. It must be made clear that medically necessary services include those services that support patients' daily lives, including food, laundry, maintenance, record-keeping, lab tests, diagnostics and therapies. These services are not second-class to patients; they are essential to infection control, nutrition, diagnosis and recovery. They should be provided on a non-profit basis.

One only needs to look at the whopping increases in the cost of drugs, the area of the health system most dominated by transnational profit-seeking corporations, to see the high cost and threat to public access posed by privatization. Fundamentally, the motivations of profit-seeking corporations fly in the face of the principles of comprehensiveness, accessibility, universality and the single-payer system.

The P3 projects commenced by the Tory government here in Ottawa through the Royal Ottawa Hospital and in Brampton through the William Osler hospital, and the seven more that Mr Smitherman has admitted are still in the planning stages, should be immediately stopped, along with the delisting of services.

It has been estimated that such private models can cost at least 10% more than their public sector equivalents. The evidence that so-called public-private partnership hospitals cost more is overwhelming. Following the same model as the privatization in Britain, our proposed P3 hospitals are already showing cost increases from initial projections. In Ottawa, costs are up from an original cap of $100 million to $132 million. In Brampton, capital costs alone have increased from a projected $300 million to over $350 million.

Making the operation of a hospital private but keeping the ownership public through a mortgage, as Mr. McGuinty announced, does not change the private for-profit character of a P3 organization. I would argue that the mere characterization of public-private partnerships is contrary to the fundamentals of the Canada Health Act. It is a step away from medicare and toward private hospitals. It is one step closer to the for-profit system where those who can afford care receive topnotch health care while those who are not as fortunate receive just OK health care.

If part of Bill 8 is to confirm the accountability of the health care system, P3s are definitely not the answer. P3s put billions of dollars of public funds into the hands of profit-seeking corporations for whom a veil of commercial secrecy obscures public scrutiny over profit-taking and misuse of public funds.

P3s also provide an imposition of two separate sets of management under the same roof, one whose goal is providing a public service, while the other has a goal of maximizing profit and growth. This is fraught with problems. The higher borrowing costs, consultant fees, inevitable legal fees, outrageous executive salaries and profit-taking drive up health care costs, making competing claims on scarce resources.

The Canada Health Act calls for public administration of the health system, recognizing the inherent threat posed by private insurance corporations. Similarly, private hospital corporations, private long-term-care corporations, private labs and private home care corporations are a serious threat to the future sustainability of the Ontario health system.

The current government ran on a platform of stopping the Americanization of our health system. The pre-election promise was very clear: They opposed creeping privatization and committed to rebuilding medicare. Any legislation purporting to show this government's commitment to the future of medicare must include concrete initiatives to roll back privatization and prohibit future for-profit control of our health care institutions.

P3 hospitals must be banned. The private diagnostic clinics must be returned to non-profit hospitals. The tide of privatization sweeping through our health care system must be stemmed. The future sustainability of medicare and the application of the principles of the Canada Health Act depend on it.

Bill 8, as it stands, does not prove the government's commitment to the principles of the Canada Health Act. In fact, P3s preclude much of the accountability, universality and access to a public health system. Take a clear stand against any more privatization.

Thanks for allowing me this opportunity.

The Chair: Thank you, Ms Kealey and Mr McKenny. Unfortunately, we've got about three minutes left for questions. Unless there's any opposition, I propose that we give that to Ms Martel.

Ms Martel: Thank you both for being here today. I appreciate it very much.

Let me deal with the P3 hospitals. I think my colleague Mr Baird said it best just after Mr McGuinty made his announcement here at the Royal Ottawa Hospital. He said there was essentially no difference between the P3 hospital model that the Conservatives had brought in and the one Mr McGuinty announced, both for the Royal Ottawa Hospital and for the William Osler Health Centre. He is quite right.

Mr Baird: On a point of order, Mr Chair.

The Chair: I don't think you can have a point of order during a question, Mr Baird.

Mr Baird: They had red letterhead; we had blue.

Ms Martel: I appreciate the clarification.

We've gone from a Conservative lease to a Liberal mortgage, and what we still have is the fact that public dollars that should be used to provide health care services to patients will be used for profits for the private consortiums that are involved in this construction.

It is very clear, in two ways, that money is going to go in that direction. First, government can get the lowest interest rates, not the private consortium, so there are going to be increased costs because of the higher cost of borrowing. Secondly, of course the consortium is going to do this for a profit—we wouldn't expect otherwise—and that again is money that will now be incorporated into a mortgage that will cost taxpayers more. Our concern, as New Democrats, has always been that that money should be going into direct patient care, not into the profits. That's why government should be building not only these two hospitals, but also the six other hospital reconstruction renewals that the minister has talked about and, we've had confirmed by other people in meetings with him, that he intends to do.

In that respect, do you see a contradiction between the preamble, which uses great rhetorical language about support for medicare, particularly support for public administration, universality etc, and what is not included in the bill, which clearly is stopping P3 hospitals? That is nowhere in the bill. In fact, given what the Liberals have done, it's very clear that they intend continue down the road set by the Conservatives.

1230

Mr McKenny: You're right, and we agree 110% with those comments. It's not in there enough. In fact, as you indicated, it's not there. There's nothing preventing the P3 hospitals from moving forward. Our understanding is that we're going to see a number of other P3 hospitals built across the province, and that really is a shame. So yes, most assuredly, there should be a lot more in the bill, inclusive of the preamble, preventing P3 hospitals from being built.

Again, don't misunderstand the words; those who hear the message from us saying not to move forward with the P3 hospitals, it does not mean in any way that we don't need new hospitals and we don't need the current hospitals that we have renovated, as here in Ottawa with the Royal Ottawa Hospital. The Tories were really good at that, and John was really good at that when he was in office in trying to make it sound that way—again, those who were in opposition. The reason they were in opposition was that they didn't want to see a hospital built, and nothing can be further from the truth.

Just on that note, we've had a couple of occasions to come in. I'll just be a moment.

The Chair: It'll have to be—

Mr McKenny: Just if I could, and it's in reference to this.

The Chair: It will be a 20-second moment.

Mr McKenny: OK. A number of years ago, when John first came to office, he came into the labour council. He wanted to address those of us from the labour council. He spoke to us as a Tory. At one point during the meeting—there was a number of people there, a number of union leaders from this community—he said, "I'll have you know that my father was a member of the union," and the then president at the time, Mohamad Alsadi, fired back, "I guess your father didn't do a very good job raising you."

Again, the same thing holds true, whether it's a Tory P3 or—

Mr Baird: He said it with the same class as he did.

The Chair: Thank you very much for attending. We did appreciate your input. We'll move on to the next delegation.

Ms Smith: On a point of order, Mr Chair: I'd just like to note that I have fulfilled my undertaking to Mr Klees, who unfortunately is not here with us at this moment, but I would like to deliver to him a copy of the letter that I faxed to the minister this morning, attaching his motion.

The Chair: Wonderful. Thank you very much.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 479

The Chair: We're now going to move on to—

Interjections.

The Chair: Can I have some order?

We're going to move on to a presentation now by the Ontario Public Service Employees Union, local 479, from the Royal Ottawa Hospital. Marlene Rivier is president. Same rules as everybody else: You've got 30 minutes. The floor is yours, and I've got 12:34.

Actually, before you start, they've extended the checkout to quarter after 1, but that's a firm checkout time. You may find somebody else in your room if you're not checked out by then. So we'll make that 12:35 now. Ms Rivier, the floor is yours.

Ms Marlene Rivier: My name is Marlene Rivier. I am a front-line health care worker, and I am also president of OPSEU, local 479, which represents nearly 200 health professionals at the Royal Ottawa Hospital. We are among the 25,000 health care workers represented by OPSEU in this province. The facility in which we work is on track to become the site of the first P3 hospital in Ontario.

We are grateful for the opportunity to participate in this public consultation and applaud this effort to restore transparency and public confidence in the process of setting policy and direction within the health care system.

We have serious concerns with this bill as it is currently drafted and intend to offer our views on its major sections, concentrating our remarks on privatization in particular, the ROH P3 redevelopment and related issues of recruitment and retention within the health care professions.

I'm not really going to say too much about the first section, except to reiterate the disappointment that many of us have that the very encouraging words of the preamble do not seem to manifest themselves in any concrete plans within the bill to bring some very important new initiatives into our system, like pharmacare.

In terms of the Ontario Health Quality Council, we feel that it should also be required to report on the extent, or otherwise, that the Ontario health care system complies with the CHA principles of public administration, comprehensiveness, universality and portability, and on issues relating to two-tiered medicine, extra billing and user fees.

During the tenure of the previous government, we witnessed a serious erosion of the ability of the people of Ontario to exercise democratic control over the health care system through democratically elected boards reflecting and inclusive of various community constituencies, service users, patient advocates and health care staff.

In light of that, we recommend that the council should not simply be appointed by cabinet but should be assembled through an inclusive, representative process exclusive of for-profit providers, given their obvious conflict of interest.

In addition to the requirement that the council deliver a report on the health care system on an annual basis to the public, we would also empower the council to make recommendations as to the future course of actions to be undertaken.

In terms of opting out and extra-billing, we support a ban on extra-billing and opting out. However, the act must be amended in order to assure that it is absolutely unequivocal in this regard.

My main remarks will be around queue-jumping, particularly as they relate to privatization and health care. We commend the inclusion of this section. However, we maintain that this section must not be limited to insured services. As the list of medically listed services is restricted, this provision would not protect those seeking delisted or as yet unlisted services from queue-jumping.

The major threat, however, is the systemic shift from public to private for-profit health care services. Currently, the most insidious form of this privatization is what is termed public-private partnerships, or P3s. The P3 projects of the previous Conservative government in Brampton and Ottawa, along with seven others in various stages of planning, continue to be advanced despite promises made by the new Liberal government during the election and must be immediately halted, along with the delisting of services. The consensus seems to be that minor contractual changes announced by the government in November 2003 do not substantially change the character of these P3 projects.

Despite claims by P3 proponents that such projects are cheaper, a five-member panel of economists, including former TD Bank chief economist Doug Peters and a former director of audit operations for the Auditor General of Canada, Lewis Auerbach, concluded the Royal Ottawa Hospital redevelopment will cost the public at least 10% more than a hospital built in the traditional manner. The ROH admits it has already spent $8 million planning and negotiating the P3 deal, far in excess of traditional hospital procurement costs. The estimated cost has already risen from $100 million to $132 million. The hospital's projected operating cost savings, if any are actually realized, will not be the result of the private sector's greater efficiency but will result from the planned 30% reduction in beds. Typically, P3 projects which claim to cost less achieve these savings by building smaller hospitals and reducing services.

More recently, another member of that five-member panel, Canadian Centre for Policy Alternatives research associate Armine Yalnizyan, in a February 11, 2004, report to the pre-budget consultations estimated that if the P3 approach is adopted, the additional costs to taxpayers to finance the infrastructure needs identified by the Ontario Hospital Association could reach $1.8 billion over a typical 30-year amortization period. The additional cost of private financing to the taxpayer for the two P3 projects that are reportedly set to go in Brampton and Ottawa is estimated to be in excess of $7 million annually. Surely such vast sums of money are better spent in the delivery of health care services. These un-

necessary costs will necessitate either higher taxes or further reductions in service. For every $1 million of taxpayer money that will be spent unnecessarily on the added costs of private-sector financing, the ROH could pay the salaries of 20 much-needed health care workers for one year.

In her brief, Ms Yalnizyan presents very compelling arguments related to economies of size and the consequent ability of government to command the best interest rates, without the need to raise equity as the rationale for public funding of infrastructure projects. With interest rates at 40- to 45-year lows, it would appear prudent to seize this opportunity to make an investment in the renewal of hospital infrastructure.

Inasmuch as Bill 8 endeavours to assure greater accountability in Ontario's health care system, it is important to take note of the many criticisms of P3 projects concerning their lack of transparency and accountability. It appears now that Ontario taxpayers will not see the contracts for the Brampton and Ottawa P3s, despite promises to release this information in December 2003, until the deals are signed, sealed and delivered.

1240

Despite accounts of failed P3 experiments both domestically and abroad—public audits in New Brunswick, Nova Scotia, PEI, the UK and Australia have all been highly critical—proponents continue to extol the virtues of the model, inviting Ontarians to go down a road other jurisdictions have already abandoned. British companies like Carillion, a member of the successful P3 bidder, Healthcare Infrastructure Co of Canada, both in Ottawa and Brampton, are eager to import the P3 model, termed PFI in Britain, and are bidding on projects across Canada. However, in addition to the extra financing costs associated with P3s, reductions in beds and declines in services have also been reported; among such reports the review by researcher Alyson Pollock published as a series of five articles in the prestigious British Medical Journal.

So if P3s are associated with increased costs, bed reductions and a decline in service quality, what is the attraction? It is not difficult to discern the interest of the private sector, which perceives health care as a huge untapped source of profit. For governments, P3s are a seductive means of hiding government debt in a deficit-phobic political climate. Under current accounting practices, governments are not required to include the P3 debts associated with privately financed projects in the calculation of its debt, making such arrangements irresistibly attractive to governments anxious to appear fiscally responsible. The irony is that in this effort to appear fiscally responsible, governments are anything but.

I just want to refer to a recent article that was published in the current issue of the New Yorker. It's a review of the P3s that the British government has undertaken. It's not an indictment of P3s, but rather, it identifies situations in which they do not make sense. The situations they describe are where service is a natural monopoly, which describes our health care system—I hope into the future—and where the contract is for an unreasonably long period, which is clearly the case in both Brampton and Ottawa. It goes on to point out how much money can be wasted on consultants beforehand and on lawyers later. In the first case, to try to pin down the risk-transfer issues, and in the latter case, to argue about them if they do occur.

As a result of the policies of the previous government, private stand-alone clinics such as MRIs and CTs operate outside the public medicare system and drain money from it through third-party billings, depriving hospitals of lucrative revenue. More importantly perhaps, such private clinics poach scarce reserves of skilled staff from the public system. They further enable queue-jumping for so-called medically unnecessary services. I want to give you an example from our own region where, in Kingston, there is a private MRI clinic. There's a critical shortage of many of the health care professions in Ontario, including that of registered technologists. Despite advertising across the country, the private clinic was unable to attract a candidate. Ultimately, the private clinic poached a technologist from the acute care hospital, the Kingston General. As a result, the waiting list for critically ill patients in the hospital grew, while those seeking medically unnecessary services could simply jump the queue at the private clinic. Private clinic work is far less challenging than dealing with critically ill hospital patients and can be very attractive to overworked, underpaid, stressed-out health care professionals who may be unable to resist the lure of the private sector, further undermining our public health care system.

I'm not going to say anything about home care, because my colleague Sue McSheffrey is going to address that very well this afternoon.

The drift toward American-style health care, which favours those whose wealth guarantees the ability to jump the queue and receive blue ribbon service, is alarming. Health care costs are a leading cause of personal bankruptcy south of the border. A recent New York Times article stated that 43 million Americans are uninsured, more than the entire population of Canada. The same article exploded the myth of private sector efficiency, reporting that health spending has climbed to 14.9% of the US gross domestic product. In striking contrast, according to Sheila Block, health care spending as a proportion of Ontario's GDP has ranged between 5.3% and 6.3% since 1993. Ontario simply cannot afford a private health care system.

I'm going to skip down now to the accountability and compliance directives. The most important and controversial sections that we're concerned about are contained in part III, which appears to confer unprecedented power upon the Minister of Health to require individuals and organizations to comply with whatever accountability agreements and compliance directives the minister determines to be appropriate, potentially including the overriding of legal collective agreements and other negotiated agreements. This constitutes a fundamental affront to the people's rights in a democratic society.

It also raises a lot of concerns for those of us who have lived through and continue to live through health services restructuring. We wonder what the government has in mind: another restructuring of our health care system without having reviewed the one that's already been done, the one that's still unfolding? Many of the directives have not been put into place. At present, we have three people who are facing the loss of their jobs after many, many dedicated years of service to the system due to the transfer of our children's services from the Royal Ottawa Hospital to CHEO. These sections must be repealed in their entirety.

We have been at a crisis point in recruitment and retention of health professionals in our public health care system for many years. Such draconian legislative measures can only serve to drive increasing numbers of health professionals from the public system. If they find, in addition to the high levels of stress they endure on a daily basis, that they cannot rely upon the security of the terms and conditions of their employment into which they have entered in good faith, we can hardly expect them to continue working in the public system.

Here are my conclusions:

This brief attempts to speak both to the strengths and weaknesses of Bill 8 and makes recommendations for its improvement. It seeks to dispel the myth that privatization is the panacea for our health care system woes and demonstrates how in reality privatization has exacerbated the problems in the system. Privatization is neither an effective nor a desirable remedy to Ontario's budgetary problems.

Admittedly, 2003 was not a good year for Ontario's economy. Despite this, corporate profits are up 11.5%, and the corporate tax rate will be 36% for 2004 compared to 40% in the US. We do not have an expenditure problem in Ontario. We have a revenue problem brought about by the Tory tax cuts that will take $13.3 billion out of government coffers this year alone, more than the combined cost of operating all of Ontario's hospitals. What is required is a return to fair and equitable taxation.

The Tories have left us with not only an economic deficit but also a democratic one. This consultation is an important step toward remedying that. This brief raises objections to aspects of Bill 8, which will surely add to this democratic deficit.

It recommends that the Ontario Health Quality Council not be appointed by cabinet, but rather that it be assembled through an inclusive, representative process exclusive of for-profit providers, given their obvious conflict of interest.

Part III, which appears to confer unprecedented power upon the Minister of Health with respect to accountability agreements and compliance directives, is of greatest concern in terms of inflating the existing democratic deficit. These sections must be repealed in their entirety. Public sector wages have dropped 10% after inflation, and many health care jobs sit vacant. The draconian legislative measures of Part III can only serve to exacerbate recruitment and retention problems, driving increasing numbers of health professionals from the public system. If health care workers find that in addition to the high levels of stress they endure on a daily basis, they cannot rely upon the security of the terms and conditions of the employment into which they have entered in good faith, they will have little reason to resist the siren call of more lucrative work elsewhere.

The privatization of health care, particularly in the form of P3 hospitals, was soundly rejected by the voters of Ontario. There is a preponderance of evidence, both in terms of the economic analysis and outcomes from other jurisdictions, demonstrating the superiority of publicly built, owned and delivered health care services.

We urge the government of Ontario, in light of our comments, to reconsider this bill. Further, we ask this government to hold fast to its campaign promises to restore our public health care system and to halt its erosion through creeping privatization.

Thank you for instituting this dialogue with the people of Ontario and for allowing me the opportunity to participate in this important discussion concerning the future of our public health care system.

1250

The Chair: Thank you, Ms Rivier. You've used up about 16 minutes, which leaves us with 14, so let's go with five minutes each. We'll start with the Liberals this time.

Mr Levac: Thank you very much for your presentation. We've heard from many deputations talking about the creeping privatization. I too am concerned about that. What strengths do you think need to be added to the bill in order to prevent it altogether, or to at least send the signal that there must be justification for the types of services that could be provided by the private sector? Are you making a distinction between services provided by hands, or privatization, period, cannot be involved in the public health care system, as we know there already are services provided?

Ms Rivier: There's no question that there's already an involvement of the private sector in our health care system and there are probably parts of that that can be allowed to persist. But the kinds of changes we've been seeing in the last while are very concerning for us. We've seen major destabilizations in home care. We've seen that we have a long-term-care system where we have increasing numbers of private providers, and that the funding for these facilities favours private providers, and not even private non-profit providers.

I have a grave concern about dealing with limited health care dollars and seeing any of that money going into private hands, because the outcome will be of necessity that that means services disappearing. I just don't see our health care dollars increasing appreciably, and to be taking from the little that we have to feed the private sector, I think, is deeply concerning.

Ms Wynne: Sorry; I missed the beginning of your presentation. But as I look at the first part, you talk about the makeup of the council. I'm looking at section 2 in part I of the bill, the appointment of the members of the

council. So you want a representative process. Are you suggesting just an addition to that section of the exclusion of for-profit providers? Is that the amendment that you're suggesting?

Ms Rivier: That's one of the amendments. There are some good things in there in terms of the formation of the council, but I think that needs to be extended to make sure that we are properly representing the various constituencies.

To give you an example of one of the concerns I have, in the steering committees that are implementing the directives of the Health Services Restructuring Commission, there's a requirement that a member of the business community be included in the terms of reference, but there's no provision for front-line health care workers to be involved. These are very important constituencies that have a great deal to offer and mustn't be ignored. Front-line workers have a perspective that I think is critical to understanding how the situation is operating.

Ms Wynne: Do you have specific wording for an amendment to that section that you're going to provide us with, or is that a possibility?

Ms Rivier: I don't have specific wording.

Ms Wynne: If that were possible, that would be great, because it all goes into the mix and then we discuss it in the clause-by-clause, OK? Thank you very much.

The Chair: Ms Smith, one minute.

Ms Smith: With my one minute, I just wanted to make sure that you have some clarifications with respect to the draft of the legislation you've been reviewing. We really appreciate the input that you've made. You've certainly put a lot of work into this presentation, and we really appreciate that.

I don't know if you were aware of the minister's statement on Monday. I hope you were.

Ms Rivier: Yes.

Ms Smith: So you are aware that the accountability agreements that we foresee in this legislation do not apply to collective agreements or to unions—he made that clear—and that there will be amendments brought forward to clarify that. As well, we talked about the fact that accountability agreements will apply to boards of hospitals, between the boards and the ministry.

I wonder, do you have any concerns about the structure of that accountability agreement between a board of a hospital and the ministry?

Ms Rivier: I guess part of the problem I have is that accountability itself has become such a buzzword that the appearance of accountability is not always accountability. But I don't think anybody would disagree in principle about the importance of that. Certainly those reassurances are encouraging.

Ms Smith: Great. With my last 10 seconds—Kevin, I'm sorry. You alluded to the fact that you believed there was going to be a greater proliferation of P3 hospitals in the future. I just wanted to assure you that the ministry is working in concert with the Minister of Public Infrastructure Renewal on a health infrastructure financing and procurement framework that will be applied to any emerging hospital projects. The framework will be based on the key principles of public ownership, public accountability and public control.

There haven't been any decisions made on any further projects. Certainly with the projects that do exist, we have made very great efforts to ensure that hospital ownership and control remain with the facility. I just wanted to dispel those rumours, should they be out there, that there are others moving forward. I thank you very much for your presentation today.

Mr Baird: Thank you very much, Marlene, for your presentation. It's very well thought out and it's appreciated.

The last time I was at the Royal Ottawa Hospital I was joined by a lot of my colleagues in the Legislature and our new Premier. When he says that they've scrapped the P3 hospital, what does that make you feel like?

Ms Rivier: I think that's been very problematic, because for those of us who are familiar with P3s, as I know you are, it's very clear that what we've seen is a cosmetic change which I think has misled the public. So when you speak to people about the issue they think that's sort of old news. They need to be educated in the fact that these are indeed cosmetic changes, and really, it walks like a duck and it talks like a duck.

Mr Baird: So Liberal, Tory, same old story?

Ms Rivier: I thought you said it quite well when you said that Mr McGuinty's tie may be red but his suit is blue.

Mr Baird: What problem do you have with the contract for this P3 project? I know Mr McGuinty has released it. He said he was going to release it shortly after that comment. What problem do you have with it?

Ms Rivier: Of course, the problem we have is that nobody has seen it. We haven't seen the contract as it was and we haven't seen the contract as it has supposedly been amended.

Mr Baird: Who said you could see it?

Ms Rivier: There was an announcement that the contracts would be released in December. We're still waiting for them.

Mr Baird: In December?

Ms Rivier: Yes, this past December.

Mr Baird: I wonder, because I would like to help you and OPSEU and your members—

Ms Wynne: You're a friend of labour, are you?

Mr Baird: I am a friend of labour. Marlene and I are good friends. Marlene and I get along very well.

I'd like to ask for unanimous consent—because I'm not a member who is subbed in; I'm just here to learn from the deputants—that I could put forward the following motion: That the committee request that the Minister of Health release the P3 hospital contract of the Royal Ottawa Hospital immediately.

Ms Martel: I agree.

The Chair: Does Mr Baird have unanimous consent to make the motion? No, I'm afraid you don't have unanimous consent, Mr Baird.

Mr Baird: They're denying it. They're blocking the release of this report.

Ms Rivier: I thank you for your effort.

Mr Baird: I think it's too bad. We were promised a new era of transparency, we were promised change, but they changed their mind.

Mr Levac: Like the 407—

Mr Baird: You guys said you would be different. You were the Virgin Mary. They would be different.

Mr Levac: We own the bloody thing and we still haven't seen the contract.

Mr Baird: Your government has seen it.

Mr Levac: Eight years to get it.

Mr Baird: You have it now. But you guys were going to be better.

Mr Levac: We are better.

Mr Baird: Marlene, would you do me a favour? Would you give me a call whenever you hear about that contract? I'll give you a call if I hear about it, too. Because I've honestly been trying to get a copy of it. The sad reality is that I'm not sure an agreement has been concluded. They announced something in November. I'm not sure an agreement has been concluded. We don't know if this is an ongoing debate, whether each side has a mountain of consultants splitting hairs over this word or that word. It's too bad that you weren't involved in that process. Thanks for coming.

Ms Martel: There wasn't unanimous consent to allow Mr Baird to place the motion, but I am on the committee so I would like to move the motion, Mr Chair: That the committee request that the Ministry of Health release the P3 hospital contract of the Royal Ottawa Hospital immediately.

The Chair: It has been moved by Ms Martel that the committee request that the Minister of Health release the P3 hospital contract of the Royal Ottawa Hospital immediately. Are you speaking to the motion?

1300

Ms Martel: Yes, I would like to. I think it's important to point out who made the promise to release the contract before December. It was the Minister of Health. It came on the day this bill was actually introduced, so it's appropriate that the motion is being moved here today. It came because the minister that day in November, on the first anniversary of the release of the Romanow report, announced the bill in the Legislature and presented it for first reading. I happened to be at a press conference he was at with Mr Romanow and Mr McGuinty at Hart House earlier that morning and heard him talk in glowing terms about this bill and how it would advance the cause of medicare. I guess he wasn't anticipating the kind of adverse reaction the bill is now getting.

In any event, later that afternoon during question period, the leader of our party, Howard Hampton, said that perhaps the first work of the new Ontario Health Quality Council that was announced in the bill should be to review the contract at the Royal Ottawa Hospital and the contract at the William Osler hospital. The minister wasn't too terribly excited about that proposal. I thought it was a great proposal, made by our leader, but the minister was not having any of that.

What he did when he said, no, that wouldn't be the work of this particular council because the contracts were going to be released before then, was to say in the House, and it's in Hansard, that the contracts would be released before December. Of course, here we are today, February 18, and we've seen no sign of the contracts. Regrettably, I don't think we're going to see any sign of the contracts until they're signed, sealed and delivered. Of course, then it will be too late to make any changes to them. I think that's the way the government absolutely wants it to be, because what's clear to me is that there has been essentially no change from the P3 model that was first put forward by my colleague Mr Baird's government to the one Mr McGuinty announced here in this community in November. There is absolutely no change.

It doesn't make me feel any better to know there would be public ownership of the hospital when I also know that the financing is going to be private and that millions and millions of taxpayers' dollars that should go into patient care are instead going into the pockets of the two private sector consortiums that are going to build these hospitals. Not only is that going to happen with these two hospitals, but the minister has also been very clear in conversations with others that have been repeated to this very committee that that's the same model the government is going to use for reconstruction and renewal of at least seven other hospitals. The names of those hospitals were actually released in the committee process yesterday in Sudbury by Michael Hurley, who is one of the individuals who had this conversation with the minister on December 17.

So I think that even though the P3 model is essentially the same—a Conservative lease now being replaced by a Liberal mortgage—the people in this community, the people in Brampton, have a right to see the details of those contracts before they are actually signed, in the hope that, since this government doesn't seem to be backing away from the commitment it made to cancel the P3s, the least that could be done is to deal with the more ominous, onerous and repulsive parts of the contract that are going to mean so much money going into private consortium profits instead of patient care.

That's why I'm moving this. I'm glad you mentioned today that you hadn't seen it. That reminded me again of why it was important. Even though Mr Baird couldn't do it, I'm glad that I have been able to move the motion, because I think the public has a right to see this. You're right: The public voted for change. I think they thought the Liberals were going to keep their commitments on ending P3 hospitals and keep their commitments on ending the private MRI/CAT scan clinics, and they haven't done either. None of that appears in the bill, and it's about time we saw the contracts to see exactly what the Liberal government is getting us into.

Mr Baird: I'll be brief. I was convinced by about 18 different lectures and speeches by Gerry Phillips about the need for transparency. I listened and I learned. Gerry

Phillips, in opposition, has convinced me that this is a good thing. Given that Mr McGuinty promised to release it by December, I want to congratulate Ms Martel on her very well worded motion.

The Chair: Very well written, I think.

Are there any members from the Liberal side who would like to speak?

Ms Smith: We believe this is an issue that Ms Martel or Mr Baird could raise in the Legislature when it resumes on March 22, and we believe it's inappropriate to raise it at this time in this committee.

The Chair: Any further speakers?

Mr Baird: This committee has the power to demand it. I'm not demanding. All I'm doing is requesting: Could we please have a copy? We're not demanding it, we're not procuring it, which as a legislative body we have the power to do. We're just requesting it. The House isn't sitting. Mr McGuinty was elected, and he's now taking a 100-day vacation from the Legislature and we don't have question period. This is our only format to try to help OPSEU and Ms Rivier—

Ms Martel: And hold the government accountable.

Mr Baird: —and hold the government accountable for the promises it made. All we're doing is asking, just to let a little sunshine in. The Liberals promised change, and it appears they've changed their minds.

Mr Levac: I'm very concerned about the time this is going to consume, when this particular amendment indicates immediately, and the sensitivity around contracts. Even if I were to take the assumption that the members opposite have implied, that the contract is not complete yet, I've seen companies in my community leave because information was disclosed earlier than it was supposed to be. Quite frankly, it shows an insensitivity toward contract negotiations in general, having no knowledge of what you can do or cost, in terms of the cost to the taxpayer. There could be penalties included in this. I don't even know that at this time. So I would think that assumption itself would be very inappropriate.

The comments that are being made, particularly things like "100-day vacation," show a disregard for the work of all legislators, particularly when we're moving in this direction right now and that people are working as we speak. So in terms of the debate that's taken place on this particular motion, I would ask if we could call the question.

Ms Martel: I do want to say one thing.

The Chair: Ms Martel and then we'll have the question.

Ms Martel: I'll be very brief. I wasn't going to say anything else, but I've been provoked by the comment that this motion displays insensitivity to contract negotiations. Do you know what, Mr Levac? I don't care. I'm much more worried about the public interest. I'm much more worried about how much public money is going to be squandered, going into the profits of the private sector consortium that's building this.

I know why those contracts won't be released until they're signed, sealed and delivered: because then it will be too late to do anything about them. I think your government should really worry about how much money that could go into direct patient care is instead going into the pockets of the private sector consortium. That's what your government should be concerned about and dealing with.

The Chair: All those in favour of the motion?

Ms Martel: Recorded vote, please.

Ayes

Martel.

Nays

Brownell, Levac, McNeely, Ramal, Smith, Wynne.

The Chair: Thank you, Ms Rivier, for attending today. We certainly appreciate your input.

We stand recessed until two o'clock.

The committee recessed from 1309 to 1403.

CHAMPLAIN DISTRICT HEALTH COUNCIL

The Chair: Ladies and gentlemen, if we can call the meeting to order. If we can have the cameras off too, please. Thank you.

I'd like to call forward the representative from the Champlain District Health Council, Mr Robert Miller. Mr Miller, I'm Kevin Flynn. I'm the Chair of the committee. You've got 30 minutes to make your presentation. You can use that time as you see fit. At the end of the presentation, we'll be using the remainder of the 30 minutes for any questions members of the three parties may have. The questioning at the point will begin I think this time with the Progressive Conservative members, who aren't here yet but I'm sure will be joining us in process.

The floor is yours, and if you would introduce yourself for Hansard.

Mr Robert Miller: Thank you very much, Mr Chair, for the opportunity to appear here today. I will share the presentation of the Champlain District Health Council with the executive director, Kevin Barclay, who sits to my right. In our opening statement, I'll touch briefly on the preamble in part I of the legislation, dealing with the Ontario Health Quality Council. Mr Barclay will discuss the provisions regarding accountability agreements. Those are the portions of the legislation that we've prepared comments on. I'll then close our statement with a comment and a recommendation about the relationship between the district health councils and Bill 8. We'll be brief and to the point, and we very much welcome your comments and questions. We'll try to preserve as much of the time for discussion as possible.

With that, let me very briefly make some comments about the proposed Ontario Health Quality Council. In our written submission, which has been tabled with the committee, we expressed our support and our hopes for the council. I want to reiterate both the support and the hopes. That's the good news. In my statement now, I'd

like to share several concerns and recommendations that arise out of those concerns. Perhaps that's not such good news, but I hope that this will be seen as constructive, in the spirit of improving the legislation.

I have three points that I would make. First of all, the legislation having to do with the Ontario Health Quality Council lacks a mission statement. After reading that part of the legislation several times, I'm still not entirely clear what the mission of the council is. I know that the legislation specifies functions, a function to gather information and to report to the people of Ontario, but that is not the same thing as a clear sense of mission. As all of us know, there is no shortage of monitoring and reporting where health care is concerned, but that has not added up to understanding or accountability between the people of the province and the system.

We recommend that part I of the bill begin with a mission statement expressing in clear terms the principle of democratic accountability referred to in the preamble, the accountability of those setting and implementing health care goals—the government—to the people of Ontario. Approached in this way, part I and part II of Bill 8 can be seen as complementary aspects of strengthening health care accountability.

The second point is a recommendation that the legislation should give priority to "persons from the community" in making appointments. Given our first recommendation, our view of the function or the mission of the council, the second recommendation follows. The council should be made up primarily of well-informed representatives of the community, not experts. Ontario does not need another dialogue consisting of experts talking to experts. We need a vehicle to assist citizens in holding government to account for the achievement of publicly established health care goals. Properly tasked and appointed, the council could be that vehicle.

The third recommendation that I'd make is—and here I will quote—make "helping Ontarians exercise informed accountability" the primary purpose of the council in reporting. There is a list of purposes in reporting; the last listed is promoting understanding among Ontarians. In our view, again following out of the mission statement we recommended to you, that should be the core of the reporting. If the council were to be successful in all other respects, it would still be a failure if it does not strengthen informed citizenship where health care is concerned. Properly understood, informed citizenship should include the responsibility of all of us to act in ways that protect and promote our own health.

That, Mr Chair, is the opening statement. Just to reiterate, our recommendations are that the legislation should provide for a clear mission statement; secondly, following from that mission statement, give priority to persons from the community in making appointments; thirdly, make the central, primary purpose of reporting helping Ontarians to exercise informed accountability over the health care system.

With that, I'll invite my colleague Kevin Barclay to address our remarks concerning the accountability agreements, and then I will briefly close.

Mr Kevin Barclay: In our submission, the Champlain District Health Council has recognized that accountability agreements can act as a foundation for aligning incentives with the desired outcomes. More importantly, council has also recognized that a process of creating alignment between the accountability agreements could provide an opportunity to enhance continuity of care within the system.

Accountability was a significant area of exploration for our council's recent community dialogue process, a process that lasted over the last year and involved over 150 health care leaders. The process engaged leaders from across the Champlain health system toward the goal of establishing a shared vision for health care. It is from this process that we draw our ideas.

In our explorations, accountability agreements have been defined to include an agreement built on trust, an explicit agreement that defines outcomes to be achieved, the supports required to achieve them and the barriers that will be removed so that you can achieve them. Accountability agreements have also been defined to include explicit incentives for meeting or exceeding agreed-upon outcomes, explicit consequences if those outcomes are not achieved, and a balance between accountability and empowerment that allows the organization or individual appropriate flexibility to adapt actions toward improved outcomes.

1410

The accountability agreement provisions of the bill provide a significant opportunity to align incentives with the outcomes that the government and the people of Ontario want and deserve. In too many circumstances, the current maze of incentives and disincentives works against the delivery of quality continuous care.

The bill also recognizes the importance that trust will play in successful accountability agreements. However, trust within the health system has been compromised according to recent polls and the feedback that we've received through our Champlain district process. To this end, our council is presently in the process of facilitating dialogue and action plans related to a theme we call "Care for the Caregiver." We recognize that a root cause of the challenges we face in health human resource shortages is that pervasive mistrust within the health system. Our experience suggests that successful implementation of accountability agreements will also require building trust at all levels within the health care system.

We also see that to maximize effectiveness within the complexities of the health care system, accountability agreements need to provide empowerment along with accountability. The bill stipulates the importance of clear roles and responsibilities, transparency, a reliance on evidence, and a focus on outcomes. All of these elements will contribute to empowerment.

The complexity of our health care system also requires empowerment that encourages the innovations required to create change. Explicitly recognizing the need for innovation within agreements will empower individuals and organizations to stretch toward achieving the agreed-upon outcomes.

It is appreciated that the recognition of accomplishment is identified within the provisions of the act. Positive recognition is essential for creating the incentives needed for people and organizations to succeed. Such incentives should be incorporated into the accountability agreements at the outset in order to maximize the motivation of the recognition.

To conclude on this matter, the most significant opportunity that we see within accountability agreements is the development of aligned agreements that capture "shared and collective responsibilities" that are identified within the act. Our health care system has evolved from inspired but isolated initiatives into a complex, fragmented maze of services. Individual accountability agreements and other forms of individual outcome commitments will not create a system of care from the perspective of the person using the system. A system of care will only occur when the individual commitments are aligned to ensure that necessary supports are provided and barriers removed by those who share responsibility for quality continuous care.

In our capacity as advisers, planners and facilitators, the Champlain DHC is positioned to create a clear understanding of the interdependencies between the accountabilities of the providers and to facilitate consensus on the collective responsibilities of those providing care. Through the process of accountability alignment, services will build on the contributions of other services and create the kind of quality continuous care the government and the people of Ontario want and deserve.

Mr Miller: In closing, let me add a final recommendation that goes beyond your immediate mandate, and that is that the provincial Legislature should review the legislation establishing district health councils to make sure that it and they complement the objectives of Bill 8. District health councils should be given district mandates that parallel the province-wide mandate of the Ontario Health Quality Council, and indeed the national mandate of the Health Council of Canada. If this were done, democratic accountability could be strengthened at all levels of the Canadian health care system. This is not a problem that exists only at the national level or the provincial level. The issue of accountability is one that applies within our own communities as well.

With that, our presentation is at an end. We welcome the opportunity for discussion. Thank you again very much.

The Chair: That's wonderful. I appreciate your presentation. We've got about 15 minutes left. We'll split that three ways, five minutes each, starting with the PCs and Mr Baird.

Mr Baird: Thank you very much for your presentation.

There are two issues I wanted to raise with you. First, how do you see the quality council that you'd like to see be mandated to the DHCs—how would it interact with the provincial council and then this new national council? How would that work, and how would you respond to a charge that that is perhaps duplication?

Mr Miller: I think the question of duplication is a serious one just because there are so many sources of information and so many agencies. Kevin has told me that just within our district there are something like 160 separate agencies that are somehow or other involved in delivering health care. So there should be a preoccupation with avoiding duplication and building on the work of others.

I think the first step, in answering your question, is that the mission has to be a very clear one. Our recommendation to you is that the core mission of each of those agencies or institutions should be strengthening democratic accountability. It's very easy for information providing and sourcing and discussion to become this expert-and-expert dialogue that I was talking about. But apart from all the other challenges facing the health care system, and indeed all public institutions now in Ontario and Canada, there is this pervasive mistrust, misunderstanding and even cynicism about the ability of public services to achieve their objectives. So (1) it's extremely important that, whether at the regional, the district, the provincial or the national level, there be a clarification of shared objectives; and (2) an agreement on the way we're going to gather and share information to determine whether or not we're achieving those objectives.

The reason for my last recommendation is precisely to make use of an instrument which is already there, which the province of Ontario already spends money on—the district health councils—to supplement and complement this new body.

Mr Baird: Moving to another area, the throne speech presented in March talked about dual accountability. I strongly support accountability mechanisms. I think they're a good thing. I'm glad to see that we're all talking about this, because it is important. I think most people wouldn't object to forms of accountability. I certainly prefer the meaningful accountability.

One of the challenges—this isn't a political statement; certainly it's the case now and it has been the case for the last 20 or 30 years—is with respect to what accountability a government, or the Legislature, has when it puts on limitations, whether it's on revenue sources through the Canada Health Act, whether it's if the government, the executive branch, is going to put accountability mechanisms on the hospitals, long-term care or whatever in eastern Ontario. What sort of accountability do they have? "We want you do to X," but what's Y? What is expected from them? Do you think perhaps the regional office of the Ministry of Health should have an accountability mechanism to you, to the agencies within that region?

Mr Miller: I'll invite my colleague to comment on that. I won't attempt to answer the question of whether the regional office should do it. The key point I'd pick up in your question would be the importance that there be mutual accountability. It's very easy for accountability to be a new term for an old mechanism, which is essentially command and control. It's extremely important, if accountability is to mean what it should, that it's a way

of bringing people together around shared goals and objectives. This is certainly important in the health care system.

As Kevin has said in his presentation, it's very easy to revert back to a traditional way of trying to exercise accountability. All the evidence we have now is that even if you can enforce those agreements, put them in place and so on, at the end of the day they're unlikely to be effective because there are too many ways available to people to frustrate objectives which aren't shared.

On the role of the Legislature, we have a well-established mechanism in our society for accountability, namely elections. The problem is complementing that process with reliable and trusted sources of information about whether goals and objectives are being achieved, because that too gets caught up in the political process. I think the debate about the fundamental goals of the health care system will be improved, strengthened, if we also have a mechanism that can build some kind of consensus as to whether or not goals are in fact being achieved. That's where I see something like a health council at the national or provincial or regional level being a useful supplement to the political process.

1420

Ms Martel: Can I return to the first point that Mr Baird started on? I apologize that it still is not quite clear to me what your objective is. I appreciate that you want to have the government make use of DHCs to provide any assistance that would be necessary to the council. I'm not clear what would be required, in terms of a change in legislation, to allow that. I would just think that if there's information to be shared and 10 things to be done, that could be done now, with the current structure. So maybe you can tell me what it is that would need to be done. I still have a concern, though, that there would then be some duplication. There aren't enough health resources to go around now. I wouldn't want to see that happen and I don't think you would either.

Mr Miller: Well, I agree with that. The essential change I think is to make the mandate explicit. One of the problems that faces DHCs is that their mandate has been defined in very, very broad, general terms as advising on virtually everything from time to time that the minister may require advice on or that we may deem necessary. That gives the DHCs some flexibility, but absent some clear directions as to what would be useful or effective, it can also leave DHCs floundering out there in this vagueness. So the purpose is not to have the DHCs do what this quality council does, but to bring to that work a specifically regional dimension or focus.

The Champlain district is a distinct district in the mix of rural and urban in the demographics of the district, of the growth of the district. Whereas the quality council can, if you like, develop a broad framework and report on the health status of Ontarians, there is this complementary thing of relating that to the particularities of each of the districts of Ontario. I see these two things working together.

I'm not suggesting that the DHCs need more resources, that they need more staff, that they need more of any of that. We have the resources to do it. It's more a question of clarifying the mandate and inviting the opportunity for effective collaboration between us and this new mechanism.

Ms Martel: Regarding the point above that, number 3, "Make 'helping Ontarians exercise informed accountability' the primary purpose of reporting," I'm not sure if I do understand. I think there's any number of people out there who would have a sense of what was needed and who would want to assume some responsibility for that. My concern continues to be around the whole notion of the council, that they will do some good work monitoring and reporting, and then it's going to stop at the report stage and there would be no implementation of what necessarily came from the reports. Because they don't have a mandate now to actually make recommendations; the only recommendations the group can make is future areas that they should report on. I think that's lacking. I think they should be able to make very clear, concise recommendations about what they find. So it's not clear to me, when you talk about number 3, what that's going to do to essentially change health care in the province, to move us beyond reporting and to actually move us to some action based on the reports.

Mr Miller: I guess the first requirement is to address the kind of confusion that we sense, in contact with the community, that exists about the nature of the system and the way it works. Individuals approach the system with their own needs in mind. They're either well served or they're not well served. But in addition to that, people are citizens, and they're trying to arrive at some kind of informed judgment about the way the health care system in Ontario or in the area where they live is working. I would say that the average person in our society, and I include myself in that, finds it extremely difficult to form a picture of what this is about, what it's attempting to achieve, and therefore what a basis is for evaluating whether or not it's succeeding. It's not clear to me that the primary function or mission of the proposed Ontario council is to assist citizens in making those kinds of informed judgments.

People in the system have all sorts of sources of information, and they can align that information with their institutional interest and so on. What's much more difficult is for the citizens in general, the people out there who are looking at this debate, these discussions and so on, and deciding, answering a very simple question: What are we trying to achieve here over the next few years? What are we trying to improve as a society? Second, are we succeeding or are we failing? Certainly, in my conversations with people, I get the impression a lot of people find it extremely difficult to answer those kinds of questions.

Ms Smith: Thank you very much for your presentation; I really appreciate it. I appreciate that you represent a large area. I've travelled most of your district, actually, in the last couple of weeks on my long-term-care review, so I'm familiar with a lot of the hot spots along the way. There is certainly some great innovation happening in the

long-term-care facilities in your district. You should be very proud.

I also had the benefit of meeting with my DHC in the last couple of weeks, so I have a better sense of what DHCs are doing. I appreciate the thought you've put into this. We've brought this bill forward for review after first reading in order to allow various stakeholder groups and citizens in Ontario to give us input, and we appreciate the time you've taken to do that, and specifically your input around improvements to the council. The suggestions about the mission statement and the membership are important ones for us.

I particularly appreciated the discussion you just had on what you think the council can do, because I very much see that as how we see the council performing, providing that service to the people of Ontario. There are so many studies and papers being done on quality of care in various areas, and the health field is so vast. I think it would be important to have that one place we can look to that will gather and provide that, and reflect it back to the community so they understand what their tax dollars are being spent on and where improvements are being made and can be made. So I appreciate that we see that in the same way.

Your suggestions on how to integrate the district health councils into that system I thought were important as well. One of the things we're looking at the health quality council doing is amalgamating all of the studies that are out there. I was impressed when I had a list from my district health council of all the studies they've done for my area. I think it's important that we pull all that information together. There's so much good work being done and not being reflected back to the general population. So let's pull all that together and get it back out there. That would be an integral role of the council, and I think that's probably the role the district health councils will play, that filtering up of the information that they're already working on so diligently. So I appreciate that.

You had a question about membership. One of the amendments that we look forward to bringing forward is precluding membership on the council for stakeholder groups. We will be looking at broader representation from the community and actually not allowing people who have executive positions on colleges, boards and stakeholder groups to have a position. I think that will broaden the expertise around the table and allow for a greater dialogue from a community point of view, which is what I think you were looking for.

I think Mr McNeely had a question, but I just wanted to bring one more thing. Kevin, in your presentation you spoke of explicitly recognizing the need for innovation. Was that in section 20, where you were looking at the various matters that can be reviewed in an accountability agreement? There was the "Clear roles and responsibilities." Is that where you wanted some kind of recognition of innovation?

Mr Barclay: Yes. The council has had a number of conversations about the importance of really energizing that creativity that's going to have to come into decisions that help us change toward a better future. Often it seems as though we think about accountability only after something has gone off the rails. I'm suggesting, and the council is suggesting, that accountability should be something that we take a proactive approach to and include in those kinds of incentives and those kinds of empowerments that will lead to innovation and create positive change.

1430

Mr Phil McNeely (Ottawa-Orléans): Thank you, Mr Miller. One of the issues that came up last fall was inequity across the province. Waiting times were approximately double here compared to Toronto, with less than half the MRIs per capita that they have in Toronto. There were comparisons made all across the province, but certainly those two stood out. Also, the funding of the health care system in the Ottawa area was about 85% per capita of what it was across the province. You must see that, as part of your council.

I am hoping that the accountability also has equity across the province in here and it will change. In Ottawa the explanation you always get is, "You're servicing a great number of clients in Quebec." But that's no longer the case. It hasn't been the case for a few years, yet it has prejudiced our funding here very badly. Do you think the accountability, as it's written here, has equity across the province built into it? Are we looking at the same outcomes across the province?

Mr Miller: I think you raise a good point. Part of the problem with the legislation—it's not something I commented on but it's something I'll mention now—is there is no explicit connection between the preamble of the bill and the provisions for the health council: Does the preamble apply to all parts of the bill? Does it apply to certain parts of the bill? Do certain parts of the preamble apply to the council?—and so on. That's why I'm suggesting that in a mission statement or whatever the health council portion of the legislation should itself have a kind of preamble introduction saying what this is about, what principles it should be guided by. Certainly equity in access is one of those principles enunciated in the preamble.

However, the one thing I would emphasize in a results-based or an outcome-focused quality council—and that is indeed what the council is about—is that the debates about how many of this, how many of that and how many of the other thing are going to be resolved finally by looking at the health care outcomes for citizens. Those kinds of debates tends to become, if you like, a secondary debate about, "Are we being treated equally? Do we need more of this? Do we need more of that?" The bottom line that this kind of initiative, at the national level, the provincial level and, we would say, at the district level as well, is trying to get at is, whatever the differences in the system, at the end of the day, what is the difference in terms of your health and my health, the health of the people in the district? That needs to be the focus for the work of the quality council, and all the other things are then seen as inputs into that. Perhaps you

need to spend more. Perhaps you need to have more of this or less of that.

Sometimes the means to the end become the substance of all of these kinds of discussions and we never get around to the question: What, at the end of the day, is being delivered by these investments, by these institutions and so on? That's what we would like to see at the heart of this quality council.

The Chair: It's not the end of the day but it is the end of your time, unfortunately. Thank you. We appreciate your input, Mr Miller and Mr Barclay.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 481

The Chair: We move on now to the Ontario Public Service Employees Union, local 481, Renfrew County Community Care Access Centre. We've got Susan McSheffrey, the president of the local, with us today. Make yourself comfortable.

Ms Sue McSheffrey: It might take a while.

The Chair: No problem. While you're setting up, I'll explain the rules. You've got 30 minutes. You can use that any way you like. At the end of your presentation we're going to split the remaining time among the three parties to ask you questions.

This is going to be interesting.

Ms McSheffrey: Show and tell.

The Chair: At the end of the period, you're going to have that time split among the three parties, and this time we'll be starting with the New Democrats. Ms Martel will be starting the questioning. I've got 2:35. The floor is yours.

Ms McSheffrey: Before I start from my prepared text, I'd just like to say I have a deep-seated appreciation for the work you're doing. It's a lot of work sitting here and listening and going across the province. I think from listening in now, you've had a lot to take in and I really appreciate that you've given it the time. Thank you.

My speech: This is my first time doing anything like this, so you'll have to forgive me. I'm really nervous.

It is an honour and a privilege for me to be here to appear before you. I am so happy to be asked for my opinion, actually. It's been eight long years since anyone listened to front-line health professionals, except doctors of course, so I hope you'll forgive my giddy excitement.

I am a physiotherapist with the community care access centre in Renfrew county, just up the valley from here, and I've been there for the past 12 years. I'm part of the brain gain. No one really talks about that, but I chose to come to Canada from Britain 18 years ago because you had the best health care system in the world. I want to tell you that the body of that system is still there. It's a little anorexic but, with some therapy, I think it could soon be restored to its past magnificence.

As well as working as a community physiotherapist, I'm the president of OPSEU, local 481, the professional staff at the CCAC, and I'm a member of the Canadian Health Professionals Secretariat, which links health professionals across Canada. I was going to have somebody with me to hold my hand, and that would have been Nancy Surkes. But she got sick, so I'm on my own.

After eight years of uncertainty and instability in health care, we looked forward to the promised restoration of stability and respect for health care workers. Bill 8 doesn't provide any reassurance to us that this will be the case, and I did listen to your discussion on Monday, so I have had a chance to add some of that in. I share Mr. Klees's concerns that we are asked to comment on a bill that is being rewritten as we speak. I can only comment on the information available to me last week, but I recognize that Minister Smitherman provided some clarification on Monday.

Community care access centres—not action centres, as the minister believes—are the daughters of the old home care programs. To highlight some of the gaps in Bill 8, it might help to explain what has happened in my world. Initially—this is where I get my toys out; I do paediatrics—we were all part of the health units. We were sharing space and administration costs in one building. Then came the CCACs, and that doubled; we were created as separate agencies. Then what happened was that all direct service staff was divested, which is really a euphemism for privatized. So the nurses went to three or more agencies, therapists went to one or two, and equipment and supplies went to another. We now have all these buildings with administration costs, lease costs and everything that goes with that, out there in our little community, which is big geographically but not big with people, where we had one before. These separate entities cost much more to operate than when the staff was in-house. For example, in privatizing my service, the therapy service, the cost doubled from $2 million to $4 million. It's the same staff doing the same jobs with the same patients. I think it's easy to see why: The overhead and administration costs went up, and profit margins had to be built in.

When local CCAC boards began to cry foul, that this wasn't cost-effective at all, and some even balked at wasting money this way, along came Bill 130. All the CCAC boards were fired and new ones inserted. The fact that every single member of our board was a member of the local Alliance and Conservative riding associations, I'm sure, was just a coincidence.

The result has been a dramatic reduction in service at the client level, as money was being redirected to run all these other organizations. Personal support at home, surely the most effective segment of our health system, has been all but eliminated. For a few dollars a day, the frail elderly and chronically sick were provided with assistance to grow old and die in their own homes. This is what they wanted, and it kept those people out of hospital and nursing home beds. These services no longer exist. Over 100,000 people are no longer receiving care at home, and home care caseloads have been cut by more than a third. Front-line staff have been laid off, while the little fiefdoms we see here are growing in profits and administrators. Just yesterday, and the timing of this is

unbelievable, we heard that three more professional staff at our organization—a social worker, a dietitian and a case manager—are to be laid off on Friday. In the past three years, our professional staff has been reduced by 14.5, while administration and support has increased by 8.5. That's full-time-equivalent people. We're a very small CCAC with a budget of about $13 million to $14 million. In-home nursing has been cut 50% and home support by 60%. We've been through six years of turmoil and change, and we are change-fatigued.

1440

That brings us to Bill 8. To me, the most disappointing thing is an absence of the mention of democratic governance, an absence of ending privatization and the absence of a commitment to honour the Long-Term Care Act. In fact, there is very little in Bill 8 that applies to the community care sector.

The preamble sounds so wonderful, and the statement that preservation of our publicly funded health care services is essential for the health of Ontarians now and in the future made me think, "They've got it. Yes. Finally." But further examination was a little bit more disappointing.

Subsection 9(2), opting out and extra-billing, does extend the prohibition against extra-billing by eliminating the right of physicians and other designated practitioners to opt out of the Health Insurance Act and receive direct payments. This does seem to strengthen the prohibition on extra-billing and opting out. But when you read further, in subsection 9(4) there's language that may well open up the possibility of the government itself, through regulation, allowing extra-billing and opting out.

Block fees are a further example of this, and I can tell you that in my rural community these are viewed as extortion. When there are few doctors and you are lucky enough to have one and a bill for $400 comes through the door, most patients feel compelled to pay. They fear being struck off if they don't. There is no alternative to change doctors because of the shortage of doctors who are actually accepting new patients. For many of my elderly caseload, this is a huge amount of money. The fee-for-service model actually actively encourages this, and the sooner we have physicians on salary, the sooner we can have an integrated system with accountability for the money being spent.

It's our view that block fees should be banned. Block fees are another mechanism to erode the publicly funded system and shouldn't be allowed in regulations or anywhere else. So we support a ban on extra-billing in any form and opting out, and we think the act should specify this clearly.

The superpower being given to the Minister of Health in Bill 8 is very troublesome. Sections 26, 27 and 28 enable interference in workers' rights to decide where to work and the terms of their employment. I do recognize there has been clarification on that with respect to collective bargaining, and I thank you for that.

The violation of free collective bargaining and a worker's right to choose that could happen—maybe just to divert from my text a little here, I'm not just talking about the collective agreements we have. When this divestment of services happened, there was an assumption that the staff would just go, that they would move with the flow. Many of us choose whom we work for or where we work based on a lot of things, not just the salary—in fact, a lot of we physiotherapists in the public system would do much better in the private system. It's the type of work or the people you work for or the philosophy of the people you work for. To sort of sell people like slaves to the highest, or lowest, bidder has really caused a lot of uncertainty in the health system. My colleague Nancy Surkes is going through that right now with an agency in Ottawa that is being re-divested into three separate groups from one. So it's not just the collective bargaining part but the treatment of the staff who work in the system.

I will say that I think it's true that the government has lost considerable control over health dollars through contacting out to the private sector. Individual contracts, as we learned earlier this morning, are shrouded in secrecy, and the results have not been published so we can make true comparisons with the public system. Fixing problems becomes an expensive proposition, as disputes must be solved in the courts, resulting in lengthy legal wrangling and court costs. Wording that mandates all agencies being funded with public money to account and report publicly for their expenditures will go a long way to facilitate meaningful dialogue. We do have a right to know how and where our money is being spent. This would be an admirable role for the health quality council and would enable the public to read a report card on different aspects of the system.

Given the Canada Health Act principles enshrined in the preamble to this bill, it's surprising that the health quality council, outlined in part I, does not ensure reporting on the way Ontario is doing at meeting those principles. Further, it's not required to report on issues relating to two-tier medicine, extra-billing and user fees.

No person who has a financial interest in for-profit health care corporations should be allowed to sit on the council. It would be a clear conflict of interest. As we read in yesterday's papers, there is a clear example of this in the way drug companies failed to report unfavourable results of their drug trials. Suppressing information that impacts on your business might be a good business practice, but it doesn't pass my taxpayer accountability test.

The appointment of the council by the government is inappropriate for a body that's supposed to increase accountability and objective reporting. Rather than an appointed body, this council should be comprised of a democratically selected group appointed by all parties who represent patients, advocates and people like me who work in the system, as well as so-called experts. The council should include representatives from diverse groups as well as geographically remote areas and equity-seeking groups.

The council should be required to investigate how the health system conforms to the principles of compre-

hensiveness, universality and accessibility. It should be required to report on two-tier access, user fees, service charges and extra-billing. Further, this democratic and representative council should have the power to make recommendations regarding these issues and should be required to conduct its operations in a completely transparent manner.

Part III of the bill needs significant rewriting. In the post-Bill 26 era, there is zero trust in vague language with no explanations. The sweeping powers that the minister is proposing to grant himself are unprecedented. If this act is passed, no one will be allowed to take legal action against the minister or the crown under the provisions of this bill upon its passage. At the same time, the government is free to prosecute anyone not complying with an order by the minister. It's time to bring on the kryptonite and diminish those powers.

Before closing, I'd like to say that our local is an active member of the Ontario Health Coalition and supports their brief to you. We're also active on the Renfrew and District Labour Council and support the position of the Ontario Federation of Labour.

Politicians have tremendous power, and what guides you shouldn't be the interests of large corporations like Extendicare, or even me. What guides you should be the lady at home in Renfrew who's dying of a brain tumour or the little boy in Espanola with muscular dystrophy who needs physiotherapy, occupational therapy and very expensive equipment to reach his maximum potential. This legislation is too significant to blow it. There's a huge chunk of money in the system that could be used more effectively. The best service at the best price is with a publicly funded, publicly administered system. I know this from the results in Britain, and all the evidence at home in Canada supports this, too. Bill 8 needs to as well.

Thanks, and I'd be happy to take some questions, I think.

The Chair: Thank you, Ms McSheffrey. You've taken—

Applause.

The Chair: You have a fan. You've taken 15 minutes. You did a great job. You've left us now with 15 minutes for questions, and we'll start that with Ms Martel.

Ms Martel: Thank you very much. You did a very good job. Without taking anything from the other presentations, it was really good to see the impacts on the CCACs and to have those clearly spelled out. I think it speaks to why competitive bidding in home care absolutely has to be stopped, why we need democratically elected CCAC boards again and why the divestiture should never have happened. What you report here is exactly what happened in my community. Just to give you a bit of an example: In the last round of contracts for nursing services about a year ago, the VON, which has an 80-year not-for-profit history in my community, lost the contract to a for-profit outfit out of Mississauga that didn't even have an office in our community, merely because the VON chose to pay benefits and the CCAC didn't want to pay benefits. That is why we need to end competitive bidding in home care.

On that note, as I look at the preamble, which talks in glowing terms about home care and ending two-tier, it would seem to me that if the rubber is going to hit the road here, then somewhere in this bill it should say we're going to end competitive bidding in home care. What do you think?

Ms McSheffrey: As an experiment, we've proved that it didn't work. Service to clients is way less but the cost has gone up, and the money has gone somewhere. We know the money has gone somewhere; we can see it. It's in all the—we like to call them fiefdoms, because that's what they are. We lost VON in our community too. VON was the first victim of the competitive bidding process, along with the Renfrew Visiting Homemakers Association, which was a small not-for-profit local business.

1450

Ms Martel: Can I ask you what happened—and I don't want to put you on the spot—in terms of wages and salaries within the system? The other impact of competitive bidding has essentially been to drive down wages and salaries or get rid of benefits or whatever of people working in the system. Can you comment on that with respect to your own CCAC?

Ms McSheffrey: The significant thing has been—and I think the theory was, that through driving down the cost of payments to professionals, you could save money. The problem is that health professionals are in short supply in Canada, so they couldn't really do that. So you've seen the changes in fringe benefits like mileage and compensation for driving. But with the non-professional staff, the home support workers, their wages have dropped by half and they don't get any mileage at all, they don't get any compensation, they get split shifts—all the things that were protected before. So they might get a lady out of bed at seven in the morning and then the next job they have is at three o'clock in the afternoon, giving somebody else a bath or getting them their supper.

Those are the changes, and they've eroded workers' lives. These are real people who have their own lives to live too.

Ms Martel: And who want to perform and provide high-quality health care. It's hard to ask people to provide high-quality health care on an ongoing basis when their benefits are being taken away, when their mileage is being taken away, when their wages and salaries are being eroded, when they're moving from full-time work to part-time and then to casual, which is exactly what has happened in the home care system, not to mention what that does to clients, who need and deserve continuity of high-quality care. It's hard to provide that under that scenario, despite how committed you may be as a health care provider.

I would have hoped the government would recognize the attack that home care has been under in the last eight years and would, in this legislation, bring forward the changes that would end competitive bidding and restore funding to home care, because certainly the restoration of

funding to home care was an election promise. The end to competitive bidding was not a promise, and it should have been.

It is clear that workers have suffered, it's clear that the people who depend on the service are suffering. I'm looking at your extraordinary number of people who are no longer receiving care at home, so now they're going into long-term-care facilities and it's costing all of us a whole whack more money to keep them in a long-term-care facility. And I won't even go into what's going on in long-term-care facilities these days, which has been so public.

If I go from there—you didn't mention this, but I'm going to assume your concerns would be the same. If you move from what's happened to this privatization and look at the privatization of MRIs and CAT scans, which is technology that could be and should be in public hospitals and operated there—the move to private hospitals—do you have a similar concern about what the impacts are going to be, given what you've already seen with the CCACs?

Ms McSheffrey: I think more so from the CCACs. It's my experience in Britain. What we're seeing in Britain is individual institutions trying to get the best deal. My mom needs a knee replacement, and the best deal they could get for a knee replacement wasn't in-house but actually 57 miles away at a nearby hospital that offered them cheaper. So it's a brokered deal in health care.

We joke at work about how next we'll be told that everybody has to have heart attacks on Tuesday, because then you can be cost-effective and bring in the heart experts just on Tuesdays and don't have to pay them any other days. Health care can't be done like that. Best business practices don't always apply in health care. My daughter is a haemophiliac with a rare form of haemophilia. You have to treat those people, even though there's only one of them in an area. You have to make that available. It's not cost-effective, and thank God we have a system that doesn't look at it that way.

Mr Levac: I obviously pick up on your passion and appreciate your teaching tools. I'm a former educator. I know exactly how visuals can help, and they most indeed did.

I'll ask a simple question, and then I'll pass it on to my colleague the parliamentary assistant. It's not meant to be insulting, it's just a simple question. The way you've described it—and I appreciate deeply what you discovered before and are now making very public—do you believe that the public health units in our communities would be the best place for us to provide the services that all of these cups on the table are now broken down to? I think you said at the beginning that that's where our health units did all these things in the first place. Is it your proposal that the cups should be put back into the one spot under this bill?

Ms McSheffrey: Actually, there's a reason I'm not a politician or a lawmaker: I'm a physiotherapist. In the health units, it worked well. We were all involved in community care. We would meet the public health nurses, who would say, "Look, this lady has just had a baby, and we're worried that he's not meeting his milestones." We've lost that dialogue now; we're all in these separate boxes.

If I could remake the system myself, I would build it more on a CLSC-type model, where you had a community agency linked in with rural hospitals maybe, so that all of the health workers who work in an area would be able to meet each other and there would be some discussion and free flow of people. That's why we elect you as lawmakers and policymakers, to talk to different groups. We're just glad to have had a chance to have some input today, and I hope it's the start of something new, because those of us who work in the system do have some insight. Maybe we don't see the policy side as clearly, but we can certainly tell you how it works on the ground.

Mr Levac: That's great. In the context of the bill, if we could apply it across the board in different ways, still achieving the same goal, you'd be satisfied?

Ms McSheffrey: Exactly, yes.

Ms Smith: I too want to thank you for your presentation. I think it was great. It was very down to earth and gave us some real, firm examples of how this impacts on the real lives of the people you deal with every day. I have similar stories to Ms Martel about the VON in my area and the CCAC and what has happened there, and I think your graphic display has helped us today immensely.

Yesterday we had a presentation where someone was most concerned about the fact that they couldn't get information about the CCAC and the spending there. I just wanted to point out that in the legislation that we are proposing, one of the things that will be a part of it is the accountability agreements between the health providers, which are hospitals, long-term-care facilities and CCACs. There will be a requirement that they be posted and made public.

Ms McSheffrey: Good.

Ms Smith: So those accountability agreements will be made public and people will have access to them, which I think will go some way to answer some of your concerns; maybe not fix the whole problem but at least get some answers out there.

You raised some concerns about subsection 9(4) and about the possibility, by regulation, of allowing extra-billing or opting out. In fact, 9(4), just to clarify, only applies to opting out and, if I'm correct, and I may get the officials to help me on this, it will be prescribed in regulation and it will deal very specifically with areas where physicians are working in hospitals under alternate payment plans and are not billing OHIP but are working on a different system. That allows them to continue those relationships. So it won't be a big window of opportunity; it will be very prescribed, very specific.

I think you've already acknowledged that you've heard the minister speak about the fact that this legislation—

Ms McSheffrey: Yes, there are changes.

Ms Smith: —does not apply to collective agreements and does not apply to unions, and I hope that has calmed those fears somewhat.

You talked about the health quality council and the fact that it does not ensure reporting of the way Ontario is doing in meeting those principles. In fact, I think that is one of the main goals and objectives of the Ontario Health Quality Council, that it will collect the data that is available that is being produced by so many different entities and will provide it to the people of Ontario in order to report back on how we are doing. We do list in the legislation the core functions on access to publicly funded health care. So they are to monitor and report on access to publicly funded health services, health human resources in publicly funded health services, consumer and population health status, health system outcomes and they are to support quality improvement. The things you mentioned that you were concerned about I think would fall under the rubric of those four areas.

1500

The Chair: Thank you, Ms Smith.

Ms Smith: Oh. There you go. I'll answer your other one afterwards. Thank you very much.

The Chair: You were on a roll.

Ms Smith: I was.

The Chair: Mr Klees.

Mr Klees: Ms McSheffrey, thank you for your presentation. I appreciate it very much, particularly the emphasis on home care. The Liberal Party campaigned extensively during the election campaign on their commitment to home care. In fact, if I recall correctly, their long-term vision, as articulated in that election campaign, was to make home care a medically necessary service and thereby effectively underwrite it through OHIP for all of its services. That certainly is a huge undertaking. There are other processes going on now that relate to pre-budget consultations, and it will be interesting, when the budget comes forward, where the order of priority will lie for this government in terms of where they're putting their funding. I'm sure you and many Ontarians will be looking very carefully to see where that promise fits into the many others that have been made.

With regard to your observations on home care, one has—I don't think any political party or any government of any political stripe, and we've had them all in Ontario, sets out to undermine or to destroy a particular aspect of health care delivery. I don't even believe that this health minister had that in mind when they crafted this bill. I give him credit, the benefit of the doubt, and will cut him some slack. It's his first piece of legislation he's bringing forward and obviously it's a learning curve. So we'll bear with that. We are going to be very vigilant to ensure that whatever does come forward hopefully will address the issues that you've referred to, as well as others. Every presentation we've had since we began hearings on this bill acknowledged that it was terribly flawed, that there is an absolute disconnect between the well-intentioned preamble, which I don't believe anyone would disagree with, and the content of the rest of the bill. Somehow that has to be bridged.

But the issue is accountability, really. Again, no one is going to disagree with that. You agree there should be accountability, and it should be a two-way street as well. The government has to be accountable. So it gets to the heart, I believe, of the point you're making. A lot of money has been funnelled into CCACs, and there is a reliance, then, on the local board, the local chief executive officer, to ensure that that is administered properly. Do you have some advice in terms of what kind of mechanism could in fact be put in place to ensure that we get much more for our dollar, the taxpayers' dollars?

Ms McSheffrey: The best advice is that if you have a board that's made up of people who live in the community, who are from a wide range of backgrounds, and especially clients and/or parents of children who are clients, who are often forgotten as a big part of the CCAC, they will then look at what fits best in their community and say, "We've been getting great service from VON. Even though their bid was slightly more expensive, we're getting better value for money. Therefore, our decision is that we're not going for the lowest price, we're going for the best quality."

What's happening with our board at the moment is that they're looking at equipment and supplies. The prices have increased by 20% in the last year. They're saying, "If we bring them back in-house, we could probably bring the price down 25%." So I think the answer is, it's all accountability; it's the boards, if they represent the people of the area. There has to be some accountability back to the ministry.

Mr Klees: You raise a very important point: the local knowledge. No two communities are alike. It's going to be very different in Ms Martel's area than it is in Ottawa or in York region, for example. So it's important that we have the input from the local community, even more important, therefore, to deal with and extricate the part of this bill that would effectively take away the ability of a local board to make decisions, because what this bill does, as you rightfully pointed out, is place that into the minister's hands and the Ministry of Health then has the unilateral right to make all of those decisions. The scenario that you may well see, then, is that the Ministry of Health determines that in order to save $500,000 in your CCAC, they will, in turn, decide what the priority services are and how they're to be delivered.

The Chair: Thank you, Mr Klees. Our time, unfortunately, has expired.

Ms McSheffrey: Thank goodness.

The Chair: We do appreciate your coming.

Ms McSheffrey: I even colour-coordinated my report with my outfit today. That's the extent of my knowledge. Thank you very much for your time. Good luck in the rest of the province.

The Chair: Thank you very much.

COUNCIL OF CANADIANS, BROCKVILLE CHAPTER

The Chair: We now call forward Mr Jim Riesberry from the Council of Canadians, Brockville chapter.

Mr Riesberry, the floor is yours. You've heard the rules. I think you were sitting in the audience. So we'll just let you get comfortable and start when you want to.

Mr Jim Riesberry: Is this water or—

The Chair: That's inspected water.

Mr Riesberry: Members of the standing committee, thank you for the opportunity of making a presentation on Bill 8.

First, a little bit about who I am and my credentials. My name is Jim Riesberry. I'm a graduate geologist and a retired Anglican clergyman. It seems like maybe a strange combination there. I am 70 years old with a wife, three children and five grandchildren and we all live in Brockville. I am here as a concerned citizen of Ontario, a husband, a parent, a grandparent and chairman of the Brockville chapter of the Council of Canadians.

Two years ago I was involved with about 50 others in a door-to-door collecting of over 4,000 signatures on a petition in support of the Romanow report in Brockville and district.

In January of this year I had an angioplasty in which I received a stent in one artery—I thought this would be a good test for it here—five months after my initial visit to the Brockville General Hospital emergency and two and a half weeks after my angiogram. The two procedures are usually done at the same time, but in my case, because there was no bed for me to stay overnight, the two were done at different times, costing both me—since I live 75 kilometres from the hospital, my wife and I needed a motel room for four nights—and OHIP about twice as much. This is one small example of how a shortage of beds can cost more rather than saving us money. In the five months between my visit and my angioplasty, I visited the emergency twice and spent four days in hospital, an additional cost to OHIP due to the waiting time.

1510

Where does one begin to speak to Bill 8 with its grand title, Commitment to the Future of Medicare? I'll begin by comparing it to this little election booklet entitled The Health Care We Need: The Ontario Liberal Plan for Better Health Care. I'm sure the Liberals at least are all familiar with it. I picked it up when I was phoning for Steve Mazurek, who was the local Liberal candidate in Brockville last September. What surprised me with Bill 8 was that it has no mention of many things referred to in the booklet—in fact, I was wondering whether I was studying the right bill at times—such as ending the creeping privatization of hospitals, MRI and CT clinics, the establishing of 150 health teams, home care and mental illness. Does this bill really cover the future of health care in Ontario, or is it just a small start? Hopefully, it's the latter.

On page 3 of the booklet it states, "We will pass a commitment-to-medicare act that will make universal, public medicare the law in Ontario." Evidently Bill 8 is this act. If you think Bill 8 is going to deal with everything in the booklet, you are sadly mistaken. Let's compare the booklet and the bill.

On page 3 of the booklet it states, "Under our plan, two-tier medicare will be illegal in Ontario." While this high goal is mentioned in the bill's preamble, it is not mentioned in the four parts of the bill. Hospitals still have wards for the poor, semi-private rooms for the well-to-do and private rooms for people like Lord Black. The rich can still jump the lines for MRIs.

On page 5 of our booklet it says, "We will make sure that your health care dollars are invested wisely." Yet the P3 hospitals—we are up to eight now—being built involve fundraising by corporations, which could be done more cheaply by the government, and there is nothing in Bill 8 to stop this. Why would the government get somebody else to finance a hospital when it could finance the hospital more cheaply itself and pay the loan off over the life of the building? It doesn't make any sense. Private financing interest rates are 0.5% to 2% higher than the government would pay. Then the financer would want a profit for his troubles of 5% to 15%.

The new hospital plan is little different from the old Tory one. In fact my wife was visiting her doctor the other day, and the doctor's view was that Liberals just took the Tory plan and made it theirs to have it out by November, sort of thing. I don't think that happened, of course.

The Royal Ottawa spent $8 million on lawyers alone, putting together a P3 deal. P3s are bad. They cost more by an estimated 10%, and they cut staff and beds—the British Medical Journal says they cut staff by 26% and beds by 30%—to make room for higher borrowing costs and profit. They reduce democratic accountability, using commercial confidentiality to keep financial information and performance data away from auditors and of course from the public.

There is nothing in Bill 8 to stop P3s in Ontario, in spite of the terrible reports we get from Britain, Australia and the USA. Private health companies have a terrible track record. Also, the MRI, CT and dialysis clinics that are for-profit include paying shareholders a healthy rate of interest on their investment. They are still in existence five months after the election, nor are they threatened, or even mentioned, by Bill 8.

On page 6 of the booklet it reads, "We will cancel the Harris-Eves private clinics and replace them with public services." Bill 8 does not do this. In fact, in the bill it refers to paying "health facilities," "provincially funded health resources," "health system organizations" and "entities," all of which could be for-profit MRI, CT, dialysis or other diagnostic clinics. If such for-profit clinics are not to be funded by OHIP, it should be made perfectly clear in Bill 8. It isn't.

On page 7 of our Liberal election booklet we read, "We will deliver better family health care through family health teams." The phrase "family health teams" doesn't show up in Bill 8, not even in the preamble.

On page 9 of the booklet it reads, "We will invest in home care so that Ontarians can receive better care at home." Again, home care is not mentioned in Bill 8, and when I contacted the home care office in Cornwall, the staff knew of no impending change. As an Anglican minister, I visited the elderly in their homes. Often I would meet homemakers making meals and cleaning house. Correct me if I'm wrong, but that work doesn't seem to be financed by the government any more but, in Brockville's case, by the Red Cross through the VON.

On page 10 of our booklet the government promised, "We will build a seniors strategy that guarantees our seniors will be treated with respect and dignity." The recent abuse reports in the news of residents in nursing homes makes us wonder when that strategy will be coming. It is not in Bill 8. The hours of care per resident in nursing homes and long-term facilities have shrunk and are inadequate. Bill 8 says nothing about them.

Can we have confidence in for-profit nursing homes? I think not. I lived in Cochrane, Ontario, from 1987 to 1998. Around 1995, Extendicare simply pulled out of Cochrane to go to Stoney Creek, where it could evidently make more money. It simply left Cochrane with no nursing home. For-profit nursing home facilities are being encouraged at the expense of public ones.

Instead of talking about adding to the list of drugs covered by OHIP for seniors, the government is thinking of giving financial means tests and cutting out the universality of the program. Bill 8 refers to catastrophic drug costs in the preamble, and that is the last we hear about it in Bill 8.

On page 11 the booklet says, "We will help families struggling with mental illness." Mental illness doesn't even get a mention in the preamble, nor does the promise of more doctors and nurses.

But enough about what is in the booklet and not in Bill 8. Perhaps we should look at what is in Bill 8.

There is a lot in Bill 8 that concerns me and many others, including the medical unions, which I understand have taken a strike vote in case the bill goes through. To begin with, I loathe being referred to as a consumer of health care. This is done repeatedly in the bill, and I wonder whether an attempt is being made to set us up for for-profit health care, as if going to the hospital is like going to the mall. To my mind we are people, human beings, patients, individuals who at times need health care and have a right to health care. We are not consumers of health care, some of whom have more money to spend on it than others.

The council: At least the council is in both the booklet and the bill. I think that a person who has a financial interest in a health system organization should not be a member of the Ontario Health Quality Council. There should not be a hint of conflict of interest. A second look should be taken at who appoints the council. Should it be elected? In clause 4(a) there is a list of things to be monitored by the council. Conspicuous by its absence is its responsibility to monitor for-profit creeping privatization, in spite of the Liberal promise in the booklet to end it.

Accessibility: I am worried about the term "a health facility," which evidently, by definition, is the same as "a practitioner," either designated or non-designated. This definition of a health facility appears to open the door to for-profit, private clinics to be funded by OHIP, as are doctors. For example, on page 11 of the bill, subsection 14(1) reads "At the request of the general manager, any person or entity"—now a for-profit health facility is an entity—"that provides a provincially funded health resource...." Where we read "practitioner" or "entity," can we now read "for-profit health facility"?

1520

Again, back on page 8 of the bill it reads, "The minister may enter into an agreement with a specific person or organization other than an association mentioned in subsection (2);" that is, the doctors', dentists' and optometrists' associations. Would such an organization be a for-profit health care one? It doesn't say.

On page 12 it refers to a provincially funded health resource as meaning "a service, thing, subsidy or other benefit funded, in whole or in part, directly or indirectly, by the province." Can this provincially funded health resource be a for-profit enterprise? It doesn't say.

Are block fees paid in advance for possible uninsured services a good thing, as advocated on page 3 of the bill? I don't think so. Why should we have to gamble on our health with a doctor who is far richer than most of us? Sure we can change doctors, they say, if we don't like our doctor's block fees. Lots of luck trying to do that.

Accountability, part III on page 15 of the bill: A health resource provider is defined as meaning "any corporation, agency or entity that provides, directly or indirectly, in whole or in part, provincially funded health resources...." Can it be a for-profit corporation, agency or entity? It doesn't say.

In summary, what is wrong with for-profit privatized health care? All doctors are for profit.

First, according to the Romanow report, other studies and from common sense, it doesn't save money. It costs more in the long run. The experience of Britain and Australia confirms this.

Second, it relies on cutting corners in construction, in maintenance, in service and in wages to make a profit. In the case of P3 hospitals, few boards can afford to pay lawyers out of operating funds to sue when a problem arises. When health service is cut, patients suffer. We see this especially in nursing homes and long-term care. In for-profit facilities we see two managements, one for health care and one for profit. Sounds like great fun.

Third, the Liberals got elected by promising us publicly delivered health care that does not have operating money being siphoned off continually as profit.

Listen to a letter I received on January 8 from Premier McGuinty, when I asked him to clarify whether or not the P3 plan was the same or different than the Tories' plan. I quote:

"The new Royal Ottawa and William Osler hospitals will be built as open and accountable hospitals. Under the new agreements, the hospitals will remain in public

hands and be owned by their boards, which will direct all work by the private contractors. In addition, the agreement will be made public, and the public will also have full access to services at the new hospitals."

Sounds great. Unfortunately, Bill 8 doesn't support the impression this letter gives. Neither the bill nor the letter says who will borrow the money for the hospitals, or who, besides the contractor, will make a profit.

If I had to choose between the Liberal election booklet and the Liberals' Bill 8 for the future of health care in Ontario, I'd choose the booklet.

The Chair: Thank you, Mr Riesberry. That leaves us with about 13 minutes, so why don't we give each party five minutes, starting with the Liberals.

Ms Smith: Thank you, Mr Riesberry. Let me first just confirm for you that in fact this piece of legislation is but a start to our changes to health care in Ontario. So you can be assured that there was no intention of trying to fulfill all of our promises in this piece of legislation. I would, however, point out that on pages 3 and 4 of our booklet we are making headway and we are certainly meeting a number of the objectives that we set out there, saying that we would pass a commitment to medicare act that will make universal public medicare the law in Ontario, and that is what this is intended to do. We believe that all Ontarians should have access to medically necessary health care services based on need, not on ability to pay, and certainly that remains our intention.

Also, on page 4, we outline that we will report directly to the people of Ontario on health care, because we believe the people of Ontario have a right to know what their health care system is doing. That's exactly what the council is being constructed to do. It goes on in more detail. I won't repeat the rhetoric, but certainly that's what the council is intended to do and that's where we're at.

I'd just like to clarify a couple of things you stated in your presentation. Your concerns about P3 hospitals, that there were now eight P3 hospitals in the works: In fact, you have the words of the Premier with respect to the two hospitals in question and there are no other hospitals in that same structure right now. No decisions have been made with respect to the other six or seven hospitals that you refer to.

In fact, the ministry is working in concert with the Ministry of Public Infrastructure Renewal on a health infrastructure financing and procurement framework that will be applied to emerging hospital projects. This framework will be based on the key principles of public ownership, public accountability and public control. As we have stated in the past, we are against private hospitals and we will continue to work toward finding solutions on the construction of those next projects.

You raised the issue of private MRIs. Again, we're moving toward bringing them into the public realm. That will take some time but it remains one of the commitments of this government, and hopefully, over the next four years we will see those things happening.

You raised, a couple of times, something that's near and dear to my heart. I'll just comment on it and then I know one of my colleagues has a comment. You did talk about nursing homes and long-term-care facilities. I'm presently reviewing nursing homes and long-term-care facilities across the province. I was requested by the minister to do that. I've taken two weeks out of that to do Bill 8, but I'll be going back to that at the end of next week. Certainly we hope to see some major improvements in our long-term-care facilities across the province after we bring back some recommendations. So far, I've visited over 20 across the province and have spoken to front-line workers and stakeholders. We're doing as full a review as we can in a short amount of time so we can bring some improvements to the system.

I'm pleased that you agree with the concept of accountability. I'm going to try to provide you with some clarification about section 14, but maybe I'll just go back and look at my notes and let my colleague—

Mr Ramal: Actually—

Ms Smith: Did I address it already?

Mr Ramal: Yes, all the points.

The Chair: Ms Wynne, you've got about a minute and a half.

Ms Wynne: Just a quick question. Thank you for your presentation. You mentioned a little bit about the council. The council is sort of a centrepiece of this legislation—the legislation isn't intended to do everything we promised. You've said who shouldn't be on the council, but as it's laid out in the legislation, are you generally satisfied with the way the composition is laid out, or do you have suggestions about who should be on that council in order for it to work and report on the health of health care in the province?

Mr Riesberry: I think I'd agree with my predecessors that we don't just have experts on the council.

Ms Wynne: So community representation would be important to you.

Mr Riesberry: Right.

Ms Wynne: If there's anything more specific that you think of on that, you could let us know.

Mr Riesberry: I have a question. There's talk about Osler and Royal Ottawa being public. I guess the basic question is, who is going to borrow the money? Is the corporation going to borrow the money or is the government going to borrow the money?

Ms Wynne: You've got the information from the Premier. I don't know if the parliamentary assistant wants to comment on that.

Ms Smith: I don't have any more information than that.

But I did want to go back to your presentation. I did remember what it was that I wanted to clarify. You were concerned about the definition of "entity." I just wanted to assure you that as we are looking at amendments we are looking at clearly defining what entities will be covered under very specific parts of the legislation. I think you'll see that coming forward in the next round, after we've had a chance to bring forward some amendments, some clarification.

The Chair: We can move on to Mr Klees.

1530

Mr Klees: Thank you, Mr Riesberry. I would be very interested in how the geologist and the pastor came together at some point. I'm sure there's an interesting story there.

Mr Riesberry: Maybe it had to do with mosquitoes and black flies.

Mr Klees: I see.

Mr Riesberry: Levity.

Mr Klees: I was interested in the letter that you received from Mr McGuinty regarding his apparent reaffirmation that there would be no P3s under his administration. You're a learned gentleman and you see through rhetoric. I think you've gone to the heart of what a P3 is: Who pays? It's either paid for with public money, underwritten by government, or the private sector. The parliamentary assistant couldn't answer your question. I'm not sure you were here earlier when my colleague put forward a motion to this committee that I think would help us certainly get to the heart of it. In the interest of being open, an open government, the motion read: "That the committee request the Minister of Health to release the P3 hospital contract for the Royal Ottawa Hospital immediately."

Having full disclosure of that contract would certainly let you and everyone else in the province know immediately whether or not this, in fact, is a P3—call it what you will—and to see whether or not there is a follow-through on the promise that was made. I wasn't here at the time, but I understand that Mr Baird and Ms Martel voted in favour—I think it was actually moved by Ms Martel—and that the Liberal members of this committee voted against that. I would be very interested, as I'm sure you probably are, to have an explanation from the parliamentary assistant as to why each Liberal member of this committee voted against that motion. Shall we take the time to hear that. Ms Smith?

Ms Smith: I don't believe it's your prerogative to be asking questions of us. I believe this is the time for Mr Riesberry to provide us with information. Perhaps you have some questions you'd like to ask him.

Mr Klees: Perhaps. Well, no, actually, that's not true. It is my prerogative to have a dialogue. It's my time. We have the right, as members of this committee, to direct questions in any way. Through Mr Riesberry, who said he's very interested, I would ask you again: Could you give us an explanation?

The Chair: Certainly it can be asked. It doesn't have to be answered.

Mr Klees: That in itself will be an answer.

The Chair: That's fine. That's how the rules work.

Mr Riesberry: I find it interesting to find myself agreeing with a PC member of the provincial government.

Mr Klees: As the world turns.

The Chair: Maybe one of you has moved.

Mr Klees: When you're on the side of justice—thank you. I have no further questions. I thank you for your presentation. I think you have touched a very sensitive nerve. We're all going to be watching very carefully, as I'm sure did the many who did as you did, support your Liberal candidate, voted for a Liberal government that is turning out to be something very different than was represented on the campaign trail.

Mr Riesberry: This is the worry. I even did phoning for a candidate, as did my wife. I put an NDP sign up too, as a matter of fact.

The Chair: Ms Martel, that's a good opening.

Ms Martel: It is. But since we don't follow you behind the ballot box, we don't know what you actually did, so we'll just leave it there. How's that?

I thought your presentation was very good because, frankly, what it did was point out the huge contradiction between what was promised by the Liberals during the campaign and what is now being delivered. Let me start by your very last sentence, which said that if you "had to choose between the Liberal election booklet and the Liberals' Bill 8 for the future of health care in Ontario, I'd choose the booklet."

Many people did choose change. The Conservatives are gone, the Liberals are in government, and people are still waiting for change. They're not going to get it in Bill 8 because if you really look at what the bill does—and you've articulated it very clearly. Let me give you my take on what it does. You've got part I, which sets up a quality council whose sold function is going to be to monitor and report on health care outcomes. They've got no responsibility to even make a recommendation to the minister about what changes should come. We've got lots of people making reports, and those reports get shelved. I have a great fear that that's exactly what's going to happen to this council.

Part II is what used to be the old health services accessibility act. It's an act that was already in place. It has been essentially lifted and put into this bill with a few changes. So there's very little that's new in part II.

Part III is the sledgehammer provisions where the Minister of Health takes over control of hospital boards when he wants, wherever he wants, at any time that he wants and for as long as he wants.

So there's Bill 8, with the exception of the preamble. Who could argue against the preamble? Nobody in Ontario. Maybe there are some who really believe in private health care, but by and large Ontarians look at the preamble and say, "Yes, we want medicare. That's what makes our country different." When I'm really cynical, I think that Bill 8, the preamble itself, was really set up as a public relations exercise. I don't think it's any accident that this bill was introduced in the Legislature on the first anniversary of the Romanow report; I think it was no accident at all. The government has continued to use the preamble as a cover for the rest of the bill, most of which is not new, and other parts of the bill have provisions that nobody wants.

If the government was serious about giving effect to the preamble, then somewhere in this bill there would have been some provisions to implement what was in the booklet. Let me give you an example. If stopping P3s

was a priority, and it certainly was promised by Mr McGuinty, who said really clearly he was going to stop P3 hospitals, that would appear in the bill. It doesn't. If it was a priority for this government to cancel the private MRIs and CAT scans and put that equipment into public hospitals, that would be in this bill, because they promised it, and it's not. If it was a priority to improve home care, then the government would be ending competitive bidding in home care. Although home care is referenced in the bill, there's no provision to allow that to go into effect.

I regrettably see the bill, announced on the anniversary of Romanow, as little more than a public relations exercise from a government that would like to claim that they are doing something to support medicare. But when you look at the details, you see there are no provisions whatsoever to actually do that.

You didn't get an answer to your question about whether the private corporation is going to be borrowing money. If it wasn't going to be the private corporation borrowing the money for the Royal Ottawa, we wouldn't have negotiations going on right now with the private consortium to put the deal together. If the government, using public money, was going to fund this, then they would have been saying, "The deal is done. You can go away now. We're going to build this." You haven't heard that announcement because that announcement is not coming. You're darn right this is going to be paid for by the private sector, and the taxpayers are going to pick up the costs for the very reasons you mentioned.

It costs more for the private sector to borrow money than it does for the government, and the private sector isn't going to do it for free. They're going to want 10%, 15% or 20% profit off the top. So in the mortgage arrangement that the hospital is going to get stuck with, taxpayers are going to pay a whole lot more, because it is going to be the private sector who's building. That's money that should be going into patient care, not into the profits of the consortium.

As I look at this bill, and as I read what you had to say, which was very good in pointing out the difference between the promises made and what's being delivered, I think at the end of the day we have a bill that was big on public relations, given the date it was announced, but very short, frankly nonexistent, in terms of any provisions that actually support or enhance medicare.

1540

If this was the priority for this government in terms of its health care commitments, we are in serious trouble in terms of what else may, or probably may not, happen with respect to the rest of their promises in their booklet.

The Chair: Thank you, Mr Riesberry. We did appreciate your input. Thank you for coming today.

Just a little bit of housekeeping before I introduce the next person: For members of the committee, the vans will be leaving the hotel at 5:15. There will be two vans. One will be for the people who are getting off in Toronto. The other van will be for the people who are going on to Windsor. It's important that you take the right van, because you may go one way and your luggage may go the other.

Mr Klees: On a point of order, Mr Chair: In light of the fact that Ms Smith was unable to provide Mr Riesberry with an answer—I understand she may not have the information—I would respectfully request that Ms Smith at least undertake to provide Mr Riesberry with an answer when she's had an opportunity to research this specific question. Would it be appropriate for us to do that?

The Chair: When Ms Smith comes back, perhaps we can ask her. I think it's appropriate to ask.

Mr Klees: OK.

The Chair: The answer of course will be her own.

ELAINE TOSTEVIN

The Chair: We can move on at this point in time to Elaine Tostevin, who may or may not be here. Oh, very good. Thank you for coming, Ms Tostevin.

Ms Elaine Tostevin: It's nice to see a friendly face.

The Chair: Make yourself comfortable. Once you are set to go, you've got 30 minutes. You can use that time any way you like. At the end of your presentation we'll split up the time equally among the three parties. This time around, the PCs will be asking the first question. The time is 3:44.

Ms Tostevin: My name is Elaine Tostevin. I live in Ottawa now because I fled the problems of Toronto, as Kathleen and I have been through Citizens for Local Democracy issues for years. I'm so happy that you are now an MPP.

I have my degree in political science from Western. I was a teacher. I've been involved in many political issues. I work with native artists and promote wholesale their sculptures and their art across Canada. I've driven across a few times. It's a long drive.

So I am quite aware of the concerns of many Canadians, and the top one is medicare. We can't cut it any more than it has been. Any poll, any kind of public opinion research, and I've been involved in some of that, has always proven that issue.

The night the Liberals won, I was so relieved and happy because I had suffered so much under the Tory regime, as so many other people have—disability and other issues. I even campaigned and prayed for Liberals, voted for them, as I have provincially and for Chrétien too. I meant to wear my pin of Dalton. In the long term I trust him, but I hoped for better bills than this.

Some friends were chatting to me about worrying about Ontario going the same route as British Columbia. Before the election, I said, "Oh, no, they wouldn't do that. It's a whole different group of Liberals and a different style." But I still hope they will not allow our treasured legacy of universal health care to slide down the slippery path to the US style of privatized, extremely limited medicare that costs the average American thousands annually for extra coverage, as basic medical coverage covers so little.

I'm also sad about the Quebec Liberals. I was doing my sales calls in Quebec during the election period and doing whatever I could to promote the Liberals. I even chatted with Jean Charest a while before then, before he ran as leader of the Liberals, and he seemed so concerned about the mess in Ontario. So I just hope he isn't going down that same messy path as the Harris regime did.

My degree in political science taught that new parties must change all deputy ministers and assistant deputy ministers immediately, as they set the policy too often and are still promoting the former regime's programs and lobbyists' interests. That's a basic rule for political science.

I was also initially pleased that BC went Liberal, but then they started this trip down the slippery path to privatization, and there's so much pain in BC. There, 6,000 workers have been laid off and 20,000 workers will be laid off. I have a friend who's a manager of a hospital in Abbotsford who had the dreadful job of being forced to cut all these jobs and being forced to deal with the trauma and the pain that the workers were suffering, and then trying to run a hospital with not enough staff. The PPH deal was cutting the quality of the staff so much and giving the six-week trainees important jobs which should have been left to RNs.

So why can't the Ontario Liberals learn from history and evade the mistakes of the other provinces, and other countries in the world? I've travelled widely. After visiting Brazil and Mexico, those mistakes of globalization are so obviously dreadful, with very low-paying jobs, no pensions and no unions to protect their workers from severe abuse and give them medicare, which is very two-tiered, with the poor having little or no health care and thousands of street children who literally die in the streets.

Before I went to the 1992 Global Forum for the environment, I had read that some 83 children had been murdered. I thought this can't be happening, and it's one reason I went. I thought this can't be a situation.

We don't need to go that route, and I'm really dismayed that Pierre Pettigrew is now the Minister of Health, because he and Paul Martin were the architects of globalization.

We need to celebrate the benefits we enjoy as Canadians.

Those hospital workers in BC who used to make $18 an hour are now making $9 an hour. Also, after visiting most American cities, I am shocked at the poverty. Everyone complains about the lack of medicare, and they can lose their homes if they get seriously ill even if they have a job with medicare. And they're paying so much more for drugs because they won't allow generic drugs.

I was at the Ottawa Hospital Civic Campus the other day and I picked up this article. It outlines their concerns about Bill 8. I'm sure everyone has gone over all this before about the accountability agreements and compliance directives, which allow the Minister of Health to order a reorganization of health services in a community that allows the ministry to use those powers to order that all patient records and clerical functions etc be contracted out. That allows a single company to operate all these services for all the facilities for value for money. That's giving too much of a monopoly to probably an American health care corporation, because they're the ones lining up and limo-ing the Tories, anyway, to take over.

I chatted with a CUPE worker, and he thought for sure it was no problem. He hadn't read the paper. He said, "I have a contract that ensures that if I'm forced to go to a privatized company, I will get the same wages and benefits." I said, "Uh-uh, that's not what's happening in BC and Quebec. All they have to do is pass this Bill 8."

So it lets the wages and benefits be cut and pretty well guts the unions, as they've done globally, and in the US especially, though other countries are in much worse shape than even North America and Canada. Why are the Liberals continuing with these Tory injustices? That's not what we voted for.

Referring back to the importance of new governments—I don't know any of your alliances here or your parties, except Kathleen.

1550

Mr Klees: Those are the Liberals over there.

Ms Tostevin: Oh, he's laughing. That's good news.

Mr Klees: It's a nervous laugh.

Ms Martel: He doesn't want to cry.

Ms Tostevin: Referring back to the importance of new governments immediately replacing all deputy ministers and assistant deputy ministers, according to a Toronto Star article written by Ian Urquhart, the architect of this bill is Phil Hassen, a former BC assistant deputy minister who helped design the destructive BC cutbacks. Pourquoi? He was brought into the ministry by the former Tory health minister, Tony Clement, over a year ago. I would imagine this was supposed to be done before the election, but they ran into SARS. I have to congratulate the health care system for how they handled SARS. It's so sad that workers and health care people were killed by that disaster.

The P3s—I'll just call them that, because everyone knows the term—that are determined to build new private hospitals have to be stopped immediately, as the Liberals promised, as they're beginning the privatization of Ontario's health care system. It's a foot in the door. Once they get that foot in the door, NAFTA rules and all these other globalization rules won't allow us to stop the privatization. The Liberals have to be more brave and let the banks, who are definitely expecting a huge profit, take the government to court. Any court settlement will be much less than the huge overruns in English PPH costs, which almost doubled the costs. From their basic estimates, most of the hospitals' costs were almost doubled.

We have to trust the court systems to rule in favour of the public interests and not corporate greed. Hospitals in PEI dropped out of PPHs when they realized the private hospitals would cost significantly more. So why can't we learn from PEI?

Liberal health leaders need to study the British PPH mess that Margaret Thatcher forced on them, and I'm sure you've been hearing all about that. They cut the staff and the beds by 26% in P3 hospitals, and they used much poorer quality stuff. Their hospitals are falling apart.

Savings to public hospitals are made by having government lending rates that are at least 2% to 4% lower than private loans, so why not use it? Sooner or later government has to pay for these hospitals, so why not? That's a big difference in interest rates and costs over the life of a 30-year contract. In Britain, they were actually paying for 30 years and never owning the hospitals, which is totally ludicrous. As a mortgage payer myself, I wouldn't be paying that. I want to own it someday. But because I'm on disability, I've had to lose two houses and gear down. I had to lose my Victorian townhouse in Toronto, go down to a cottage on Lake Simcoe, and then I couldn't even handle that because they keep taking all my money away when I make it. That is so wrong—this is later in here, but I'll do it now—because the $165 we're allowed to make a month was designed 15 years or 20 years ago, OK? You can't live on $930 a month. My monthly pay is down to $700, and I'm allowed $165. I'm working. They took another $200 away from me. I like to work a bit. I can't work full-time. I used to be a teacher and work a lot, but I've got—it took me three years to get MRIs on my shoulders. There are totally torn tendons, and I can't even sit or stand without—I'm glad we can sit. Because of all this backlog of—well, because no doctor would believe me—"Oh, you look great." I'm in agony. It also took me three years to get that hip replacement done before this specialist finally did MRIs.

It takes cabinet five minutes to change the $165; take monthly out, change it to weekly, and the most unlikely person told me this. He was a minister for the Tories. What was his name?

Mr Ramal: He must know.

Ms Tostevin: No, it's not him.

Mr Klees: That's how easy it is. You just do it.

Ms Tostevin: I was doing speeches to save the moraine, and I'm upset about that too. Let them take you to court. Judges will rule for the right thing, not necessarily for the huge realtors.

So he said it takes five minutes in a complete cabinet to change $165 monthly to weekly, just change one word. You don't have to have hearings, you don't have to spend a lot of money running around the country. That would allow me to keep this third—I'm in a condo-townhouse. For me it's dreadful because of all the stairs, but I couldn't afford anything else.

Mr Ramal: Shameful.

Ms Tostevin: Yes.

Mr Ramal: We're in government now; we can fix these things.

Ms Tostevin: Please, because I'm in the process of actually losing this one.

Interjection: The cheque is in the mail.

Ms Tostevin: No, I want this for everyone, just changing it from monthly to weekly, because there are people committing suicide, especially in the north where there aren't jobs, because they cannot live on disability and they're too disabled.

For the for-profit MRI and CT clinics, this opens the floodgate, and they've already jumped in and have the huge American multinational companies to privatize health care. The Calgary experience shows that costs were 21% to 25% more as privatized in Calgary than they were as a public system. So why do we follow these mistakes? They're already proven wrong. It's a foot in the door, again, of this multinational corporation takeover of Canada's health care.

Health care is a human right, not a commodity to be bought and sold without conscience or concern for public risk. I find any time I have tests, and I've had a variety of them, in a privately run place, they'll do the same ultrasound or whatever in five minutes. But I have it done at Ottawa Civic and they're very thorough. They'll take at least 20 minutes and you feel that you're being much better diagnosed. The faster diseases are diagnosed, the cheaper and faster the cures are, and that saves the system money.

The Liberals did make a commitment to return these clinics. Now the Ontario Health Care Coalition backgrounder also states that the Liberals promised to review long-term-care facilities, and I would imagine this has been covered quite often. They need to be inspected. I was so happy with my mother's care place. It was the IOOF in Barrie, and it was sort of a public type of system, and they really seemed to care for her and the other patients so well. I've heard such nightmares in the Toronto system where it's more private. Extendicare is being kicked out of different states in the US, but it's taking over Ontario. Literally they've stopped Extendicare from functioning in several states. Read the New York Times. Any of you people who are heavily involved with making decisions, all the Liberal cabinet, please read the Sunday New York Times and the others. I should quote the record. Anyway, this is all written, I'm not quoting every source.

Privatization of health and hydro is a Tory Trojan horse, critics say, as the Ontario Health Coalition and the Ontario Electricity Coalition took their Trojan horse across Canada. Paul Kahnert and Ken Abram of the electricity coalition have fought so hard to save our public hydro. He actually phoned me—I had signed up to become more involved in it—and said: "You won't believe it. I'm being asked to speak all over the world on how to stop the privatization of hydro." This is a global mess. This is a global problem. We were all so happy about that stop. Now I hear that Dalton McGuinty has travelled to Alberta to study their privatized hydro system, which costs my sister in Calgary three to four times more now that it's privatized. This was never mentioned in the election promises, so it can't be done. It's just not democratic to go totally backward on such an important issue.

1600

Since the Liberals have cancelled the tax cut bribes to be elected, the $5-billion debt will be eroded over time.

The Tories were taking us that much into debt almost annually, right, Kathleen? We were studying that. The Liberals should not try to balance the budget quickly. Taxpayers aren't that concerned about an instant balanced budget, because we don't want drastic cuts to public health care or any of our other services. Just let us keep public what hasn't been gutted by the Tories. Privatization is just based on greed and profit, and they always do it by cutting jobs. They take $9 away from that $18-an-hour worker, and that's their profit. The 30% bed cut is their profit. But if it's public, it costs half the price for the hospital and the beds aren't cut.

Here are some other hints for budget problems. Why not a 2% tax increase, as suggested by Linda McQuaig in the Star, instead of gutting our health care system? Also, cut the quarter-million-dollar Tory contract with Andersen Consulting, of Enron and WorldCom fame—now masquerading under the new name Accenture, which means nothing—which is wrecking our social system and ODSP. They were bragging about being responsible for, I don't know, 500,000 people off welfare or something like that.

They're really being rough on disabled people and minorities. They have to go through all these message systems, and if they don't understand the language they can be cut off so easily, and they're doing it. It's a heartless crowd at Andersen Consulting. So cut that quarter of a million and let them sue you. Any decent court won't give them a big settlement, because they've been cut across the world. Read the New York Times: All the countries in the world cut Enron and Andersen Consulting.

Cut back the $15-million school testing program that is a copy of what's happening in the US. There's an excellent article in this amazing book called Bushwhacked, which is an exposé of what's happened to the US under the Bush regime. He started all these school testing programs in Texas, and now one third of Texas high school students are leaving the school system because they can't pass these stupid tests. They're doing this in Ontario. If you're a third-level student, you aren't taught first-level math or English. Those third-level kids have to do a first-level test. I marked them for EQAO, and I couldn't believe all these empty books. They said, "Oh, they're third level." That is not at all fair. Those kids have to pass it eventually, and they're going to be forced out of the system. What kind of job are they going to get?

We have to save our health care system, because it's good for Canadian business. Medicare means that Canadian business only has to pay 1% of gross pay for health benefits for their workers. American employers have to pay 8.2%, eight times more, so it makes Canada a much more valuable country to have a company in.

Hopefully, we won't have to follow the Salvadoran people's struggle against their privatization of health care and social security, which took nine months of strikes and citizen mobilizations that successfully stopped the privatization of their system and stopped reprisals against the strikers. Sadly, people were killed in this, even a child. I read about it in the New York Times.

Let us keep our CPP so we can get some benefits. I could get $233 from CPP early. That's federal money; it doesn't cost the Ontario Liberals anything. But ODSP takes that $233 off, and I'm down to $700. My housing costs are $700 or more because of condo fees and mortgage—I have a low mortgage. Then with hydro supposedly going open, we're going to be faced with twice the hydro costs, and I haven't paid that bill for two months.

I could rent my basement room with a little two-piece bathroom off it, which is why I bought this condo townhouse. I did, and they took 60% of my rent away. It cost me two ads at $50 each. Why not just let disabled people keep rent money under, say, $500? You have expenses: It costs me over $50 more a month for hydro. And that girl was schizo and threatened to—it was a nightmare. Anyway, the police were very kind and took her away.

Also, if people on workfare could make an extra $500 a month and keep it, then they would go off workfare, because they would discover they are valuable workers in the system, and they wouldn't have to be lining up on street corners begging for money. Once they get used to making that extra money, they'll work full-time, if they're well.

I'm waiting now for two reattachments of shoulder tendons, which is a serious operation and, because I've waited so long, may be difficult. There's one specialist here, and I have to wait seven months to see him. That's seven more months of extreme pain, especially at night, and I can't stand with my arms down, because it's too much pain on the shoulders.

Increase the $930 monthly to $1,200 for the severely disabled—in wheelchairs and that kind of thing. Have a heart, and quit taking all our money away. If the government has to survive on the backs of the severely disadvantaged, then it's not a good scene. This is a Tory regime that I'm complaining about, because I'm sure the Liberals are going to make it just great for us. I would actually go off disability if I didn't know I was going to be stuck for a couple of months with each shoulder and no way of working or making an income.

I feel the best legacy we can leave our grandchildren is not volatile stocks and bonds but our cherished medicare system, which we have to fight to keep. Over the long run for our children and grandchildren, it won't matter what kind of money we leave them if medicare is gutted, because medicare is the most valuable legacy we have for them.

I really want you to read my full dissertation—it's like doing a thesis. If you need any assistant deputy ministers, I'm available. I'm just kidding, but I would actually work for free to help with changes in disability, because it's such an issue, and not just for me. I'm in better shape than most, but I can't believe the horror stories I hear.

Please read this from Bushwhacked, this new best-seller that's a big hit. It's one page out of it—I don't

know if it's legal to do that. It outlines the mess in the US system of health care and how it's controlled by privatized scams or schemes or whatever.

Also, I did a dissertation on privatization of hydro whenever that was occurring, and I thought my arguments were great.

OK, hit me.

1610

The Vice-Chair (Mr Jim Brownell): Thank you very much, Ms Tostevin. I've taken over. I've been asked, as the Vice-Chair, to take the chair. There are three minutes left. It doesn't give us much time. Mr Klees, would you have a quick question?

Mr Klees: I won't ask a question. What I will do is empathize with you, though. You sound in agony over the promises that the Liberals made and didn't keep.

Ms Tostevin: Well, we'll give them time—not much.

Mr Klees: It's been almost four months and, as you say, just to make that one change would have taken them five minutes. Instead, they came up with a bill, this Bill 8—

Ms Tostevin: Well, maybe they never thought about it.

Mr Klees: —that quite frankly is an affront to most people in this province. So I feel for you. Continue to pray for them. They need a great deal of wisdom and a lot of courage.

The Vice-Chair: Mr Ramal? Oh, I'm sorry. Ms Martel. Sorry about that. It was written down incorrectly.

Ms Martel: Thank you for coming here and taking the time to make the presentation, especially when you have a number of your own health care concerns.

I don't think I have a question. I just appreciate your raising the spectre of what happens when you have for-profit health care and some of the concerns we have around that.

Ms Tostevin: It's a disaster.

Ms Martel: For anyone looking at what's happened in the US with their HMOs, with the number of people, the—what is it?—48 million Americans who don't have health care and many others who think they have until they get to a hospital and find out all of the override clauses that make sure they don't have it, it is not a road we want to continue to go down. Health care money should be going into patient care, not into the profits of for-profit providers. So I certainly hope the bill is going to come back amended and that the amended form will have a section that says the government's going to cancel the P3 hospitals and the private MRI and CAT scan clinics. I hope that's what we're going to see when it comes back.

Ms Wynne: Elaine, thank you for coming here today. I just want to say two things. First of all, I do remember you very well from Citizens for Local Democracy, and all the things that you have mentioned today—I mean, you've made a sweeping statement about a whole bunch of—

Ms Tostevin: It's my concern. I didn't write the bill.

Ms Wynne: No, but it's interesting, because there are so many areas where there is so much work to do. In just about every sector there has been so much damage, and we're trying to put back together this jewel that was Ontario. We've had a very rough eight years. So the second thing I want to say is, I just hope you appreciate that this is a start on one piece, and we're bringing this bill out very early in the process.

Ms Tostevin: I was surprised at that.

Ms Wynne: Exactly. It's coming out after first reading, which is unusual. We're trying to get it right. We're trying to put a framework in place around the council and to close loopholes around privatization issues and around extra-billing and queue-jumping. So we're trying to put some accountability measures in place. There have been a lot of comments over the last couple of days, and there will be more, so there will be amendments that come forward, but it's just a start. On those other issues—

The Vice-Chair: Thank you very much. The time has run out.

ONTARIO ASSOCIATION OF SOCIAL WORKERS, EASTERN BRANCH

The Vice-Chair: Next on the agenda we have Margaret Nelson of the Ontario Association of Social Workers, eastern branch. I don't know if you were here to hear the rules for the presentation. You have a half-hour for your presentation. If you don't use all that time, we will have questions and answers. Welcome, Ms Nelson.

Ms Margaret Nelson: Thank you very much for the opportunity to speak to you today regarding Bill 8, the Commitment to the Future of Medicare Act. I am the past president of the Ontario Association of Social Workers, eastern branch, and chair of the social justice committee of the branch.

The Ontario Association of Social Workers, OASW, a bilingual membership association, was incorporated in 1964. It is one of 11 provincial/territorial associations of social workers belonging to the Canadian Association of Social Workers, which is in turn a member of the 76-nation International Federation of Social Workers. OASW has approximately 3,000 members. The practising members are social workers with university degrees in social work at the doctoral, master's and baccalaureate levels.

OASW has 15 local branches across Ontario. Our association embodies the social work profession's commitment to a civil and equitable society by engaging in social action related to vulnerable, disadvantaged populations and by taking positions on important issues.

I will be speaking to you on behalf of the eastern branch of OASW. Our branch has a membership of approximately 400 social workers, of whom approximately 80% live in Ottawa and the remainder in surrounding communities in eastern Ontario.

Bill 8 is titled Commitment to the Future of Medicare Act. It was introduced in the autumn in fulfillment, as we

understand it, of the Liberal Party's promise to enshrine the Canada Health Act, CHA, in Ontario law, create a health quality council to monitor and provide accountability, and prohibit two-tier health care.

We are disappointed that the bill as it stands does not provide, as promised prior to the recent election, "a fresh injection of the values, commitment and leadership that built medicare." We are concerned that the bill does not further the implementation of the principles of the CHA, does not provide improved democracy, transparency and accountability, and does not prohibit the further erosion of the scope of medicare, the increasing problems of privatization and profit-taking, and two-tiering for those services that have been delisted. Further, we feel it gives the Minister of Health sweeping powers without clear intent or democratic control.

Yesterday in Sudbury, a brief was presented to this panel on behalf of OASW. That presentation set out a vision and called for changes in the bill that would ensure a commitment of the Ontario government to the following:

(1) Rebuilding the universality, comprehensiveness and accessibility of medicare.

(2) Prohibiting two-tier medicine and extra-billing.

(3) Creating a health quality council to report on compliance with the principles of the CHA.

(4) Prohibiting block fees and charges that create a barrier to access.

(5) Ensuring public accountability, democratic control and transparency.

(6) Putting an end to privatization and ensuring democratic public, non-profit delivery of service.

In our presentation, we will address particularly the first of these and the last two; in other words, reinforcing the importance of rebuilding universality, comprehensiveness and accessibility into medicare; ensuring public accountability, democratic control and transparency; and putting an end to privatization in the system. In doing so, I will give examples of situations in Ottawa that limit the ability of government to provide for vulnerable people in need of health care and call for action on the part of the Ontario government to correct these situations.

Universality, comprehensiveness and accessibility—the loss of community care access centre homemaking services:

In April 2002, the Ottawa Community Care Access Centre, OCCAC, announced a decision to eliminate homemaking from its "basket of services." Homemaking had previously been provided to clients who qualified medically and also required personal care. The tasks that were eliminated included basic laundry, shopping and meal preparation, vacuuming, washing floors, dusting, mending, ironing, and cleaning the bathroom. The cuts affected 6,000 CCAC clients in Ottawa.

A study carried out by OASW, eastern branch, soon after the cuts demonstrated the kinds of negative effects that these cuts were having on 62 previously eligible seniors and persons with disabilities. Social workers acted as key informants in this case study. They reported on clients who required homemaking to enable them to live safely and with some semblance of dignity in their own homes but were unable to receive the service from OCCAC. Clients ranged in age from 31 to 96; 35 were younger than 65 and 27 were seniors. All of them had disabilities or infirmities. The majority were living on low incomes; 39 of the 62 were female and more than half of the 62 were living alone.

1620

In those early weeks after the cuts, they turned to a number of sources for help: 32% turned to family and 24% to commercial services, for which they or their family would have to pay. Free agency support was available to only 6% of clients, and 8% were able to access partially subsidized services. Friends or volunteers would offer some help to 4%. For 14%, no assistance at all was available. Social workers reported that those clients, and in some cases, their families, experienced frustration and anxiety and various losses.

Extra financial stress and an extra burden of care were placed on families. Social workers reported major concern regarding caregiver burden and inadequate homemaking, and saw clients and family members at risk for physical injury or illness as a result. There was particular concern for clients who were subject to falls. A few clients were expected to have to give up living in their own homes prematurely. Effects were seen or predicted for the community, as well, such as more hospital care, more support from social agencies, and more costs as a result of admission to long-term-care facilities.

Other community groups protested the cuts. A meeting in June 2002, hosted by a non-profit organization called Home Care Forum, heard from 70 people who were affected. Major concerns expressed in the focus groups were:

(1) Echoing the findings of the social work study, they described great harm and burden to the clients of CCAC, their families and friends, the support system and the wider community.

(2) The fact that the cuts were made without warning or consultation with the community caused great concern.

(3) The cuts represented a step backward in the philosophy, intention and promise of the CCAC, and government policy, to look for humane and cost-effective ways of dealing with the care needs of constituents.

At a meeting of the city's health, recreation and social services committee in September 2002, Graham Bird, the man appointed by the provincial government to chair the OCCAC, stated that the cuts were temporary and had been necessary in order to shift resources to the 500 people who were on the waiting list for acute care. He reported that, from May to September, the waiting list had been reduced to zero. Some resources could now be shifted back to homemaking, he stated. A year and a half later, no such shift has occurred, and it is clear that the OCCAC does not see restoring homemaking to its basket of services.

At a public meeting held in Ottawa in November, 2003, to explore the availability of homemaking services

for those formerly served by OCCAC, Sandra Golding, executive director of OCCAC, stated that under Bill 130, the Community Care Access Corporations Act of 2001, all CCACs were required to carry out their mandate in a consistent manner. Thus, those centres that had provided homemaking services were no longer permitted to do so, except under very strict criteria. These criteria permit a CCAC worker who is in the home to assist a client with a shower only to clean the tub used for the shower or water spilled on the floor that might create a safety hazard. Laundry can be done only for an incontinent client. Even if the worker has free time while carrying out authorized duties, he or she is prohibited from using that time to carry out any other homemaking task needed by the client.

Community response to the cuts resulted in funding from the city and from the province to enable community non-profit organizations to increase homemaking services to serve the most needy. Home Help, a city service, provides homemaking free, but only to people whose income is extremely low. This is how low: Those receiving social assistance or single people with an income no greater than $3,000 a year, or a couple with an income of no more than $5,500 a year. I can't imagine where they live. Non-profit organizations in the community, such as seniors' centres and resource centres, are able to provide homemaking for a fee of $10 to $12 an hour. Thus, there are some services for some people. It is not known how many people do not receive such services because they are not poor enough to obtain them free but cannot afford to pay even the rate charged for non-profit services.

What I have described is just one example of how a service that was universal has been downloaded onto the community and families. No longer is homemaking a right for people medically qualified for it. This change in policy on the part of the former provincial government was a step in the wrong direction, a step backward from the stated goal of this government to ensure that "Ontarians can receive better care at home." It ignores the findings of recent studies in British Columbia that point to homemaking, in particular, as a service that saves money in the health care system, even in the short term. I would refer you to Marcus Hollander's study Unfinished Business: The Case for Chronic Home Care Services, a Policy Paper.

Homemaking services are not a frill; they are necessary to enable medically qualified seniors and persons with disabilities to live safely and with dignity in their own homes. They are cost-effective services, saving costs in the acute care and long-term-care systems. We are encouraged by the promise made by Premier McGuinty prior to the election: "We will invest in home care so that Ontarians can receive better care at home." Again, "Our first step is to get our vulnerable and elderly the services they need."

We look to Bill 8 to provide a clear commitment to restoring universal access to medically necessary services such as homemaking.

Ensuring public accountability, democratic control and transparency—the loss of community boards for CCACs:

A second important concern related to the CCACs is the loss of community boards. The Community Care Access Corporations Act, 2001, gave the government the power to appoint both the boards and the chief executive officers of Ontario's 43 community care access centres. The resulting imposition of centralized control over the Ottawa CCAC was strongly resisted in Ottawa at the time and has led to a lack of open communication between the OCCAC and the community and a lack of trust in the OCCAC. The right to a publicly elected community board must be reinstated for the OCCAC. This government has promised a more democratic Ontario. We call for a revised Bill 8 to ensure a commitment to accountability that is coupled with democratic control of public services.

Putting an end to privatization and ensuring democratic public, non-profit delivery of service—the case of the P3 hospital for the ROH:

Prior to the election, Premier McGuinty promised to cancel the P3 deal for the Royal Ottawa Hospital, ROH. The changes in the deal announced in November 2003 do not significantly alter it. The principle remains the same: The proposed P3 deal will introduce the profit motive, conflicting with the hospital's goal of providing a public service. The building will be paid for with a 20-year mortgage, with the mortgage payments coming out of the operating budget of the hospital. This method of funding threatens the ability of the hospital to maintain the volume and quality of services that the community will require over the next 20 years. Further, although the proposed hospital is to serve the whole of eastern Ontario, it will have 19 fewer beds than the present hospital. It is also expected that the focus of the hospital will shift from patient care to research. With fewer beds and a changed emphasis in the hospital's role, what provision will be made to provide service for patients no longer being served at the ROH? What will the costs be for providing those services elsewhere in the community?

There is convincing evidence, based on the experience in Great Britain and elsewhere in the world, that public-private hospital arrangements are more expensive and less satisfactory than those built in the conventional way, with capital funding raised by government. Costs with public-private consortia are higher, fewer beds are provided and, in some cases, the hospitals designed privately are not conducive to good patient care. The imposition of two separate sets of management under the same roof, one with the goal of providing a public service, the other with the goal of maximizing profit and growth, has been found to be fraught with problems. Ultimately, the taxpayer loses and so do patients. I would refer you to a report in the British Medical Association Journal, 2002, on "Private Finance and 'Value for Money' in NHS Hospitals: A Policy in Search of a Rationale?"

1630

Part of the P3 deal for the ROH includes what we understand to be a 66-year contract for so-called non-clinical services. These are medically necessary services

that may include provision of food, laundry, cleaning and maintenance, record-keeping, lab tests and diagnostics. These are services that support patients' daily living. They are essential to infection control, nutrition, diagnosis and recovery. In a public health care system such as ours, they should be provided on a non-profit basis.

Lack of openness and transparency is a characteristic of public-private partnerships. This is already clearly evident in the nature of communication regarding the deal for the new building at the ROH. Instead of being the open, democratic process this government has promised, the deal is still cloaked in a veil of commercial secrecy such that the plan of the building and the exact nature of the contract being considered are not known to the public.

If the hospital in Ottawa is built according to the public-private arrangement that is now planned, there's a very strong likelihood that six other hospitals slated for construction elsewhere in the province will be built under similar conditions, thus firmly establishing private, for-profit financing as the preferred method of building hospital facilities by this government.

The issue of the P3 hospital for the ROH is a particularly critical one not only for the reasons discussed above but also because it provides, for the taxpayers of Ottawa and the province, a litmus test that will indicate how committed this government is to its pre-election promises such as this one: "We will end the Harris-Eves agenda of creeping privatization."

We maintain that there is no place for P3 hospitals in a public health care system. They skim off millions of dollars of public funds, funnelling that money into the hands of private, for-profit corporations. They threaten the sustainability of medicare. If this government is serious about its commitment to the future of medicare, it will amend Bill 8 to ensure that all privatization, including P3 hospitals, is indeed ended in the Ontario health care system.

The Vice-Chair: Thank you very much, Ms Nelson. We have 12 minutes left. We'll start with Ms Martel.

Ms Martel: Thank you very much, Ms Nelson, for taking the time to be here today. You're right: One of your colleagues was in Sudbury yesterday. We appreciate that social workers, as a group, are taking some interest in this bill.

I want to focus on privatization because it seems to me that if the preamble was to have any effect at all, a preamble which talks in glowing terms about public care and public administration and medicare, then the rest of the details of the bill would support that. There is nothing in the rest of the bill that supports any of that, regrettably. Maybe the government intends to do that at some other time, except that if these things were a priority for them, I would think that they would be coming forward in this bill that purports to be supportive of medicare, to promote medicare and enhance medicare.

I worry about the P3 hospitals because we haven't seen the arrangements that are being done behind our backs, both here in Ottawa and in Brampton. At the point that we will see them, which the government has said is when they are essentially signed, it will be a little late to do much about it, won't it?

Ms Nelson: Yes.

Ms Martel: The government might tell you that no decisions have been made with respect to other hospital renewals, except that we heard an interesting presentation yesterday from Michael Hurley, who leads the Ontario Council of Hospital Unions, who reported to the committee yesterday that in a meeting they had that he was part of, with the OHA, the Ontario Hospital Association, before Christmas, the OHA made it very clear that they were in discussions with the Ministry of Health with respect to either six or seven other hospitals that have to be reconstructed, and the government was certainly looking at a private financing model. The OHA was very up front with Mr Hurley and others who were at their meeting about that.

I think there is no doubt that's where we're heading. If I had any doubt about that and if I thought the government was doing something differently, it would have come with the November announcement, which should have been, "We're cancelling these deals, and the public sector is going to finance hospitals." That's not where we're heading. So it will not be surprising to me in the least to see that reconstruction of hospitals that flow after William Osler and Royal Ottawa will in fact use a P3 model as well and private financing, which will cost all of us a whole lot more.

I appreciated the very specific references in terms of what to do that you made with respect to the CCAC. Correct me if I'm wrong: Is the CCAC here being taken to court now with respect to the homemaking issue?

Ms Nelson: There is a court case at the moment, yes.

Ms Martel: I think that was to start in the new year on behalf of a very specific client, but obviously if the case can be won, it should have impact on the rest of those who lost their homemaking services.

Ms Nelson: It's on today, actually.

Ms Martel: I will watch that with some interest, because I certainly was given some advance notice that this was going to go forward, and I hope they are successful. It would have been my preference that this government would end competitive bidding in home care, and that might deal with some of the problems we're having if the government invests more, as they promised.

In terms of what you see with the CCAC, you made it very clear that the board again should be democratically elected—I agree with that for obvious reasons—and that there has to be a major change in terms of dealing with clients' needs. Was there any further follow-up after the follow-up that was done by social workers in June 2000? Was there follow-up done again with these particular clients to see where they have ended up? Have they ended up in long-term-care facilities, a consequence of not receiving this, or did you go back and do that?

The Vice-Chair: This will have to be very short. We're running out of time.

Ms Nelson: There is a study that's underway. It should have been completed, actually, by the OCCAC, but we are looking for the report on that. It was to have

come out. I believe it was to have been ended in November; we were to have heard in December, but still not. So what that will show, I don't know. We weren't entirely confident in the terms of reference of that.

Mr Levac: I'll pass it over to Ms Wynne for a moment. I'm just going to make an observation.

Thank you, Ms Nelson, for your presentation and the work that your group and all social workers do in our province. Obviously, the work is not just confined to health care. It's education and long-term care and senior citizens and everything else. By way of why I'm concerned about that is that recently in my riding there were some concerns about elder abuse and stuff, and we're applying to receive permission to proceed with the social worker who will act as a complete advocate for our senior citizens, unconnected to the agency. So obviously I have a vested interest in ensuring that your words are heard. I will make sure that those words are passed on.

My final observation is one for this committee and for the people who are listening. Just as a caution, everybody wants to put words in everybody else's mouth. That's the bottom line. What's happening is that some people have a duty to say we're wrong; some people have a duty to say we're right. We're going to have a duty to say we're right and we're trying to accommodate things. The bottom line that I'm aware of is, as my committee work over the years has indicated, that this is the place where we probably get the best ideas and the best opportunities because it comes from the people who are providing the services. So take heed that your words are heard, your words will be dealt with, and people will continue to move forward, as we have tried to do in all our committee works. But we have to remove the cloud and smoke of people who are trying to tell us what our thoughts are and what are actions are.

My last comment is to the committee, although I'm leaving the committee; I was subbed in. I want to take a moment to thank the people in the background, obviously, as they continue to work. They've put this thing in place so that the public can come forward and present to us. So to the translators, to the audio people, the clerk's office and everybody else, thank you so much for the diligence that you put into this work. Thanks to the committee members for going around Ontario and hearing the voice of the public.

The Vice-Chair: Ms Wynne, about two minutes.

Ms Wynne: Just a couple of quick points, and thank you very much for your presentation.

I just wanted to reaffirm the issue around the hospitals where decisions have not been made, the six or seven hospitals that are being discussed at this point. There has been no decision made on exactly what the framework will be except that we're committed to public ownership, public accountability and public control. So whatever we're doing going forward, those are the principles that we're operating under. I just wanted to reaffirm that.

I don't know if you had a chance to see Minister Smitherman's remarks from the beginning of the hearings—I'll give you a copy of those—because we're acknowledging that there are a lot of changes that need to be made to this bill.

There are two things I wanted to say. First of all on the home care issue, which is of huge concern to all of us: The reason home care is mentioned at the beginning of this bill is that this is the future of medicare act. So what we're trying to do is put a framework in place that will deal with all the issues that we're going to have to deal with coming forward. We know there are changes that have to be made. They're not all being made in this bill.

My last point: I wanted to ask you, in terms of monitoring privatization, do you have any specific suggestions? You talked about privatization in a number of contexts in your presentation. Do you have a specific suggestion about how we might do that? This is a bill that is set up to put a framework of accountability in place. So if we were to monitor privatization, how would you think we would do that? You can think about it too, and you can let us know, but I think it's an interesting question.

The Vice-Chair: That might be the case here for the simple reason that we've run out of time.

Ms Wynne: OK. If you have any comments, I'd love to hear them.

The Vice-Chair: If you could get back to us.

Next we'll move on to Mr Klees.

Mr Klees: Thank you very much. I appreciate your presentation. The work of social workers around the province is certainly appreciated by all. I will be very interested to see how much substance there is to Mr Levac's comment about how effective the work of the committee is in actually incorporating the many good recommendations that came forward to this committee.

We have had numerous representations from well-meaning people, front-line people who effectively are saying that the best part of this bill is the preamble, which sets out all of those objectives that very few Ontarians are going to take exception to. However, everything past that seems to be smoke and mirrors, and worse than that, can be very detrimental to the delivery of health care services in this province. So the recommendation really has been to scrap anything after the preamble and get back to work putting a bill together that's based on the good recommendations that have come forward from people like you. That will be the real task of this committee. I ask you to stay tuned to see how much of your good advice ultimately will be incorporated into the work of this committee. Thank you again for joining us, and for the good work that you do.

Ms Nelson: Thank you. We certainly will be watching to see what the outcome is of the hearings.

The Vice-Chair: Thank you very much, Ms Nelson.

That brings us to the end of our deliberations here in Ottawa. I would like to thank the citizens, the stakeholders, those who work in health care, those who have made presentations here today. I would like to thank the committee for your focus and for your good work here, and also the staff who work so hard to bring this all together. It's very important.

We now stand adjourned to Windsor.

The committee adjourned at 1644.

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CONTENTS

Wednesday 18 February 2004