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Monday 23 February 2004

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Lundi 23 février 2004

Standing committee on justice and social policy

Comité permanent de la justice et des affaires sociales

Commitment to the Future of Medicare Act, 2003

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

Monday 23 February 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE ET DES AFFAIRES SOCIALES

Lundi 23 février 2004

The committee met at 1000 in room 151.

COMMITMENT TO THE FUTURE OF MEDICARE ACT, 2003

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

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

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr Kevin Daniel Flynn): Our first delegation this morning is from the Ontario Hospital Association. Joining us, as I understand, are Hilary Short, Tony Dagnone and Ruthe-Anne Conyngham. The rules are that you have 20 minutes. You can use that time any way you see fit. If there is any time remaining from your presentation within that 20 minutes, we'll either split that among the three parties or, if there are only two or three minutes left, we'll allow the one party to ask you a question. Other than that, the time is yours, and I've got 10:01. The floor is yours.

Mr Tony Dagnone: Good morning, Mr Chairman and committee members. It's our pleasure to be here to provide you with some very significant information and advice around Bill 8. My name is Tony Dagnone. I am here in my capacity as chair of the Ontario Hospital Association. That association represents 159 hospitals throughout our very proud province of Ontario. That membership employs over 200,000 valued health care professionals working in partnership with over 50,000 volunteers. That's a lot of people who have made a commitment to our hospitals.

Representing the 4,000 hospital trustees this morning is Ruthe-Anne Conyngham. She is the board chair of St Joe's health care in London and also a member of the OHA board. With me, as you indicated earlier, Mr Chairman, is Hilary Short, the president and CEO of the Ontario Hospital Association.

I begin by just making a general comment that hospitals are very vital community resources that touch the lives of millions of Ontarians. This year alone some five million citizens will call upon one of our hospitals for some type of care.

As MPPs in this province, you are aware that the hospitals in your home communities and across your large ridings are governed by dedicated voluntary boards. The members of these boards are community leaders, business people and others with a civic orientation to community service. Many of you will know them as your neighbours and friends. These people are entrusted with the oversight, fiscal stewardship, mission and strategic direction of their hospital with a single purpose in mind, and that is to create healthier communities. In part, these community leaders are a big part of the reason why today Ontario hospitals are viewed as leaders in both accountability and value for taxpayers' money.

Our hospitals have some of the most extensive patient satisfaction surveys and hospital performance reporting in North America. We take those particular results very seriously each year.

We are here today to tell you that we unequivocally support the government's goal in introducing the Commitment to the Future of Medicare Act. We do enjoy strong collaboration with our minister, with ministry officials and his advisers. Significant progress has been made, and we have narrowed the range of issues down to just a few.

We support and embrace key provisions of the bill, including the establishment of a new health quality council; embracing the five key principles under the Canada Health Act; adding that very important principle of accountability; and entering into accountability agreements for our hospitals. But unfortunately key parts of the bill, as originally drafted, run contrary to these principles because they fundamentally take away the very essence of local hospital boards and weaken accountability goals.

Several sections, as written today, permit the government to ignore hospital boards and make unilateral decisions directly affecting the management, the priorities

and ultimately the patient care delivered in each and every hospital in Ontario.

It is a given here that there is more to do in making our hospitals even more accountable than they are today. That is why we have been working collaboratively with the Ministry of Health and Long-Term Care on the development of new funding formulae for hospitals, as well as the development of workable performance agreements.

It is the OHA membership, led by voluntary community boards, that agreed to developing such agreements to guide the delivery of care in your respective communities across Ontario. For that reason, we believe strongly that all sections of Bill 8 must support community governance before the OHA membership can endorse the final bill. With that, I would ask Ruthe-Anne to continue.

Mrs Ruthe-Anne Conyngham: Good morning. Roy Romanow reported, "People are no longer prepared to simply sit on the sidelines and entrust the health care system to governments and providers. They want to be involved, engaged and acknowledged, and well informed as owners, funders and essential participants in the health care system."

It is through our volunteer boards that communities across Ontario have the ability to influence how local needs are met. We are the eyes, ears and hearts of our communities, positioned squarely at the centre of our cherished health care system.

As a board chair, I believe strongly in accountability. If a hospital does not live up to the necessary standard of accountability, then the minister already has powers under the Public Hospitals Act to take action. We are prepared to work even further on improving these measures and identifying other remedial approaches.

The central problem with Bill 8 is that it gives Queen's Park the power to impose absolutely anything it likes on an individual hospital. The government can ignore the expertise of the people who know the most about the hospital and the services it provides to the community.

I urge you not to underestimate what is at stake here. In this time of severe funding shortages, local volunteerism is the cornerstone of efforts that raise hundreds of millions of dollars each year to help sustain our hospital system. I am not talking about a system that allows people to be involved who are merely interested in being associated with their community hospital. Those days are gone forever. I am talking about a system that taps into the best and brightest talent in our communities right across this province. I am talking about a commitment that creates passion and allows Ontario hospitals to meet the standard of excellence already being achieved. I am talking about a commitment on the part of volunteer trustees that has been shaken to its foundation because of this bill. Hilary?

Ms Hilary Short: Since the introduction of Bill 8, I want to let you know that the OHA has been working very closely with Minister Smitherman and all his senior staff from the ministry as well as our hospital members on proposals for amendments.

We have made some significant strides, as you have heard, in refining the bill as outlined in the minister's February 19 draft framework for potential changes, but I am here to say that several fundamental issues still need to be resolved.

First of all, in section 20, we strongly recommend that the accountability provisions of Bill 8 be amended to ensure that the public interest is one of those being considered that will ensure greater government accountability. As the bill now stands, the government would be less accountable, in our view, for ensuring timely access to quality care in communities across Ontario.

Second, while we do support enhanced accountability as indicated in section 21, it is imperative that the government not impose the accountability agreements. They really need to be negotiated with the hospital boards. The ministry has agreed these agreements should be negotiated with the boards, but we think it is important that they not be imposed; that they be in fact negotiated.

Third, to keep from undermining the role of local hospital boards, as Ruthe-Anne has indicated, we believe strongly that sections 26 and 27 should be deleted in their present form. In that present form, it puts the CEO really and truly in conflict with the board. As you'll see in our more detailed presentation, the BC Auditor General clearly rejected this approach when it was introduced in British Columbia.

In conclusion, we want to assure you that we do support this bill. Ontario's hospitals support medicare. We support local voluntary governance. We very strongly support greater accountability. Bill 8 has the potential to be a powerful symbol of our province's commitment to public health care. That is why we will continue to work with you, the committee, the minister and his team to achieve the improvements we believe are absolutely critical to make it a success.

Thank you for the opportunity to present, and we're all ready to take any questions.

The Chair: That's wonderful. Thank you very much. You used up about nine minutes, so I'm going to propose we split the rest of the time, starting with the official opposition.

Mrs Elizabeth Witmer (Kitchener-Waterloo): Thank you very much, Mr Chair. Good morning. That was a great presentation. I know you have been working with ministry staff in order to ensure that this bill obviously does, at the end of the day, demonstrate the sincere commitment of this government to the future of medicare and also ensures there will be accountability but that that accountability goes both ways, that the government is also accountable to the people. I know there are some key changes that you're looking for. I know you have some very serious concerns, and I know the minister has already acknowledged that the tone of this bill was not right. There are going to have to be some very, very substantive amendments made in order to ensure that the accountability goes both ways and that obviously local boards continue to play a critical role in their hospitals.

My question to you is, what are the key amendments—and I know you've made reference to them here—could you expand upon the key amendments that you as the Ontario Hospital Association need to see before you can wholeheartedly support this bill as an instrument that is going to demonstrate the commitment to the future of medicare?

1010

Ms Short: I will focus on three issues. Number one, we are working very constructively in a collaborative way with our hospitals and the government to work on performance agreements. We think the performance agreements that we enter into need to be negotiated. This is a whole new approach to hospital funding, management and governance. We believe very strongly that those agreements need to be negotiated between the ministry and the hospital boards in a collaborative fashion.

Number two, we really believe that this issue of public interest needs to be up front and centre. Under the Public Hospitals Act at the present time, if you as a government have concerns about the care and management of a hospital, what is happening in a hospital, the provisions of the supervisor kick in. The government has the authority to send in a supervisor, an investigator or an inspector. That is a good power and it has been used, but that requires approval of cabinet. It can't be done arbitrarily. We're not suggesting this minister would do anything arbitrary, but we feel there needs to be protection so that under the Public Hospitals Act it's clear when you can use that power. Under Bill 8, as it's currently written, that is not required.

We've talked to the ministry about the fact that they see this as being used only in very exceptional circumstances, but we have not yet been able to define exactly what those exceptional circumstances are, so we believe that needs to be really carefully looked at.

Furthermore, if the government is able to reach in and deal with a CEO problem in exceptional circumstances, that really puts the CEO in a very blurred line of accountability, so that is the third piece that needs to be changed.

So, negotiated agreements, a public interest provision and our preference would be to see 26 and 27 removed entirely.

The Chair: Mrs Witmer, your time has expired, unfortunately. We'll go to Ms Martel.

Ms Shelley Martel (Nickel Belt): Thank you for being here this morning. Can I ask when you first saw a copy of this bill?

Ms Short: We saw it the day it was introduced.

Ms Martel: I think it would have made much more sense for the government to actually have consulted with you before they came forward with this because, to be quite blunt about it, the government hasn't been getting much of a good ride on this bill to date. Frankly, it's no wonder to me, because if you look in the accountability agreement section, for example, it says things like, "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." There are at least four other provisions between sections 19 and 32 that are the same.

On Thursday we got a copy of some of the proposed changes that the minister intends to make. I regret to say the government still isn't getting it right, despite all the negotiations that seem to have gone on. You talked about the word "preamble" needing to be in "Matters to be considered," section 20. I agree with you. Unfortunately, in the draft he gave us on Thursday the minister said the reference to public interest is only going to appear in the preamble. It says nothing about it being in section 20.

Two other points: It says very clearly in section 22 that the minister still has the sole ability to issue a compliance directive or an order. The word "negotiation" does not appear. Third, it's still very clear that the ministry can claw back compensation from a CEO, which would be totally contrary to the role of the board.

I regret to say that despite the consultations you say have gone on, what we saw on Thursday doesn't give me any sense whatsoever that the government has actually listened. In fact, the government still has the power, the minister himself, to issue a compliance directive or an order—it doesn't sound much like negotiation to me—and still is assuming the role of being an arbitrator in terms of compensation clawback from CEOs, which is clearly the role of the board.

What do you have to say about this, which we saw Thursday?

The Chair: You have about a minute to say it.

Mr Dagnone: Points well made. I think what we have to underscore here is that we have made very good progress. On those items that you have identified, more progress is wanted. That's what our members are all about. We want to do the right thing. There's too much at stake here. We need to embrace what the volunteer governance system is all about here because in other provinces, where there's an absence of volunteer governance, I can tell you that they've got even more challenges than Ontario does.

I guess the bottom line is that we will continue to work with the minister, his advisers, to make sure that we have the right solution here that will answer the public interest.

Ms Kathleen O. Wynne (Don Valley West): Thank you very much for your presentation and for the tone of the presentation. Although the final amendments aren't out, because we're not at that stage yet, I know you've been working very hard and we really appreciate that.

One of the things about bringing out a bill for hearings after first reading is that there are a lot of changes that are going to be made to it, and that was the point.

Having said that, I just wanted to check two things. The public interest issue: You've raised an issue of where you want it specifically in the bill. If it were to be in the preamble that public interest were to underpin everything that is done, would that work for you? Can you talk about

why that would be a problem, or whether it would be enough for you?

Ms Short: It would certainly help a lot, and the minister has indicated that that would be in the preamble. I guess we're just used to seeing—in the Public Hospitals Act, that's how it really is shaped. We just want to be really sure that there is no opportunity for any kind of arbitrary action by any government.

Ms Wynne: Yes.

Ms Short: That's the issue.

Ms Wynne: Fair enough. I think what we're trying to do is infuse the whole bill with that need for action in the public interest.

The second issue is on the negotiated and renegotiated accountability agreements, because it won't just happen once. I understand you're looking for the term "negotiation." Can you talk about what that framework of negotiation or discussion would look like? If we were to move toward giving the boards the sorts of standards and information about what the issues were going to be ahead of time, and there were some time for them to prepare to respond and then there were a discussion, is that the kind of thing you're looking for, or what exactly is it that you need?

Ms Short: I just say to you that before Bill 8 was introduced, we'd already made that commitment to work with the ministry on working on performance agreements. We have an extensive committee structure, if you like, of literally hundreds of people working jointly with hospitals, with the ministry, on trying to work out this new approach to how we could get to performance agreements. That work is continuing, and I would say we don't quite know yet what the shape of those agreements will be. This is all very new to Ontario.

I would like to stress, as we have talked with the ministry, that we leave that work to the processes already in place and that we'll learn from that collaborative work. So we don't know exactly what the agreements will look like. The point is, we think they should be negotiated, there should be a say, there should be a discussion between the local community and a clear understanding between the hospital and the government rather than their being imposed.

Ms Wynne: Right. I understand that. Did you want to add to that? No. We're done.

The Chair: You've got about 20 seconds. Can you do it in 20 seconds, Mr Dagnone?

Mr Dagnone: I'm just trying to further respond. We believe that the best agreements can be arrived at if there's a meeting of the minds in terms of exactly what it is that we're trying to achieve on behalf of our communities, have our trustees represented there, have the Ministry of Health represented there, and then have the people who will be charged with making these agreements happen. They ought to be part and parcel of that at the front end. If you've got that joint concurrence at the beginning, the chances of that succeeding are so much higher.

Ms Wynne: We need buy-in from them.

Mr Dagnone: Ownership.

The Chair: I'd like to thank you for appearing before us today. We certainly did appreciate your presentation.

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ONTARIO DENTAL ASSOCIATION

The Chair: I now call forward the Ontario Dental Association: Dr Blake Clemes, Frank Bevilacqua and Linda Samek. I'd like to thank you for attending today—same rules as before. If you could identify yourselves for Hansard when you start, that would be appreciated. You've got 20 minutes. You can use those 20 minutes any way you like. At the end of the presentation, if there is any time, it will be split among the three parties, unless there's a very short period of time. In that case, it'll be only one party.

Dr Blake Clemes: Good morning. Thank you for this opportunity to address the standing committee on justice and social policy regarding Bill 8, the Commitment to the Future of Medicare Act. I'm Dr Blake Clemes, president of the Ontario Dental Association. With me today are the ODA director of government relations, Frank Bevilacqua, and Linda Samek, the director of professional affairs.

The Ontario Dental Association, ODA, is a voluntary professional organization which represents over 6,000 dentists, more than 80% of the dentists of Ontario. The ODA supports its members, is dedicated to the provision of exemplary oral health care, and promotes the attainment of optimal health for the people of Ontario.

As a professional organization representing independent health practitioners, the ODA is committed to the delivery of quality care within an accountability framework outlined under the Regulated Health Professions Act, the Dentistry Act and related profession-specific regulations. The ODA believes in and promotes the delivery of patient-centred care based on the individual needs of the patients.

As we begin our remarks to the committee today, it is important to note that the ODA recognizes that Minister Smitherman has indicated that a series of amendments will be made to the bill in an effort "to get it right." Without the opportunity to consider all of these amendments fully, it's difficult for the ODA to understand if the proposals will improve upon the existing bill. We look forward to having more time to examine the amendments and providing a more detailed written submission to the committee.

I would be remiss if I didn't make a brief comment about the approach taken by the minister and the process for Bill 8. It is healthy to acknowledge that a piece of legislation may be flawed. Allowing an opportunity to make substantive revisions to a legislative proposal before it is accepted in principle serves the best interests of Ontarians. A process that allows ample opportunity to develop the best possible legislation is a goal for which we should all strive. The ODA thanks the minister for expressing his personal interest in addressing some of the concerns raised by the health sector.

Subsection 9(1) prohibits a physician or designated practitioner from charging more or accepting "payment for more than the amount payable under the plan for rendering an insured service to an insured person." The ODA stresses that some procedures provided by dentists are deemed to be insured services in certain instances, yet these same procedures provided to an insured person are not deemed to be covered services in other settings. Dentists seek confirmation that nothing in this proposal will interfere with the current practice of dentists to charge for these same procedures, irrespective of where they are performed, when the OHIP coverage criteria are not met.

The application of subsection 9(2) creates great concern for the ODA and individual dentists. It is unnecessary and inappropriate to force the dental practitioner or other designated practitioners to deal directly with the plan rather than with the patient. Even though many practitioners may choose to deal with the plan, this is an intrusive provision that should be removed.

Section 10 continues to allow the Ministry of Health and Long-Term Care to enter into an agreement with the Ontario Dental Association to negotiate about insured dental services and the amount payable to dentists under the plan. The ODA values the importance of such a mechanism.

It is the view of the ODA that the existing Health Care Accessibility Act did not achieve appropriate balance. To introduce greater fairness in the negotiating process, the ODA recommends that the ministry be obligated to negotiate with the named associations on a timely basis.

The need for timeliness reflects ODA's first-hand experience of having no change to the OHIP schedule of benefits for the services of dentists between 1987 and 2003. This is not because of real or perceived costs for dental services rendered under the plan. Quite simply, there was no commitment from the ministry to get to the table until just a few years ago. This is not an acceptable process, and that is why dentists seek these important changes to the bill.

On a related matter, subsection 10(3) permits the Lieutenant Governor in Council to "make a regulation providing that the minister may enter into an agreement ... with a specified person or organization other than an association mentioned in subsection (2)." The ODA recognizes that this section reflects the current provisions outlined in the Health Care Accessibility Act; however, the ODA continues to oppose the specific wording of this section. The ODA recommends that subsection 10(3) be revised to read, "The Lieutenant Governor in Council may make a regulation providing that the minister may enter into an agreement under subsection (1) with a specified person or organization other than an association mentioned in subsection (2), provided that there is consultation with and the agreement of the profession-specific association named under subsection (2) regarding the person or organization to be named under this subsection."

This proposal ensures fair and appropriate representation for the specific profession or a subcategory of the profession and protects against having a single individual arbitrarily named to enter into such negotiations who may not have either the consent of the association or represent the interests of the profession or the patients served under the plan.

Section 14 introduces broad disclosure provisions related not only to insured services, but also uninsured services provided to an insured person. Dentists are independent, self-regulated health professionals who provide a wide range of oral health services, and these services are primarily not insured by OHIP. The complexity of the care, the co-morbid medical status of the patient and/or the need for intubation and anaesthesia require some oral health procedures to be delivered within the publicly funded hospitals. However, many of these dental procedures are not covered by OHIP. The ODA believes that any services not covered by OHIP should not be reported to the general manager.

The ODA recognizes that related regulations may provide more clarity and detail regarding the application of this section. Nonetheless, this approach appears to abrogate the spirit of the new provincial privacy protections being considered in Bill 8. The reporting provisions under section 14 are excessive and take primacy over confidentiality, other regulations or acts and appear to apply directly to reporting about uninsured services. The ODA does not support the introduction of such sweeping powers and requirements. Given that the minister has indicated that Bill 8 provisions will not supersede the protections contained in Bill 31, this section should be clarified in Bill 8.

Section 15 sets out conflict-of-interest rules and requires prescribed persons to report their beliefs that a breach of the conflict requirements has occurred. Dentists, physicians and optometrists, the professions named in the legislation, are self-regulating professions, and this requirement to report a matter to the general manager interferes with the accountability process of self-regulating professions and the professional colleges charged with regulating the profession. Moreover, this section and others within the bill must be clarified to ensure that dentists, who provide a very limited number of OHIP-insured services under very restrictive circumstances, are not seen to be permitting patients to queue-jump when they charge for the same non-OHIP-insured services, regardless of setting. To place this into perspective, the vast majority of patients are cared for within the private practice setting; however, some patients need to have some oral health care provided within the hospital setting. A limited number of the procedures provided in hospital are OHIP-insured. It is important to ensure that the dentist who provides these same services in the private office setting is not deemed to be charging a fee to queue-jump.

Section 17 sets out penalty provisions. The ODA is pleased to learn that the minister will be addressing the excessive penalties set out in the bill. The ODA asks that the penalties be reduced, both for the individual and the corporation. According to existing provisions, regulated

health care professionals cannot incorporate with anyone other than a member of his or her own profession. Therefore, the corporation often is an individual practitioner, and the extraordinary penalty of $200,000 does not appear to consider this fact. The ODA recommends that the penalty provision for an individual and a health profession corporation be the same. Further, the ODA believes that the proposed penalties are excessive and must be reduced.

The ODA does not support the proposed provisions for retroactivity set out in section 18. How are individuals expected to comply with regulations that are not yet in draft form? This provision should be removed.

Despite the reference to accountability agreements in this part of the bill, the reality is that there are no provisions for agreements to be reached. Instead, the powers to compel a health resource provider, prescribed person, agency or entity to enter into an accountability agreement are invested entirely with the minister. Further, the ODA supports the minister's suggestion that the explicit reference to the minister's capacity to unilaterally vary or terminate an accountability agreement be removed from section 24. This change is required to ensure this legislative proposal envisions the introduction of an open and fair accountability process.

1030

The minister has indicated that section 19 will be amended to make it clear that individual dentists, or group practices, along with organizations like the ODA, are not subject to part III of Bill 8. The ODA supports such an amendment to Bill 8.

Section 28 underscores the problems with part III of the bill. Despite any agreement, the unilateral changes of the minister to the agreement are to be deemed to have been mutually agreed upon and, despite any provisions to the contrary, the recipient or party to the contract or agreement would not be entitled to any sort of payment or compensation. The philosophy of entering into agreements in good faith should serve as the foundation of any agreement with the minister. This proposal provides the minister with excessive, unrealistic and unreasonable powers.

Subsection 29(3) provides for public disclosure of personal information. If "personal information" includes personal health information that identifies and is linked to an individual, it's disturbing that the minister would be permitted to disclose such information publicly without the consent of the individual. Bill 31 must also take precedence in this regard.

The section 30 exemption from liability for the crown, the minister or others acting under this part further erodes the fundamental expectations of dealing with the ministry in good faith.

There are extensive regulation-making powers under section 32. These powers undermine the professional working relationship between the ministry and the health care community. The proposals threaten the process of arriving at agreements to provide publicly funded services. Bill 8 sends a strong message to all health care providers that the ministry does not trust or respect the remarkable commitment that is made to Ontarians by health care providers on a daily basis. The ODA encourages the minister to move ahead with changes that would legislate a mandatory 60-day consultation period on all regulations.

Section 15 raises concerns for dentists who work routinely with their medical colleagues in the delivery of care within a hospital setting. For instance, anaesthetic services are insured services in some instances when performed by a physician as an adjunct to a dental procedure performed in a hospital, but at other times, the anaesthetic procedure is not deemed to be insured. The ODA seeks to clarify that a physician providing the anaesthetic services would be able to obtain payment from a patient where the procedure is not deemed to be an OHIP benefit.

The ODA has similar concerns in subsection (3) of section 15. There are several instances where insured and non-insured services are provided to the same person during a single visit. It frequently is necessary for dentists to provide non-insured services within the hospital setting even though the adjunct anaesthetic procedure is insured under the plan. The ODA seeks clarity that this section will not interfere with the existing billing practices related to such circumstances.

The amendments to the Health Insurance Act under section 40 include permitting the minister to "make an order amending a schedule of fees referred to in subsection (2) in any manner the minister considers appropriate." Once again, the ODA questions why the minister would put a wedge between the ministry and health care providers. Bill 8 goes a long way toward demoralizing the health care sector and does nothing to foster a willingness to work with the government. For years, the dental community has substantially subsidized the delivery of publicly funded oral health services. Dentists have continued to provide medically necessary OHIP-insured services in-hospital despite having no increase in the OHIP schedule for almost two decades following 1987. Just as this profession considered that it was turning a corner and improving on the working relationship with and understanding of government with respect to these important payment issues, this bill was introduced. An amendment to address this major concern should be introduced.

In its original format, Bill 8 raises significant concern about the interest of the ministry to work with health care providers in good faith. The ODA believes that health care providers should receive fair compensation for the delivery of care without the fear of coverage rollbacks, clawbacks or elimination. The principle of fairness is missing completely from the tone and language of the bill. We trust that the amendments will address this and the other concerns raised by the ODA.

Thank you for this opportunity to address the committee, and we would entertain any questions that you might have.

The Chair: Thank you, Dr Clemes. You've left us with about six minutes. That's time for a brief question from each party, starting with Ms Martel.

Ms Martel: Thank you for being here this morning. I think the presentation was quite clear. The question I had, however, was on page 2, top of the page: "The application of section 9 creates great concern for the ODA and individual dentists." Could you just outline to me your specific concern there so I understand the example?

Dr Clemes: Do you want a specific example?

Ms Martel: That would be great.

Ms Linda Samek: I guess the issue is that there are a very small number of services that are considered to be insured. What happens here is that those same services provided in another setting are not deemed to be insured and it's the setting sometimes that makes this, because they have to be in the hospital setting to be insured. However, sometimes, even in the hospital setting, they may not be insured because they don't meet all of the criteria for coverage. It's really that difficulty that dentists have in trying to understand how this bill is going to capture those services. There are a number of services that are routinely done in the office, but because of the complexity of the presenting patient, they would have to go to the hospital setting for other times. It's just making sure that we're not caught up in—seeing those as somehow caught under this bill.

Ms Wynne: Thank you for your presentation and the explicit suggestions. I just wanted to follow up on that question because certainly it's not the intention of this legislation to undermine what's going on and what's working. I guess I have a general question: Do you agree with the concept that we need to put an accountability framework in place?

Dr Clemes: Certainly.

Ms Wynne: So you concur with that. OK. The way the bill is written, it's dealing with insured services—subsection 9(1)—right? So what would the language look like that would give you comfort there? Because, as I hear your explanation, nothing that's written here would change what you're billing for. So instead of saying all the things that we're not dealing with, we're talking about what we are dealing with, which is insured services, which includes where they're performed, right? So what's the language that you'd be looking for?

Mr Frank Bevilacqua: I think one of the major concerns we have around that is, as was outlined by Dr Clemes, the OHIP schedule of benefits contains the exact same services that are, in that situation, deemed insured, but in other settings the exact same service may not be an insured service.

Ms Wynne: But then it's an uninsured service, right?

Mr Bevilacqua: But when we read the legislation, that doesn't come across clearly.

Dr Clemes: I just want it to be clear that that will be the case.

Mr Bevilacqua: If you could clarify that, we would certainly feel much better about it.

Mrs Witmer: Thank you very much to the ODA for your presentation. You mentioned here on the first page that, without the opportunity to consider the amendments, it would be very difficult for you to understand if the proposals are going to improve upon the existing bill. I guess we've heard a tremendous amount of concern about the drafting of this bill and even the tone of the bill, which the minister has acknowledged they didn't get right. My question to you then, because there's going to be a complete overhaul of the bill—amendments obviously; parts taken out—do you think additional hearings should be required after the amendments have been made to the bill?

Dr Clemes: We would welcome the opportunity to have the hearing in addition to being able to provide a written submission later on. Certainly, we would always welcome an opportunity to comment face-to-face with the committee.

The Chair: Thank you for appearing today. We do appreciate it.

Dr Clemes: Thank you. We appreciated the opportunity.

1040

COALITION OF FAMILY PHYSICIANS OF ONTARIO

The Chair: If I could call forward the 10:40 delegation, which is the Coalition of Family Physicians of Ontario, represented by Dr Douglas Mark and Dr John Tracey. Please come forward and make yourselves comfortable. Same rules as every other group we had before us today: You have 20 minutes to use any way you see fit. At the end of the presentation we will try to split up the remaining time equally amongst the three parties. If it is only a short period of time, I may assign that time to one party. The floor is yours.

Dr Douglas Mark: Good morning. My name is Dr Douglas Mark, and it is my privilege to serve as the president of the Coalition of Family Physicians of Ontario. Dr John Tracey and I are grateful to have this opportunity to share our concerns about Bill 8 with you.

The Coalition of Family Physicians is a voluntary, member-driven, grassroots organization, representing over 3,600 family physicians, that continues to grow. It is dedicated to protecting the rights and independence of family physicians across the province. We advocate, on behalf of our patients and members, solutions to improve our health care system and health care delivery to the people of Ontario. To present to you our main concerns, I wish to introduce to you the chair of the coalition's political action committee, Dr John Tracey.

Dr John Tracey: Mr Chairman, ladies and gentlemen, thank you for allowing the Coalition of Family Physicians to present our thoughts and concerns about Bill 8 to you today. My name is John Tracey. I'm a family physician in Brampton and chair of the political action committee of the Coalition of Family Physicians.

Bill 8 is a complex body of work that has widespread ramifications for our members and our health care system. We understand why the minister wants to introduce this bill, but in the process, let me explain as a prac-

titioner why this may buckle the system you are trying to protect.

The minister, in his earlier remarks, has identified key components to this bill.

Part I deals with the Ontario Quality Health Council. I wish to draw the attention of the committee to sections 4 and 6.

Some of the many functions of the health council are, under subsection 4(a), "to monitor and report to the people of Ontario on ... consumer and population health status, and ... health system outcomes."

In order to do this, there are prescribed regulations in section 6, of which I draw your attention to:

"6(1) The Lieutenant Governor in Council may make regulations....

"(h) governing the transfer of information from persons provided for in the regulations of information, including personal information....

"(i) governing the confidentiality and security of information including personal information," again.

The committee is aware that there is currently a proposal to introduce health information privacy legislation, Bill 31, in this province. In the embodiment of this legislation under part IV, section 45 there is a provision that, on the request of the minister, a health information custodian shall disclose health personal information to an approved health data institute.

Notwithstanding these requirements, there is also a process of primary health care reform occurring in Ontario at this time.

It concerns us greatly to report that patients, when enrolling into family health networks and family health groups, are likely giving consent for the release of their personal health information directly to the ministry when they sign the enrolment forms.

There is concern shared by many patients that this legislation can bind a physician to releasing personal patient health information to the ministry; patients may have given consent for such release when signing an enrolment form for FHGs (family health groups) and FHNs (family health networks); and, by order of the Lieutenant Governor in Council, the quality health council may have access to this information.

Bill 31 attempts to protect the release of the information to a health science data institute for monitoring the health care system. However, there is a provision for the release of personal health information in this bill to ostensibly perform the same monitoring function through the health council.

Together there is the potential for confusion, and since there are severe penalties for wrongful release of personal health information, we are asking this committee for clarification.

Part II around accessibility: We have serious concerns here with how the bill addresses accessibility to health care services. The bill, as it stands, conveys what we can only describe as extraordinary powers to the minister and to the manager of the Ontario health insurance plan.

Section 9 imposes the OHIP schedule of benefits upon all doctors as a sort of unilateral employment contract without any explanation or provision as to how this document is to be negotiated and agreed upon. Subsections 9(1) and (2) state that physicians shall not charge more or accept payment for more than that provided by OHIP for a particular service.

We wish to point out that in Ontario today the plan provides a fee of approximately $24 for providing care to a patient for 24 hours—that's $1 per hour—whilst that patient is in hospital. There are hundreds of thousands of orphan patients in this province who do not have comprehensive family care physicians and require hospitals to contract with physician hospitalists and subsidize the fees received from OHIP for hospital care. This bill has the potential to make these and similar subsidized payments illegal.

Section 9 removes a doctor's right to bill his or her patient directly for services provided. This effectively could conscript doctors to assume the role of employees, possibly changing their status under Revenue Canada, to be compensated as the ministry sees fit, since the government sets the schedule of payments independent of any proper bargaining process.

Section 10 imposes a bargaining agent selected by the minister and permits the minister to select other bargaining agents as the minister decides. There is no acknowledgement of physician rights to select their own representative agent.

We are concerned and object to the provision in this act that recognizes and entrenches in law that the sole representative body for the physicians of Ontario be chosen to be the Ontario Medical Association.

If there are later amendments to this act that provide for the removal of the necessity for individual practitioners to sign accountability contracts and require only that corporations sign these contracts, then there is considerable concern among our membership that the minister might include in the next master agreement a provision that a representative body sign a joint accountability contract on behalf of the profession as a whole.

I would point out that the Coalition of Family Physicians recently held a referendum of our membership which asked if they believed that physicians should be given the right to choose their bargaining agent. The results show that 92% of the 1,545 respondents clearly indicated that physicians should be offered a choice as to whom they wish to represent them. This is, after all, a right of every other individual in this country. Why would this act seek to impose a representative body of the minister's choice on physicians?

Having acknowledged a representative body that would enter into negotiations on behalf of physicians and having removed the rights of physicians to bill for their services, it is essential that this committee enforce the provisions of the Canada Health Act, section 12, which provide for a legal framework for negotiations and a dispute resolution mechanism that includes binding arbitration.

Section 11 sets aside the provisions of the statutory powers act and permits the manager of OHIP to make

arbitrary judgments about whether someone has made an unauthorized payment for a service. Should the manager arbitrarily decide that the service payment was unauthorized, then it empowers the manager to declare the doctor as indebted to the plan and to recoup these payments through a garnishment process from other bone fide accounts payable to the physician.

Last year physicians were regarded as heroes as, with other health care professionals, they risked their lives daily to battle SARS. This bill now seeks to criminalize our profession, not just with severe fines, but with up to 12 months' imprisonment if we are found guilty of charging a fee that is judged by the general manager of OHIP to be an inappropriate fee. Removal of jail sentences for billing misdemeanours would be viewed as a necessary priority amendment.

Section 12 limits any form of a proper review of the arbitrary decisions and actions set out in section 11. This is contrary, in our view, to the principles of natural justice.

Section 16 imposes restrictions upon or limits the charging of fees for services that are not even designated as medically necessary and thus not even part of the OHIP mandate; this, despite jurisprudence otherwise on the matter. This would include the bundling of fees for uninsured services and offering patients the opportunity to pay a one-time annual fee, otherwise known as block billing.

Section 17 imposes the penalties on individuals that contravene a provision of this part of the act. These penalties include $50,000 fines and/or 12 months' imprisonment. Imprisonment is absolutely unacceptable to the medical profession and needs to be struck from this bill.

This bill sets out to remove the rights of certain individuals to set their fees for their intellectual property, make the minister the sole payer and, in order to be paid, demand that the individual independent service provider sign an accountability contract.

On the matter of part III, accountability, section 21 allows the minister to compel physicians, who at this time are independent contractors, to enter into an accountability agreement with the minister or other agencies as so directed. This of course begs the question of choice to enter these so-called agreements and whether these agreements are a matter of law when in fact the terms of the agreement are imposed and not negotiated.

As you may appreciate, doctors are already accountable to our patients in at least three different ways:

We are subject to strict regulation of our practices and wide-ranging scrutiny and discipline by the College of Physicians and Surgeons of Ontario. The complaints and disciplinary process grants the patient the right to present their concerns to the college at no cost to him or her.

We are subject to an extensive array of civil law penalties in the courts, akin to any other contractor.

We are subject to the discipline of the marketplace, though we do admit that the opportunities for market discipline are rapidly diminishing for our patients as doctor shortages worsen around the world.

Thus we already have three levels of accountability to our patients. This bill does not enhance a doctor's accountability to his or her patients. It attempts to make doctors accountable to another layer of bureaucracy.

Section 22 allows the minister to compel a physician to comply with a prescribed compliance measure. We have absolutely no idea what these compliance measures may be but we are concerned with the tone and intent of this section.

1050

Section 26 states that if a physician fails to enter into an accountability agreement, fails to comply with any terms of the agreement or fails to comply with all or part of the compliance directive, then the minister may impose the following corrective measures: a fine of not more than $100,000; reduction, variation or discontinuation of funding; or variation of any term of any agreement or contract between the crown and the physician. These provisions have the potential to bankrupt physicians, as they have long-term lease commitments and staff contracts to meet. It is essential that these impositions be removed from the bill, as no one could possibly enter into terms of employment under these conditions.

These measures within the bill will further erode access to care for the people of Ontario. Imposition of this bill and all that it implies at this time, we are sure, will add to the pressure for physicians to seek other jurisdictions in which to practise their craft. This legislation expects physicians, who are regarded as legally independent contractors, to sign accountability contracts so that they can receive payment for their services from OHIP. How many bright young people about to begin their careers in medicine will remain in Ontario if they must sign these accountability contracts in order to be paid?

We have not made specific amendments to particular sections of this, simply because we believe that the entire bill, as it is currently constituted, is flawed and requires a complete revision. Dr Mark?

Dr Mark: One million Ontarians cannot find a family doctor. They are rightly concerned that the situation will grow worse, as 25% of family doctors are expected to retire. Ontario physicians' fees rank seventh in Canada. The numbers of trained family doctors coming out of medical school residency programs are diminishing rapidly. There is a critical shortage of doctors across the developed world. Well-trained family doctors have skills that are in great demand throughout the world. Physicians will leave Ontario or move to live and work in more hospitable environments or find other employment avenues should present trends continue unabated and unchanged.

Recruiting new graduates in a legislative environment that suspends their civil rights and liberties will indeed become a difficult travail. Indeed, the credibility of the government's commitment to the future of medicare depends upon fairness and respect. The physicians of Ontario deserve the same rights as their fellow citizens. Physicians must have the right to choose their own bargaining agent and framework for bargaining in a meaningful way with the province.

The Minister has indicated his intention to make all health system players accountable, particularly to patients. This bill is supposed to empower consumers by entrenching accountability. But accountability, in our book, is a mutual responsibility. With respect, we see little accountability by government to its doctors and, by extension, to their patients.

In our view, having scrutinized this bill in its entirety, we see little evidence of any accountability by central health ministry planners to patients. In fact, where the burgeoning health administration is concerned, accountability appears to be unidirectional, radiating out to physicians. We think that this is a serious oversight.

If this bill goes through without very significant and fundamental amendments, there will be a serious negative impact for patient accessibility to care in this province because doctors simply will choose to not practise where they do not enjoy the same rights as other citizens.

Thank you for this opportunity to present today. We would appreciate a further opportunity to present again if this is possible, after ministerial amendments are available. We would be pleased to serve on any committee that is so constituted in order to give meaningful input.

The Chair: Thank you, doctors. We've got about six minutes left, so let's start with Ms Wynne.

Ms Wynne: Thank you very much for your presentation, and thank you for your willingness to keep talking to us about these issues. I just wanted to raise a couple of points. On the issue about the transfer of information, the way the legislation is written and will be amended, the intent is not that there will be any conflict with Bill 31. I just wanted to reassure you of that. As far as the incarceration provisions go, they will be gone. I think if you look at the comments made by the minister on the first day of the hearings, he talked about the tone and that some of the provisions, some of the remedies, were harsh, and we've acknowledged that. So that will be changed.

On the larger issue of accountability, you haven't made specific suggestions about what an accountability framework might look like. This bill is designed not to deal with sole practitioners, but with organizations, institutions. Can you talk a little bit more specifically about what you think an accountability framework could look like or some of the key features of that?

Dr Tracey: I'm not qualified to do that, to be honest with you.

Ms Wynne: OK. Do you agree with the concept that there should be an accountability framework in place?

Dr Tracey: You tell me, and you define what you mean by accountability and then perhaps I could relate to your question—a little bit more than just the word "accountability."

Ms Wynne: OK. I don't know how much time we've got, but I think there's a general feeling that there's a lot of money that goes into the health care system, and I think what we're looking for is a way to track what's happening. If the government has—and we do—some general directions where we'd like to go, we can articulate those in specific standards or specific directions with institutions and then talk about whether we can move in that direction and how we can do that and then hold the institutions accountable for doing that.

Mrs Witmer: Thank you very much, Dr Mark and Dr Tracey. I think this is an excellent presentation. I see that you have reached a conclusion that I would have to say I have reached as well. I do believe that the bill, as presently constituted, is fatally flawed—"fatally" is my word; "flawed" is your word—and I do believe it requires a complete revision.

I hear the government say they're going to introduce amendments, but I guess I wonder why it was necessary to introduce such an inflammatory piece of legislation with such harsh penalties and accountability only going one way. I guess my question to you would be, would it be your preference that amendments be made to this bill—and it looks to me that practically every section is going to have to be amended—or that there be a complete revision or rewrite of the bill, based on what we've been hearing?

Dr Tracey: I would be in favour of the latter, a complete rewrite, and I would also be in favour of asking for our organization to be a part of the committee or indeed have some input from the grassroots level. It seems to me that accountability for the health care system may be very virtuous, but the fact is, I ask, why do I have to lose my rights to allow this accountability process to go through? I would like the opportunity to talk more about that, and this is not the format today.

Dr Mark: I would echo those same remarks, and I'd also like to see that the legislation be worded so that it will empower us, and not restrict us, to do our jobs.

Mrs Witmer: I guess what else concerns me is I've had a flood of letters, and I'm sure others have as well—concerns from doctors. They see this as not improving accessibility. For many of them, they're once again considering moving out of this province, especially young doctors. As you've pointed out, we have many, many people in this province without a doctor, and I'll tell you, this is not a carrot to entice people to stay. That concerns me.

Dr Mark: We would agree.

Ms Martel: Thank you for being here this morning. The minister gave us some information on Thursday when we were in Windsor to indicate that solo physicians, group practices and trade unions are not going to be required to enter into accountability agreements and therefore they won't be subject to any of the provisions of Bill 3.

One of the more onerous provisions that you didn't reference that I actually thought you would under that section, had you been included, was section 29. Just to give people a flavour of where the government is heading, it's probably worth reading into the record. This is with respect to section 29, "Information":

"For the purposes of carrying out the provisions of this part"—this is accountability agreements—"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 meaning of the Remedies for Organized Crime and Other Unlawful Activities Act, 2001, in such form and at such times as the minister may require" etc.

So when you talk about being concerned about some of the provisions, that one was pointed out to us by another physician in another community as being extraordinarily over the top. I think the government missed the boat by not consulting with anyone before they brought this forward. I said last week, and I'll say it again: I don't think you can fix this particular bill. I think you have to withdraw it and start again.

Let me just focus on the section around the health council, because it's interesting to me to note that the council will do a number of things, but the council will not deal with wait times. In the same regard, the minister, in getting a report from council, doesn't have to do anything about wait times either. Given what you deal with on a daily basis, what's going to happen in a bill that purports to support medicare and actually does nothing, and forces the minister to do nothing, about wait times for health care services?

1100

Dr Mark: I truly believe it will make wait times worse if we bring out this bill, and will cause fewer physicians to want to work in this province.

Ms Martel: We are hoping that now that physicians know they are not included—of course, we're all waiting to see the amendments—some of that concern may be relieved. If I look with respect to the council, though, they are given some responsibility, but their responsibility certainly doesn't extend to making recommendations to the minister about how to fix some of what is lacking in the health care system. Do you see a point to having another council do another report that doesn't force the minister to do anything?

Dr Mark: I think our group would agree to that. A lot of the things that are a problem in this bill seem to be things that were tried to be passed earlier in Bill 26, so if we can look back at that time and realize that there were flaws from that bill in some of the things that are introduced here, that would help future amendments to the bill. We'd be happy to review those amendments and would be happy to work within a committee to help do that as well.

The Chair: Thank you, Dr Mark and Dr Tracey, for coming today. We did appreciate it.

CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO DIVISION

The Chair: Our next delegation is from the Canadian Mental Health Association, Ontario division. Patti Bregman is the director of government relations.

Ms Patti Bregman: A delegation of one.

The Chair: Make yourself comfortable. Being one person, you have all of the 20 minutes to use any way you like.

Ms Bregman: I think, as usual, I'm going to try to keep it relatively brief and allow time for questions. I'm definitely not going to read my submission through, so we can have a little bit more of a discussion, because I think, as usual, mental health is a little different and we have some different concerns. We have some of the same. Maybe we have some things that we can help you think through.

In our submissions, we really focus on two main things. One is the whole issue of access to care, mental health actually being part of the health care system, which is a huge, ongoing problem. The second is the issue of accountability, and if I don't touch on that as much or as long, I don't want it taken that it's not as important to us. We have a lot of concerns in that section. I think you've heard a lot of those concerns, and I'd rather focus right now on some of the more unique issues that we're bringing to the table.

Just so you know a little bit about how we work, and this is where we may be able to help you a little, CMHA is actually a tri-level organization. We have 33 branches in Ontario that provide more than $50 million worth of direct services, we have our provincial office, which has a mandate of knowledge transfer, and we have a national office. We are all individually incorporated, and so we actually do not have control over the 33 branches. So we have experienced some of the issues you have experienced in terms of how you do that, and I'm going to talk a little bit at the end about some of the solutions we've come up with.

I want to start with the whole issue of access to medicare, because I think this bill, which we support in principle, particularly the first section, gives us a really unique opportunity to speak about mental health in a much more meaningful way. You'll see that as I go through the first section, I talk about a case that the Supreme Court of Canada ruled on called Eldridge, which I know the former Minister of Health is quite aware of because it dealt with sign-language interpreters in the health care system. What's unique about that case, though, is that it was the first time the Supreme Court had said categorically that health care is a public good, it's something that everybody has access to, everybody is entitled to, and that there are obligations in providing that good. What was quite unique in that case is that ordinarily the charter does not apply to things like hospitals. The Supreme Court in this case said you that can't contract out that fundamental public right to health care, so in some cases hospitals may in fact be subject to the Canada Health Act.

We see in mental health a parallel. Right now, if you look at the mental health system, I've referred in here to the fact that the Canada Health Act really does not speak specifically to mental health, and we are making recommendations about some amendments you can bring forward.

There's also a provision in the Canada Health Act that says that if you are in a psychiatric facility, it is not in fact considered a hospital for the purposes of the Canada Health Act. We had a situation in Ontario recently where a young girl from Alberta needed hospitalization. She was in one of the provincial psychiatric facilities, and the Alberta government said, "Sorry. We're not paying, because it's not under the Canada Health Act." They forced this young girl to go back to Alberta without the care she needed until she got there. We think that's a very serious problem, and we really urge this government to take this opportunity to speak to mental health as being an integral part of the health care system. Prevention and the promotion of mental health need to be explicitly recognized in this bill. I think you could lead the way in Canada and really make a difference in terms of giving people access to mental health services. So I urge you to look at the specific recommendations that we've made along those lines. I can't say strongly enough that I think if we don't start doing that, the problem that Romanow identified of mental health being the orphan child of health care will continue.

Part of the reason our presentation is so different is that many of the services people use are private. It's the most privatized sector of the health care system right now. You have CMHA branches that provide services to the seriously mentally ill, which is what the government funds. If you don't have a serious mental illness and you can't get to a family doctor or a psychiatrist, you are in the private system. You are paying, on a fee-for-service basis, for a psychologist or a social worker. For an awful lot of people, that's not affordable. One of the trends we're seeing is that employers are starting to see a huge increase in costs around mental health, and we're very concerned that even the limited insurance that's there in the private system will start to cut back.

I want to move on to two very specific aspects of the Canada Health Act. One is the catastrophic drug coverage. You obviously will know we would strongly support making sure that's in the legislation. We are a little concerned that it not be solely income-tested. There are a number of drugs for mental health problems that are very, very expensive, and we need to make sure those drugs remain accessible. We're hearing more and more that it's a barrier to employment. Employers are not picking up people for employment because they don't want to pick up the drug costs. So we may have a situation where we have the working poor who will not be covered by this legislation. We'd urge you to look at amendments that will make it very clear that it's going to be based on need but that you really have a little bit broader scope.

The second area is home care. I think right now people are probably not aware that there are a number of community care access centres in this province that will not provide home care to people whose primary diagnosis is mental illness. We think that's discrimination, we think it's a very serious problem, and we think that what it's doing is increasing the hospitalization in this province. There's a very high rate of hospitalization for mental illness. We know from research that if you can deal with people in the community, they stay at home—we actually did a little study last week on three people in the Elgin area before and after a crisis-bed program. Before the crisis-bed program, three people, 145 days in the hospital; after the program, in two years, 14 days in the hospital. That's a saving, for three people, of $67,000. That program is probably going to shut down because there is no money. So we have a very serious problem and we need to make sure we are addressing this.

I want to move now very quickly to the accountability piece of the legislation, which everybody has talked about. We absolutely support accountability. I think it's absolutely essential. We're one of the few sectors that have no regulatory framework. We have no formal accreditation process, although we are trying very hard to get one in place, and yet we've seen this as so important that within the agreements that we sign within our own organization, we require accountability on things like making sure we have patients' rights, making sure we have financial accountability. It's absolutely essential. We've been working with the ministry on an accountability framework for mental health and we certainly want to continue working with them.

We have a couple of concerns. One is what I think you've heard from everybody else. I guess the way we would articulate it is, what's the problem you're trying to solve? It's not clear from this legislation exactly what the accountability problem is, and I think you'd be well served to try to define it a little bit more. People will be able to deal with it more if we know what it is we are to be accountable for, what the criteria are. Have it really spelled out so that there's not all of this uncertainty and that people can comply. I think what you want is a system that starts on a voluntary basis and really only goes to this extraordinary breach.

1110

In our agreements, what we've done, and what you may want to think about, is that we've got the requirements, we've set them out very clearly; we've negotiated these agreements. At the end of each year every board has to sign an agreement—as do we; these are mutual agreements, and I'll get to that in a minute—that they have complied with every piece of this agreement. Therefore, they are then legally bound. What we did, for the very rare occasion when there's a problem, was put in a provision about extraordinary breach. We've put in a process, people know what the process is, and it's a graduated process. If you have a problem, you start maybe with peer review so that people have an opportunity to fix the problem before you have to use heavy measures. I think that's missing from this legislation. Even in dealing with boards, if you can get something that starts from the premise that people want to do the right thing, sets it out, and then allows them to address it, then if at the end of the day they really don't address it, you may have to take some extraordinary steps.

We certainly do not support the CEO and the accountability agreement. It's an absolute nightmare for volunteer boards to not be clear as to whom the CEO is accountable for. In our sector a huge problem is, because we have so many programs that are not ministry-funded but within an agency that is ministry-funded, what do you do when, for example, you've got United Way funding and you've got Ministry of Health funding? Under this thing, is the ministry going to come in and be responsible for all of the organization's accountability, for making sure that the CEO is accountable for the United Way funding? It's not clear, and I think you're walking into a morass that you don't really want to get into. I certainly encourage you to look at that, and we're quite happy to work with the ministry on that.

Just to close and highlight our concerns around the health quality council, and it ties a bit to accountability: When we talk about the quality councils and we talk about waiting lists, you'll never hear anybody talk about mental health waiting lists. If I went to you and you had a constituent walk in and say, "I have a fatal disease and there is a 14-month waiting list," the public would be outraged. Well, in some parts of this province there are waiting lists, for people who have serious mental illness, who are suicidal, from two to five years. In at least one of the cities, in Ottawa, half the people on that waiting list have attempted suicide. This is a really serious problem, so we've made some recommendations in here about the health quality council being able to make recommendations about data collection. There is no data collection about mental health, there is no data collection about waiting lists, so I think we need to do that.

My final point goes back to the mutual obligations. We're very happy to be accountable. We think that we need to make sure the ministry is also equally accountable back. We're dealing with the situation right now, and I think it will illustrate some of the very concrete practical problems. As you all know, I'm sure, by now, we've had no funding increases in 12 years. We are accountable. This is a sector that does not run deficits. But what happens is that they're then forced to cut people off programs. That's also accountable. So you need to make sure it's not only money, but make sure the services are where they're needed and that the ministry is funding them. The second thing is that we are now being told to do another data collection system, which we're very happy to do. Do you know what? There's no money. We have services in this province, and it's not just CMHA, but other community mental health organizations, that don't have computer systems.

If you're going to impose an accountability mechanism, the ministry's obligation has to be quite clear that they also have an obligation to provide the resources that enable the organizations to meet those obligations. Otherwise, it will continue to be this one-sided type of obligation. I think what you're aiming at, and what would be very healthy, is mutual accountability and, ultimately, accountability to the public.

I'm happy to take questions.

The Chair: That's wonderful. Thank you very much. You've used up 12 minutes. So let's go with three minutes for each party, starting with Mrs Witmer.

Mrs Witmer: Thank you very much for your very comprehensive presentation, Patti. You do an outstanding job and you're a wonderful advocate for people who have need of mental health services. You've certainly pointed out here extremely well the impact that it could have on those people who rely on the government for services. My question to you would be, what are the key amendments that you will need to see before you could give your wholehearted approval to this bill?

Ms Bregman: I'm going to give you half an answer because, as you see, this is a draft and we are continuing to work on some of the other provisions; for example, public interest. But I think there really are the two core key areas. One is on making sure that medicare includes mental health. We have to see something in there, and I think it's in everybody's interests to do that. The other is to really deal with this accountability agreement and framework and to (1) take the CEO out of that picture, and (2) to see some amendments that help us understand what its purpose is, what the criteria are and what the process will be for getting things resolved so that it's a mutually acceptable and agreeable process.

Mrs Witmer: So you see that totally lacking?

Ms Bregman: Right now it's just not clear. They talk about the accountability agreement, but there's no process for appealing it. It's just very vague right now and I think it would be really well served by making it much more clear: Is it financial accountability? Is it that you have patients' rights in place?

Also, as I said before, having a process that allows you—if there is a problem, there's nothing in this act that gives the minister any authority to go to somebody and say, "Let's try and fix the problem. Would it help if we brought an expert in to help you?" I think it's just better for everybody and it would address some of the tone issues to say, "We will recognize a problem, but we're going to work with you." The goal is to make it all work, not to be confrontational. I think that was the intention, but I don't think it's reflected in the language. So it's very important to make sure that there's real clarity on that.

Mrs Witmer: OK, and I think others have referred to the fact that it is confrontational; it is heavy-handed. As I said before, the minister has acknowledged that the tone is wrong. Do you see a connection between the preamble and the actual content of the bill? Again, we've certainly heard that there's a real disconnect there.

Ms Bregman: We raised that in part, and I do think we need to make the preamble more clear. I'm also a lawyer and I have spent enough time in courts to know that there are arguments about what preambles do. So I do have some concerns about putting too much weight in a preamble, unless you say the preamble actually counts, because often it gets to court and the court says, "It's a nice interpretive tool, but it doesn't necessarily apply." So I do think there needs to be more clarity. Again, we

need to be able to reference back and say, "Here are the principles set out. How does every section relate to that preamble?" We didn't go through all of that, but I think it's very important to do that link.

Ms Martel: Thanks, Patti, for being here. Let me follow up on that. You could go through, but you wouldn't find a link, because it isn't there. That's the problem with the bill, and I'm quite candid about this. I've said on a couple of occasions that the best part of the bill is the preamble, and you might as well throw out the rest and start again, because there is no connect between the preamble and what you want for medicare, ie, getting rid of private services, including mental health and medicare etc.

To give you a very clear idea, we could come in and change the preamble so that it would specifically reference mental health in terms of medicare. But if nothing is done for the 12-year freeze on community-based organizations, tell me how this bill is going to make things better for you or your clients.

Ms Bregman: It doesn't, and that's why we raised this and said it needs to go much further. That's why I put Eldridge in, because I do think that the government needs to begin to acknowledge that this is more than something that's nice to do. This is something that I think we've now had direction from the Supreme Court of Canada on as well, that mental health can no longer be that second-class system.

What's interesting to me—you talk about the disconnect—is that we in fact had a very good meeting last week with the policy people at health about primary care and mental health. So we're having those conversations and getting it in there, but I agree with you: We need to see that reflected here so that we are sure that when people talk about primary health care, when they talk about other services, mental health is in there and it's real and it's enforceable, that people can know that it's not just the whim of any government but that they have some rights in there that other people would have.

Ms Martel: I'm not trying to catch you, but can you give us a clearer idea? I'm not interested in, and I won't support, a bill that has a glowing preamble and then nothing to support it. If you were looking at the sector that you very capably represent, what would you have to see in the body of the bill that might actually give some life to the preamble?

Ms Bregman: It's not that I don't want to answer, because I think it's a really good question, but that is something I've actually been trying to work on so that we can come up with some more amendments. So rather than try and do something quickly, we will be coming back with further submissions, and I will certainly make a note to see if we can address that when we come back.

Ms Martel: That would be helpful. I'd appreciate that.

Ms Wynne: I just want to make a couple of points, and then I think one of my colleagues, Mr Duguid, has a question.

I take your point about mental health, and specifically as it relates to catastrophic drugs and the home care issues.

I just want to point out that the reason those are included in the preamble is that this bill is to set a framework in place for the future. So it's an acknowledgement that home care and catastrophic drugs and the issues that you identified in those two particular areas are part, I think, of another conversation. Does that make sense to you?

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Ms Bregman: Actually, no, and I'll tell you the reason why. It's because what has happened with mental health is that we are always "the next conversation." The problem is that if you don't put it into this bill—and this bill is touted as the commitment to medicare. I think we have to actually see something in this bill. I understand what you're saying, but we don't need the details on catastrophic care. I think we absolutely have to have a very clear statement in here that mental health is part of all of this. The Canada Health Act absolutely needs to be included; if the Canada Health Act isn't, this government does not see a distinction between mental health and health care.

Ms Wynne: But what I was trying to get at was that you made some very specific suggestions about needs tests and so on. I don't see where that would fit in this bill. That's what I meant. That level of specificity it seems to me is part of another conversation, because what we're trying to do is put an accountability framework in place.

The second point I wanted to make was that the way the bill is written, the accountability agreement would be between the minister and the board, right? Then a performance agreement that the CEO would have to live up to is between the CEO and the board.

Ms Bregman: As long as those other pieces are taken out. We haven't seen the amendments, and I think that's the concern.

Ms Wynne: If it's clear that that's the line.

Ms Bregman: If it's clear that that's the line that they can't jump over.

Ms Wynne: OK. I'm going to let my colleague ask—

The Chair: You have just over a minute, Mr Duguid.

Mr Brad Duguid (Scarborough Centre): I probably can't do what I want to do within a minute, but I'll do my best.

You talked about what problem we were trying to solve in terms of accountability. I think one of the problems we have with the current system is trying to negotiate and move the shift over to community-based services. I think in the mental health area, more than anything else, we've seen the impact on our communities of not being able to provide the services that we need in those communities. Would you agree there is a need for accountability agreements to try to bring these shifts about?

Ms Bregman: There's no question. In fact, we support the idea of accountability. My suggestion was only, I think—people will have an easier time understanding the bill if you can just make that a little clearer. But there's no question that we are very supportive. We

deal with one of the most vulnerable populations around, who often don't have family members. They're not going to go to the media. That's why within our own organizations and with the community mental health sector, on our own we've said we're going to do this. We've started doing accreditation without anybody saying we have to do it, because if we don't watch out for that population, too often nobody else does. So absolutely accountability is essential.

The Chair: Thank you, Ms Bregman. Thanks for coming today. We did appreciate it.

ONTARIO COUNCIL OF TEACHING HOSPITALS

The Chair: Our next delegation is from the Ontario Council of Teaching Hospitals. I think we have a delegation of four people: Virginia McLaughlin, Barbara Sullivan, Tom Closson and Mary Catherine Lindberg. It's the same rules as everybody else. You have 20 minutes to use any way you see fit. At the expiry of your presentation, we will ask you some questions on a rotating basis. If you would identify yourselves also for Hansard, it would be appreciated.

Ms Virginia McLaughlin: Thank you very much, Mr Chair. Good morning. My name is Virginia McLaughlin. I'm the chair of the board of Sunnybrook and Women's College Health Sciences Centre. I am here today with my colleagues to speak on behalf of the Ontario Council of Teaching Hospitals, also known as OCOTH. Joining me is Barbara Sullivan, who is a board member of the Hamilton Health Sciences Centre. She will assist me in presenting some of our comments on Bill 8. Also here today is Tom Closson, at the end, who is the president and CEO of the University Health Network. Unfortunately, Mary Catherine Lindberg, who is the executive director of OCOTH, is unable to be with us, as she is unwell.

On behalf of all of the members of OCOTH, I want to thank you for the opportunity to table our general comments and observations about Bill 8, the Commitment to the Future of Medicare Act, 2003. Copies of our written brief have been submitted to the clerk. Given the time allotted for this presentation, however, we have decided to focus our oral presentation primarily around observations 4, 5, 6 and 7 as contained in the written brief. We would like to encourage you at your earliest convenience to review the brief that we have left with you.

The Ontario Council of Teaching Hospitals is a not-for-profit organization. Our organization is comprised of 22 hospitals that provide primary, secondary, tertiary and quaternary patient care, research and teaching in association with Ontario's medical schools. OCOTH members offer acute, complex continuing care and rehabilitation services and manage annual operating budgets ranging from $25 million to $1 billion. Collectively, teaching hospitals consume 45% of the resources spent on hospitals in this province today.

Let me begin by saying that OCOTH believes that Bill 8 is an important, defining and complex piece of proposed legislation. It signals Ontario's intention to recommit to the principles of the Canada Health Act and proposes new accountability mechanisms to strengthen governance and accountability within the health sector. We applaud these intentions and reiterate the dedication of our members to these goals. We also want to acknowledge the statement made by the minister on February 16 that helped clarify some aspects of the bill, in particular that the proposed accountability agreements will be established between the ministry and the board of directors for those health resource providers designated under the bill, and that the ministry intends to introduce amendments which will clarify the process for entering into agreements. We are hopeful that the government will remain open to further clarifying outstanding issues with respect to this bill and will make the necessary adjustments that will ensure that we have a framework within which the health care sector and the government can work together to improve accountability and system performance.

Having said this, there are two points OCOTH would like to put on the table at the outset.

First, OCOTH believes that Bill 8 is first and foremost a message to the health care system that the government is serious about finding ways to increase accountability and enhance performance within the health care sector. These goals reflect—in large part—the priorities that most health care providers in this province fundamentally agree upon. Our concerns are not about the fundamental goals and ultimate ends to be achieved.

Second, OCOTH believes that improving accountability and enhancing performance within the health care sector will only be achieved through a process of mutual agreement and partnership between the government, hospitals and health resource providers. Such a partnership will increase understanding of the opportunities, risks and benefits of the proposed mechanisms outlined in the bill to increase two-way accountability and to ensure the flexibility that is required given the diverse nature of communities across Ontario, the hospitals which serve people in those communities, and the multifaceted range of services offered by hospitals throughout the province.

Keeping these general comments in mind, I would now like to ask Barbara Sullivan to review with you some of OCOTH's specific observations with respect to Bill 8.

Ms Barbara Sullivan: As Virginia has already mentioned, I will focus most of my remarks on observations 4, 5, 6 and 7, which are included in your written brief. I will take just a minute to comment briefly on the first three observations outlined in that brief.

Observation 1: OCOTH supports the establishment of the proposed Ontario Quality Health Council and the role it will have in reporting on progress within the health system. Its independence from government and providers is important.

At the outset of the council's work, however, we hope that there will be an appropriate mechanism to ensure that the expertise and experience of the hospital sector—both board and administration—are available to the council. The government may want to include specific regulations under the bill that would enable the council to establish advisory committees and give it the power to access resources necessary for its work.

The role of the council may also be too limited as it's currently proposed. We recommend that the mandate of the council be strengthened to give it the ability to make recommendations based on the information it has collected and reviewed.

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Observation 2: With respect to the accessibility provisions outlined in part II of the bill and the physician payment provisions in part IV, OCOTH is concerned that these sections may potentially prohibit payment of hospitalists, laboratory physicians and other types of physicians to which hospitals make direct payments for insured services. Paradoxically, this provision may have the effect of reducing access to health care services. This section should be amended to allow hospitals to continue to make these necessary payments to physicians. I also want to note that alternate payment plans for physicians are becoming the norm in teaching hospitals in many specialties and, in some cases, throughout hospital operations. Such plans are negotiated directly within the hospital with its physician cohort, along with Ministry of Health participation, and not through the Ontario Medical Association, and are put into place through mutual agreement. While the regulations under the Health Insurance Act provide for such plans, the provisions of Bill 8 appear to remove such payment options.

Observation 3: OCOTH believes that the bill must make explicit the mutual accountability of government and providers. Despite the reference to shared and collective responsibilities, Bill 8 does not facilitate the enhanced two-way accountability needed to achieve the goals to which it aspires. The bill focuses exclusively on how to make health resource providers accountable to the government, yet it is silent on the government's obligations with respect to its support for the provision of health care. If hospitals are to be held accountable for delivering a certain level, availability and quality of care, then to what extent will government be accountable for funding that level, availability and quality of care?

I'd like to turn now to some of the specifics related to observations 4, 5, 6 and 7, which are dealt with in greater detail in our brief.

Observation 4: This relates to part III of the bill, accountability. While OCOTH accepts the principle of accountability in health care delivery, we cannot support part III of the bill as it is currently presented.

The policy contemplated in part III is a complete reversal of principles upon which accountability in Ontario's public hospitals is now ensured. At present, most public hospitals and most teaching hospitals are corporations composed of members who, generally, represent the larger community served by the hospital, a board of directors chosen by and responsible to the members, and senior executive staff chosen by and responsible to the board. Directors are under a legal obligation to act prudently and with skill in the best interests of the hospital and its patients. The community and the ministry are entitled to look to the board and the CEO for the proper management of the hospital. If the board fails in its duty, the minister has authority under the Public Hospitals Act to investigate and, if necessary, to supervise a public hospital. To date, this approach reflects a sensible and workable balance. Initial responsibility rests with the board representing the community, safeguarded by the power of the minister to intervene if, for any reason, the board fails in its duty.

Sections 21 and 22 reverse this long-standing and successful policy. By imposing accountability agreements with hospital corporations, the minister now takes on primary responsibility for the performance of the hospital. Hospital boards would no longer have a meaningful role. However, the legal obligations of directors—that is, responsibility for hospital performance—would remain. Bill 8 does not relieve them of those obligations.

Under Bill 8, as currently written, directors have no power to negotiate accountability agreements and reduced or no power over key decisions relating to senior staffing. In these circumstances, any prudent director would be well advised to resign. We expect it would be difficult to find qualified directors to serve.

The absence of an involved, dedicated board would have an immediate adverse effect on fundraising. Fundraising, and most particularly fundraising for research, is absolutely critical for teaching hospitals. In teaching hospitals, research, education and clinical care are inextricably linked. A cutback in research funding will adversely affect clinical care and education, with enormous adverse effects on the health care system as a whole.

Our second objection to part III is to the proposed means whereby the principle of accountability is to be implemented. Sections 21 and 22 empower the minister to direct health resource providers, such as hospital corporations and other prescribed persons, which may include those exercising an executive function or position, to enter into accountability agreements. Where they fail to enter into an accountability agreement, the minister may issue compliance directives. Generally, agreements are understood to be consensual in nature. It is contradictory to impose an agreement. It's also contrary to the principles governing agreements to provide for enforcement of agreements by creating offence provisions under the Provincial Offences Act.

Section 27 permits the minister to order material changes in a CEO's terms of employment, including reductions in benefits and compensation, without any contractual recourse. This is a provision which is virtually unique in employment relations. No complex organization can expect to retain competent, capable CEOs under these conditions.

In summary, the policy proposed in part III and the means for its implementation will not have a positive effect. We are convinced that the effect of part III will in fact be substantially negative. We strongly recommend that part III be substantially reworked. Accountability can be achieved by far better means.

Observation 5: We want to speak to current efforts to advance our health system through collaborative initiatives. If implemented in its current form, the bill could seriously undermine progress that has been made in recent projects that have been undertaken jointly between the government and hospitals. For the past several months, for instance, OCOTH and the Ontario Hospital Association have been working with the joint policy and planning committee, the JPPC, on multi-year funding and hospital performance agreement initiatives. We understood that these initiatives were part of a mutual, collaborative commitment to develop stronger planning and accountability mechanisms within the hospital sector. We thought we were, together, on the right track. We believe, however, that much of what is being proposed in Bill 8 compromises the progress that has been made to date.

Observation 6: The current emphasis of the bill reinforces individual accountability of hospitals and other health resource providers. This focus may promote a greater inward concentration at the expense of moving the health care sector toward greater integration and systemization. This contradicts many other policy goals and directions in recent years that have called for strengthened system accountability.

A serious concern among teaching hospitals is that this bill may have an adverse impact on current voluntary discussions that are taking place to streamline service delivery in a number of communities across Ontario. In fact, there appears to be a critical disconnect between what's being proposed in this bill and the efforts currently underway to streamline and integrate clinical services as well as support services across and beyond individual organizations.

Our suggestion: Rather than government becoming directly involved in the governance and management of hospitals, OCOTH proposes that accountability be strengthened by holding hospital boards accountable to the government and the communities they serve through regular reporting on performance based on a series of overarching principles developed and mutually agreed upon between both parties—that is, hospitals and government. These principles would form part of a template that specifies in broad terms what the expectations with respect to service delivery and accountability will be for both parties. Examples of the kinds of principles that could be included in a template are outlined in our written brief.

Observation 7: Finally, OCOTH members are concerned that the bill raises a number of questions that may, at least in the short term, be difficult to grapple with. For example, it's important that service or accountability agreements be negotiated within the context of clearly defined and articulated provincial service levels predicted through the use of knowledgeable data and experience in the field by hospitals and health providers themselves. To reduce uncertainty and facilitate planning, the agreements will have to be negotiated in a timely manner. We're uncertain about the possibility of achieving individual and distinct accountability agreements with each of the province's hospitals in a timely way, given that each hospital serves a different community and that teaching hospitals have particularly complex mandates.

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In conclusion, I want to re-emphasize that although the preamble of Bill 8 articulates specific goals that are strongly supported by OCOTH, we have reservations about the effectiveness of the strategy and mechanisms for achieving those goals as presented in the bill.

We support legislation that commits to the future of medicare in this province and puts in place instruments to help achieve the goals of greater accountability and enhanced performance. Achieving these goals should not be addressed through arbitrarily altering governance structures; rather, there should be a strategy that encourages government and health resource providers to come together to develop the underlying principles needed to set common objectives, expected outcomes, targets for achievement and performance measures.

We must move toward excellence in our health care system by building on our strengths. Together we should seek first and always to catalyze and support positive, voluntary and mutually acceptable changes and progress. We are very anxious to work with government to achieve that.

The Chair: Thank you, Ms Sullivan. It was very well presented but you've left us with about one minute. We're going to let Ms Martel have that whole minute.

Ms Martel: Very briefly, last week the minister gave us some indication of where he plans to move with part III, which gives me no comfort at all. It says very clearly that the minister can still issue a compliance directive or an order. It says that CEO compensation clawback can be considered by the minister and it also says that section 27, as you pointed out, does apply to a CEO.

Tell me, do your concerns change with respect to part III, given the revised changes that the minister outlined to this committee on Thursday?

Ms McLaughlin: No.

Ms Martel: Thank you. That says it all.

The Chair: Thank you very much for coming today. Thanks for the presentation. We appreciate it.

CENTRE FOR ADDICTION AND MENTAL HEALTH

The Chair: Our next presentation is from the Centre for Addiction and Mental Health, Dr Paul Garfinkel, president and CEO, and Gail Czukar, executive vice-president, policy and planning. Make yourself comfortable. You have 20 minutes. You can use that time any way you like. If at the end of the presentation there is any

time left over, we will share that among the three parties if it's a substantial amount of time. The floor is yours.

Dr Paul Garfinkel: Thank you very much for the opportunity to speak with you today. By way of introduction, the Centre for Addiction and Mental Health was created in 1998 through the merger of the Donwood Institute, the Addiction Research Foundation, the Clarke Institute of Psychiatry and the Queen Street Mental Health Centre.

CAMH assumed the various responsibilities of these four organizations with a provincial mandate for care, research, education, public policy, health promotion and prevention throughout Ontario. We deliver these services through our main sites here in Toronto and through 26 satellite offices throughout Ontario.

We have made it a priority to promote positive change in government policy for people with mental illness and addiction.

With regard to our response to Bill 8 concerning medicare and its values, we are very pleased that the preamble to the bill affirms the system of publicly funded health services as fundamental to Canadian values. However, mental health and addiction services are often not explicitly recognized as an integral part of this system, despite the prominence of mental illness and addictions and their severe complications and cost to our society.

If one looks at the Canada Health Act, it specifically excludes "a hospital or institution primarily for the mentally disordered" from the definition of hospital. This is offensive and discriminatory and should not remain part of our law or our medicare system. Although Ontario funds these services, not all other provinces do, and this is not acceptable.

We ask that the preamble to Bill 8 explicitly recognize that all Ontarians who have physical or mental illnesses are entitled to the equal benefit of publicly funded health services, according to their needs.

The fourth point of the preamble should ensure access based on need, not ability to pay nor whether a person has a physical or mental illness.

We believe that mental health and addictions problems must be served by accessible, effective and adequately funded programs for all people who need help. A wide range of services is needed to improve and maintain mental health.

CAMH supports the creation of a health quality council to monitor and report on the issues of access to publicly funded services, utilization of resources, consumer and population health status and health system outcomes. CAMH specifically supports reporting on these issues in the mental health and addictions sector, and we want to help to develop the technologies and the processes to improve these measures. Such information will create better transparency in the sector and will help all Ontarians to better understand our publicly funded system.

CAMH supports the Canada Health Act's principles of comprehensiveness, accessibility, portability, universality and public administration and ask that you consider these principles in terms of the communities we serve.

We are especially concerned about potential defunding of addictions services. This comes up repeatedly in a recurrent fashion in our society because of the extreme stigmatizing attitudes people often hold to this population. We would ask that you support actions that increase access to mental health and addictions services.

With regard to the section on accountability, CAMH supports the government's initiative to identify opportunities for greater accountability. We acknowledge that there are strengths and real weaknesses in the current accountability framework. There is lots of room for improvement. We urge that the principles of consultation, collaboration, transparency and the public interest should guide the development of any new accountability arrangements.

Ministry expectations for hospital performance and health care outcomes must be clarified and developed, but this must be done in consultation and with agreement of the hospitals.

Together with government, we must develop unique indicators and measurement tools for the mental health and addictions sector. The indicators and measures used in the acute care sector are of limited value to our population. For example, length of stay in the acute care sector may be a very valid indicator. In our sector, length of stay in a hospital, if the person is going out to an inadequate support system, is a very poor measure.

New accountability arrangements introduced through legislation must not undermine the role and responsibilities of hospital boards. I think you just heard from OCOTH on that quite eloquently. Any new accountability arrangements should be made with the hospital boards and not directly with hospital staff.

We do, however, support the government's efforts to develop a wide range of accountability mechanisms that are graduated in their approach, starting with the most mild and working up to more definitive mechanisms with the hospital board, not the CEO.

We would suggest that much more use could be made of the role of auditors in clarifying reporting obligations of the health care facility through the board, and through the board to the ministry. It is the board's responsibility to hold the CEO and other senior staff accountable.

As drafted in Bill 8, there would be an opportunity for broader disclosure of personal information from hospitals to the minister and the general manager of OHIP. This is quite different from Bill 31, the Personal Health Information Protection Act, currently under consideration by the Legislature.

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We're pleased that the minister has indicated that he will introduce amendments to this bill to delete the minister's authority to directly collect and use personal information. It is very important that we see how this drafting proceeds.

Further, in accord with what OCOTH just mentioned, the accessibility rules in section 9 of this bill could have an unintended consequence of restricting health services by prohibiting hospitals from making necessary direct

payment to physicians. This is extremely important to us, because not all mental health services from physicians are funded through OHIP; there is direct hospital payment that has to occur. We welcome the opportunity to work collaboratively with the government to discuss mutually agreeable alternatives that ensure our clients continue to receive accessible services.

Further, we're concerned that Bill 8 leaves significant details to be determined in the regulations. We urge the government to include the proposed 60-day consultation prior to the passing of the regulations under this legislation. This consultation should not be restricted to a few major stakeholder groups that represent the traditional interests in our health care system.

We look forward to working collaboratively with the government to find solutions to these kinds of problems.

In conclusion, CAMH recommends the following:

First, change the preamble to recognize the importance of mental health and addiction services in the publicly funded health system, recognizing that these services are essential for the mental and physical health of Ontarians.

Second, the government should create the health quality council and give it a specific mandate to ensure that it studies and reports on the mental health and addictions sector.

Third, in developing new accountability arrangements, the government should be guided by the principles of consultation, collaboration, transparency and acting in the public interest.

Fourth, the government should continue the dialogue with hospitals and our associations to develop the appropriate accountability structures. These must acknowledge the role and responsibility of hospital boards and the mutual obligations of health service providers and the government to achieving increased accountability.

Fifth, the provisions dealing with disclosure of personal information to the minister must be redrafted, in keeping with the proposed model for disclosure in schedule 1 to Bill 31.

Sixth, the government must work collaboratively with the stakeholders to discuss mutually agreeable alternatives to section 9 to ensure that access to health services is not unintentionally limited.

Seventh, that a provision be added to the legislation to require public consultation prior to passing the regulations under this legislation.

As you consider this legislation and prepare to table amendments, please consider our recommendations and the need to protect and support Ontario's mental health and addictions communities.

Thank you again for the opportunity to speak to this legislation. We welcome any questions or comments you may have.

The Chair: Thank you, Dr Garfinkel. You've left us with about nine minutes, which is wonderful. Three minutes for each party, starting this time with Ms Wynne.

Ms Wynne: Thank you for your presentation. I certainly take your point about the particular needs of the mental health population. I just want to make a couple of comments and I've got one question.

When you talk about the development of new accountability arrangements, I wanted to let you know that sections 21 and 22 will be amended to be clearer about what those arrangements will be, OK? That's an issue that's been raised by a number of presenters, and the amendments will include notice and other due process provisions so that it's clear exactly what the process is.

You also made a point about the need for unique indicators, depending on the institution or depending on the area. It's not the intention that there will be one accountability agreement for everybody. That's where the discussion and the negotiation and renegotiation come in. Again, that's what will be clarified in those amendments.

You talked about section 9 and working collaboratively with stakeholders, and I think, again, that's a section that is going to be amended.

Having said all of that, this is a question that was asked earlier about the need to provide more support to community health. If the intention and the direction of this government are to move toward that reality where there is more support for community health services, which has a direct impact on the provision of service for mental health providers, do you see this bill as a step in that direction in terms of making sure that there is accountability within the existing system? Do you see that this will help us move toward that more community-based model?

Dr Garfinkel: There's no question that increased accountability in the health sector is very important. We recognize how important this is for all of us. There are some strengths in the current model, but there's a long way to go. In our sector, and I personally believe in the entire health sector, the arbitrary distinction between institution and community is very artificial, and we should be considering holistic, integrated approaches to health care. I do think efforts to increase accountability are highly valued and we should be pursuing them. As I mentioned, I think the mutual discussions with the boards, the mutual agreement with boards, are extremely important.

Ms Wynne: So that mutuality; yes, we need to get that in. Do you also see that it would be useful to have accountability agreements that were synchronized among a group of providers?

Dr Garfinkel: I do worry. That's an important question. One of the big problems we have in our sector, and in all of health care, are the silos of care. We could unintentionally make the silos a little bit stronger than they are even today.

Ms Wynne: If we focused on individual agreements. So you see—

The Chair: Thank you, Dr Garfinkel. We go to Ms Witmer.

Mrs Witmer: Good to see you, Dr Garfinkel, and also you, Ms Czukar. I thank you for your very thoughtful and insightful presentation. You've certainly provided a total overview regarding the concerns you have with the legislation, and also made some good recommendations

for improvement. I would ask you, what are the key amendments that you believe must be made before you could support this bill?

Dr Garfinkel: I think they reflect the nature of the accountability agreement and a contract that's mutually agreed that occurs with the board that has a graduated series of intrusions. The issues about privacy and how privacy is handled, the issues of physician payment—I think you and I have had this discussion before. I feel that the way the mentally ill have been historically treated in Canada is offensive, and it relates to stigma and it relates to the fact that governments directly controlled our hospitals before, and I would very much like to see something in the preamble correcting that. Gail may have—

Ms Gail Czukar: I would support that. I was going to say, in response to the last set of questions, that I hoped the indication that the unique indicators about mental health would be incorporated into the agreements isn't to say that the issues we've raised about including mental health in the preamble won't be done. We feel it's very important to create the right stage for it. I think the CMHA appeared earlier and said that mental health is always going to be the next conversation; it's not the one we're having now, and we'd like to see it now.

Mrs Witmer: When I take a look at your presentation, I recognize with sincere regret the fact that we've made so little progress. We've been having this conversation for a long time, and I don't think we can afford to postpone the conversation any longer. I certainly hope that the government would very seriously consider including, as you have asked in the preamble, that all Ontarians who have mental or physical illnesses are entitled to the equal benefit of publicly funded health services. I think that's extremely important and I don't think we can continue to delay the conversation. We've been putting off this conversation for many years. We both know that. We've made some progress, but you're right: There's still a stigma that continues to be there. You reminded me of the fact that in the Canada Health Act, a hospital or institution primarily for the mentally disordered is excluded from the definition of "hospitals." That just shows you about what has happened throughout the entire province.

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I thank you for your presentation. I trust that the government will pay heed to what you've recommended in the way of accountability arrangements. But I'm appalled, because this bill should have been a white paper. We've heard that part III is totally wrong, the preamble is wrong, there's so much wrong and there are so many flaws. I think, for the sake of all the stakeholders, many who are terrified of the implications, the government would have been better served to have had a white paper, gotten input from groups such as yourself and come forward. Once amendments are made to this bill, if that's how the government chooses to go as opposed to withdrawing the bill, do you think that additional hearings are going to be required to deal with the amendments, which are going to be very substantial?

The Chair: An extremely brief answer.

Dr Garfinkel: Yes.

Ms Martel: I thank you both for being here. It'll be no surprise to you that I'm going to go back to the accountability agreements. The government might lead you to believe that this section has been cleaned up in response to concerns. I think it's worthwhile reading into the record exactly what the minister, through his parliamentary assistant, gave to us last Thursday. Here are sections 22 and 23, which are the sections you're worried about. Section 22 reads, "Include notice and other due process provisions, including time frames for notice, to address development of accountability agreements, issuance of compliance directives and orders (eg discussion process, meetings, exchange of documents/information, representations that the minister has to consider before issuing a compliance directive or an order)." That's what the new proposed section says.

Let me give you section 23 as well, because you've made it very clear that it's the board's responsibility to hold the CEO and other senior staff accountable. Here's what the proposal from the minister says about section 23: "Include a range of remedies directly in legislation that could be issued in a compliance directive or an order to address non-compliance (eg audit, budget review etc). CEO compensation clawback or any other financial remedies to be applied to a CEO as a last resort only after all due process has been exhausted and in exceptional circumstances."

I'm sorry; I haven't seen the amendments, but enough of what I've seen and what the minister intends to do leads me to believe that there has been very little change, and the government hasn't got the message yet, because the government is still, through the minister, going to deal with the CEO and compensation, and the government is still, through the minister, going to issue compliance agreements and orders. That doesn't speak to consultation and collaboration and agreement to me. Are your concerns resolved?

Dr Garfinkel: They're not resolved. I think there has been some improvement from what I heard before. It has a way to go yet.

Ms Martel: Do you think, when the minister still has some sweeping, draconian powers to issue directives and to issue orders, that the tone is going to change in terms of the ministries working with not only your board, but boards of other institutions across the province?

Dr Garfinkel: I believe this has to be a collaborative process. But as I said, there should be gradations in what government can do, and I think those gradations have to be clarified and known to all of us. We're not there yet.

The Chair: Thank you for coming today. We certainly did appreciate it.

Dr Garfinkel: A pleasure.

The Chair: We can move on now to the last group before we recess for lunch. Oh, two more groups before we recess for lunch—sorry to get everybody's stomach going there. Everybody might want to check their phones, while we're moving around, and make sure they're on vibrate or on silent.

CATHOLIC HEALTH CORP OF ONTARIO

The Chair: The next delegation is the Catholic Health Corp of Ontario, represented this morning by Don McDermott, the president; Mark O'Regan, the vice-chair of the board; and Sister Sarah Quackenbush, the vice-president. You have 20 minutes to use any way you see fit. If there's any time left after the presentation, we'll split your time up amongst the parties.

Mr Mark O'Regan: Good afternoon. I am Mark O'Regan, vice-chair of the Catholic Health Corp of Ontario and a former chair of the St Joseph's Health Centre here in Toronto.

Sister Sarah is the vice-president of the CHCO and a former CEO of St Joseph's Hospital in Elliot Lake. Don McDermott, as mentioned, is the president of CHCO and also a former chief executive officer of St Joseph's in Sarnia.

Following my opening remarks, Sister Sarah will deliver our message, and thereafter Don will receive your questions to close out our time with you. Our chairperson, Sister Winnifred, was unable to be with us today. On her behalf, we thank you for this opportunity to appear before you as you consider Bill 8, the Commitment to the Future of Medicare Act, 2003. We are the sponsoring organization for 13 Catholic health institutions—acute, long-term care and homes for the aged—in the province.

The Catholic Health Corp of Ontario was incorporated under the Ontario Corporations Act in 1998 and includes as members the Sisters of St Joseph, Toronto; the Sisters of St Joseph, Sault Ste Marie; the Grey Sisters of the Immaculate Conception, Pembroke; and the Sisters of Charity of Ottawa. These congregations provided an initial fund to support the operational costs of sponsorship provided by the CHCO.

The purpose of the Catholic Health Corp of Ontario is to sponsor Catholic health institutions in Ontario. Within the Catholic Church, for an organization to carry on its work in the name of the church, it must have a sponsor to ensure its work is done within the values of the church. As the congregations of sisters move to other works, this corporation accepts sponsorship of the health institutions formerly founded and sponsored by the sisters. The sisters retain ownership of the institutional property.

These institutions sponsored by the CHCO are separately incorporated and include Providence Centre in Toronto, St Joseph's Health Centre in Toronto, St Michael's Hospital in Toronto, Penetanguishene General Hospital in Penetang, St Joseph's Care Group in Thunder Bay, St Joseph's General Hospital in Elliot Lake, St Joseph's Health Centre in Sudbury, St Joseph's Villa in Sudbury, Marianhill Home in Pembroke, Pembroke General Hospital, Mattawa General Hospital, Sisters of Charity of Ottawa Hospital, and St Patrick's Home in Ottawa.

These institutions represent approximately $770 million in operating budgets, 929 acute care beds, and 2,600 long-term-care, rehab and psychiatric beds, governed by over 180 volunteer directors.

With that, I'd like to turn it over to Sister Sarah.

Sister Sarah Quackenbush: On behalf of the sister-owners of these institutions, the operational governance of these institutions is delegated to the voluntary institutional boards. These directors are drawn from the communities where the institutions are located and represent the diverse nature of the communities, including ethnicity and religion, with the expertise required to govern a health care institution. All support the mission and values of a faith-based approach to provision of health care within canon law and the laws and standards set out by the Ontario and Canadian governments.

We recognize and agree with the intent of this bill to ensure accountability within the health system of Ontario and to preserve and ensure quality health care for the patients and clients requiring these services. We agree with the tenets of the Canada Health Act, including public administration that is accountable to the people.

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Faith-based institutions such as ours strive to provide holistic care that not only includes physical and psychosocial services to maintain health and treat illness but, as well, and equally important, to provide spiritual care for those of our patients and residents who wish these services.

Because Ontario is so ethnically diverse, with many cultures and beliefs, our aim is to ensure high-quality health care regardless of religion, culture, ethnicity or economic status. We work hard to make our patients and residents feel comfortable and supported within their own religious and cultural context while getting care in our institutions. We do this through our local voluntary governing boards, which represent diversity of culture and religion in the community.

The section in Bill 8 where we have our greatest concern is in part III, on accountability. Although the Minister of Health has stated that he is willing to make changes to this section, we remain concerned that contracts with the institutions and with the institutions' executives would directly interfere with the governance process of the institutions and therefore our Catholic identity and the faith-based nature of our institutions. The compliance directives, as currently described in the proposed bill, are also direct interference with the voluntary governance process that has worked so well in this province.

The most important point we want to make is that it is crucially important that the board be the sole employer of the CEO of the institution and other senior staff so that there will be no confusion as to the terms of their working arrangement and accountability. Any interference with this direct working relationship would create confusion and undermine the board's role in the executive oversight, not just for the governance process but for ensuring that the institution fulfills its obligations of providing services based on religious values and mission. Contracting with the CEO and others in any way, including penalties imposed by the government or changes to the terms of an existing personal contract, would con-

stitute interference with the employer-employee relationship and would, in fact, decrease accountability through confusion as to who is the employer.

Another point that we feel has to be emphasized is that we recommend that the provision for service contracts with institutions and the institutions' executive should be deleted, and in its place create, with the input of organizations such as the Catholic Health Association of Ontario and the Ontario Hospital Association, clear expectations of service provision for both the institutions and their governing boards. These expectations should be negotiated and bilateral. They should identify the roles and levels of services the institutions would provide within their areas of expertise, expectations for working relationships with other institutions, and the standards of care expected. There would need to be clear understanding of the rights of religious institutions to work within their mission and values.

Within these expectations there would, out of necessity, be mutual agreement as to the financial support provided by the Ministry of Health for the institution to perform these roles within the standards expected over a multi-year time frame.

Should there be disagreement around the interpretation of these expectations, there would need to be a disputes resolution process. An objective third party is recommended to ensure fairness and equitability. If dispute is centred on the religious mission and values of the institution, it should fall to the bishop of the diocese within which the institution is located to determine the ability of the institution to comply within their canon law.

We agree with the concept of holding the voluntary boards accountable for the care provided by the institutions. However, the current Public Hospitals Act of Ontario contains a good-faith clause whereby directors are protected from negative consequences of acts or omissions if done in good faith. The ability to obtain and hold high-quality expertise at our local board levels in health care institutions in Ontario will depend on this continued protection.

Mr Don McDermott: Not only should there be clear expectations outlined that all parties agree with, but also educational programs should be required to encourage and develop expertise in the governance of health institutions. The Ontario Hospital Association and the Catholic Health Association of Ontario do excellent work already in this area of orientation and education for hospitals, and we, the Catholic Health Corp, provide on-site orientation for our new board members and senior staff in their roles as institutional faith-based leaders.

Regular assessment of compliance with expectations is necessary within fair and understandable guidelines to ensure good governance. Board evaluations with indicators and standards are available and should be required on a regular basis. Public voluntary boards need education, standards and assessment to build the best boards possible. Within our Catholic institutions, we encourage regular assessments of service outcomes, including both quality patient care and staff performance, that reflect our values. This same approach could be used for other aspects of service similar to those provided by the Canadian Council on Hospital Accreditation.

Achieving standards beyond a certain level of excellence should be rewarded to encourage the diligence and hard work required for this level of governance. Any program and service expectations, as well as their assessment, would, out of necessity, need to be provided locally throughout Ontario. Institutions such as ours are located across the province and as far north as Thunder Bay and Elliot Lake. Each would require on-site orientations, education and assessment for the directors to avoid excessive travel and accommodation expenses.

I hope that these remarks provide you with an outline of our concerns: that contracts between institutional boards, their executives and government could interfere with the voluntary governance process, especially with faith-based institutions; that directors need to have good faith protection from legal actions continued; that clear expectations of roles and performance, negotiated with the institutions and with positive incentives, are more conducive to co-operation; that education, orientation and assessment of governance, including adherence to mission and values, are currently done in some institutions with success and are recommended as part of the public accountability process; and that the voluntary governance process, with clear lines of accountability to the CEO, is important to the Catholic institutions we sponsor, where the directors support and foster the spiritual side of health care.

Thank you again for this opportunity, and we would be pleased to answer any questions you may have.

The Chair: Thank you very much. It looks like you used up about 11 minutes, which leaves each of the parties three minutes.

Mrs Witmer: Thank you very much for your presentation. Certainly I have always valued and appreciated the role of the Catholic Health Corp here in the province of Ontario and the work you do.

I guess you've answered one of the questions which we wondered about, and that is, although the minister has made some suggestions as to changes that might be made, we don't know what those changes might be. Obviously, he is going to continue to move forward in a way where the accountability will continue to go just one way.

You've really pointed out here, I think, very well that this would in particular have an impact on the Catholic organizations and interfere with the voluntary governance process that has worked well in this province. This will be difficult for you to answer, but do you see this as a step in removing voluntary boards from having any jurisdiction within your organizations? Is this what the impact could be at the end of the day? Would you find that you don't have people who are willing to serve if this is going to be the relationship?

Mr McDermott: A lot of our board members come to us and work with us at our institutional level with the understanding that they work within certainly a faith-

based perspective, but as well, that they have the right and breadth to govern. Any loss of that kind of responsibility, I think, would result in a lot of our directors not willing to sit on boards and try and help their local communities.

Mrs Witmer: So if that's the case, what is it that specifically you need to ensure that the concept of voluntary governance, as it presently is constituted, would be preserved, as well as the institutions that you're responsible for?

Mr McDermott: This bill, I think, is a great opportunity to fundamentally support the public governance process. Recognizing faith-based institutions within that framework in fact, we feel, detracts from that, takes away from that whole public governance process.

We're very lucky in Ontario. Looking at the other provinces where this remains a fact, looking at individual institutions and public governance, we should be building on that. I think it's a great asset for the province.

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Ms Martel: Thank you for being here this morning. As an aside, I was at the opening of the villa two weeks ago. It was a pleasure, and the building is marvellous, so congratulations on that.

Let me ask you this: Is the corporation participating, as a corporation, in the joint policy and planning committee with the Ministry of Health?

Mr McDermott: Through the OHA we have input.

Ms Martel: I ask that for this reason: I have yet to figure out why the minister and the government thought it necessary to come forward with such sweeping and, frankly, draconian powers to take out boards, take out CEOs etc. As I see it, with the work that's going on right now—you're taken into that work through the OHA—that will develop performance agreements, and with the existing Public Hospitals Act, which talks about public interest, which has a protection for directors, it seems to me that the government has at its disposal a mechanism both to set performance agreements and, second, to deal with any hospitals that are out of control, for lack of a better word. I can't understand where this current motivation comes from, because the powers are very sweeping; they're very broad. You're absolutely right: Directors would be crazy to sit under any circumstance with the liability that they might be affected by, and CEOs would also feel very compromised.

Do you have any understanding in any of the discussions you might have had with the ministry or with the minister or anybody else related to this why the government thought it necessary to move forward with these kind of sledgehammer provisions when, in fact, some of their current processes, along with the current act, probably would have allowed them to get to the very same objective and the same goal?

Mr McDermott: No, I don't have an idea.

Ms Wynne: Thank you very much for taking part in this process. Bringing out a bill after first reading means that there is lots of opportunity for change and amendment. I just wanted to highlight the amendments that are going to be made around the governance issues in the accountability section, which is where you are concerned.

But, I have a specific question. The way the accountability agreements are going to work—because they will be between the minister or the ministry and the boards and then there will be a performance agreement between the board and the CEO. But you make a statement about the interference with the voluntary governance process, "especially with faith-based institutions." Can you give us an example—because this issue has been raised, and we understand there needs to be more clarity—of what in particular a faith-based institution would be concerned about, as opposed to any other organization with a volunteer board?

Mr McDermott: Sure. As sponsors, we're responsible, essentially, to the church for our institutions' adhering to mission and values. If there's an accountability agreement that would somehow interfere with the mission and values as stated by the institution, then it would essentially negate our ability to perform that function and would, in essence, interfere with the institution's right and ability to identify itself as a Catholic institution.

Ms Wynne: OK, because I don't think this legislation is written and is certainly not intended to interfere with mission and values. Is there a specific area that you're worried about intrusion into?

Mr McDermott: Specifically at the moment, no. I think we would have to see the regulations or the next draft of this bill. But what we want to do is alert the committee that we do have that concern and that it's very necessary that faith-based institutions have the freedom to continue on in adherence to their mission and values.

Sister Sarah: I guess the concern, if we have service arrangements or service agreements, is that we don't know what that means, as Don has said. If we were in an agreement that we could not support because of our Catholic ethics guide that we have to comply to and our canon law, and if we're forced to go into any agreements without proper consultation first, it could compromise who we are and what we do.

Ms Wynne: Well, we will probably have to talk about that further, but there will be laid out what the time frame would be for negotiating those agreements and discussing what would be in those agreements. That's certainly the amendment we're bringing forward.

The Chair: Thank you for being here today. We certainly appreciated it.

ONTARIO ASSOCIATION OF COMMUNITY CARE ACCESS CENTRES

The Chair: Now we have the last group before lunch. I call forward the Ontario Association of Community Care Access Centres, represented today by Georgina White, policy adviser; Wes Libbey, board chair of the eastern counties; and Heinz Schweinbenz, board chair of the Halton CCAC.

Welcome. The floor is yours. You have 20 minutes. You can use that any way you see fit. Any time left over will be split amongst the three parties.

Mr Wes Libbey: Thank you very much, Mr Chair. My name is Wes Libbey, and I'm also past chair of the Ontario Association of Community Care Access Centres. As you pointed out, I'm currently the chair of the CCAC for the eastern counties. Accompanying me today is Heinz Schweinbenz, who is the chair of the Halton Community Care Access Centre, and our policy adviser, Georgina White. On behalf of our association and our members, we'd like to express to you our appreciation for the opportunity to appear before this committee today.

The Ontario Association of Community Care Access Centres is a voluntary organization that represents Ontario's 42 CCACs. As the provincial voice for CCACs, our mission is to support and represent the interests of our members, to provide leadership in shaping health care policy and to promote best practices on behalf of the people served by community care access centres.

CCACs are statutory corporations under the Community Care Access Corporations Act, 2001, and provide services under the Long-Term Care Act, 1994. Under the provisions of the Community Care Access Corporations Act, CCAC board members and executive directors are appointed through the Lieutenant Governor in Council. The centres receive 100% of their operating funds from the Ministry of Health and Long-Term Care, with total annual provincial budgets of approximately $1.2 billion.

Each year, Ontario's 42 community care access centres provide coordinated access to health and support services to approximately 500,000 clients to assist them to live at home and maximize their independence. In addition to being responsible for in-home care, CCACs also manage approximately 25,000 placements in long-term-care facilities, provide health services to children in schools, provide information about other community services, and refer clients to those services when appropriate. Last year, CCACs arranged 6.5 million nursing visits, 15 million hours of personal support and homemaking, and over 1.3 million therapy visits.

The vast majority of CCAC funding is used to provide home care services, with three key objectives: First, hospital substitution to prevent the need for hospital admission or enable people to return home from hospital sooner; second, maintenance to enable people with long-term health care problems and functional disabilities to live as independently as possible in their own homes, and prevent or delay the need for long-term care placement; and third, prevention to promote wellness and avert deterioration of health to higher levels of care, and to support family caregivers.

CCACs interact with all other parts of the health care system: physicians, hospitals, long-term-care facilities, school boards, community service agencies and health service providers. CCACs provide coordinated care through our case management system and have major responsibilities in assisting individuals to navigate the health care system. CCACs manage over 1,000 contracts with nursing, personal support and therapy service providers for the delivery of services that are responsive to the changing needs of our clients and meet consistent quality standards.

Mr Chair, let me begin my comments by stating our support for the principles outlined in the preamble to the legislation. We strongly support the need to evolve to a full continuum of health care that goes beyond hospitals and physicians, and includes access to primary care, home care and catastrophic drug coverage. We also believe that collaboration between government, health care providers and consumers is essential to the development of a seamless, responsive and sustainable system of health care.

We support the creation of a health quality council to monitor and report on the effectiveness of the health care system in meeting key goals and improving population health. Although we can see the wisdom in creating a council with an expert membership that does not include health care providers, we are hopeful that there will be opportunities for providers to give advice and assistance to the council in the development and measurement of performance indicators.

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CCACs are also committed to being accountable to their local communities, their health care partners and the Ontario government for the efficient delivery of high-quality care and the wise and prudent use of public funds. As statutory corporations, CCACs are accountable to the Minister of Health and Long-Term Care through a memorandum of understanding signed by the minister and deputy minister and the board chair and executive director. In addition, CCACs prepare annual business plans and provide detailed monthly, quarterly and annual reports to government on spending and service activities.

This year the OACCAC developed a provincial database using data from CCAC monthly activity and expenditure reports and has begun providing comparative feedback to each CCAC on its own performance in relation to its peer organizations across the province. The board of the OACCAC has established a performance indicators committee to begin to develop meaningful and reliable key performance indicators for CCACs and for interested and concerned government officials, as appropriate.

However, as the minister noted in his comments to this committee last week, accountability is a two-way street. It is important that the accountability relationship between government and health care providers be focused on trust, collaboration, learning and improvement, and not simply on command and control.

In building a system that fosters collaboration and innovative approaches to system integration, we also believe it is important that the accountability relationship between the government and major health care providers be consistent, fair and, above all, workable. To this end, we believe that Bill 8 provides an opportunity for the government to reconsider and amend some of the

accountability provisions of the Community Care Access Corporations Act, 2001, that result in CCACs being treated quite differently, and perhaps inappropriately, from our other health care partners.

Under the CCAC act, CCAC executive directors are appointed through the Lieutenant Governor in Council. CCAC boards are obliged to employ as the executive director the person appointed by the Lieutenant Governor in Council and are obliged to terminate the executive director's employment if the term expires or the appointment is revoked. In addition, the minister, not the board, is responsible for fixing the salary, benefits and other remuneration of the executive director.

Our experience has been that this framework creates a system where accountability relationships are dual, often ambiguous, and board governance responsibilities are diminished. This approach also results in a corresponding increase in government obligations in administering the appointment process which are both unwieldy and place an additional burden on the public system. There is a high degree of uncertainty and instability, as appointments tend to be reconfirmed, without future terms and conditions stated, within days of the expiration of the current term. In fact, this month, 14 senior executives had OIC appointments extended the day they expired. This is no way to build morale.

Within this framework it is difficult to attract new executives from outside our sector. As it is, almost all the executive director vacancies in our system since the proclamation of the CCAC act have been filled by internal candidates. They are highly qualified individuals, but over the long term our sector will be strengthened by an ability to draw upon people with a wide variety of skills and experience.

In reviewing the performance agreements between the British Columbia Ministry of Health Services and health authorities, the BC Auditor General commented on the risks associated with ambiguity in the accountability of chief executive officers, stating: "Traditionally, boards decide on CEO appointments, terminations and remuneration. Again we found it was unclear whether the CEOs are accountable to the boards, the minister, or both. This situation creates a number of personal risks. One is that the boards can be bypassed in strategic decision-making, becoming advisory boards rather than governing boards. Another is that the CEO will receive conflicting messages. A third risk is that the CEO will view his or her job as that of managing the board on behalf of the ministry, rather than reporting to the board."

In his remarks to the committee last Monday, the minister suggested that amendments would be forthcoming that would mandate the creation of accountability agreements between the minister and boards, with a requirement for separate performance agreements between boards and chief executive officers. We believe this is the right approach to promote clear, unambiguous accountability and to enhance board responsibility for governance.

The minister further intimated that direct government intervention in CEO employment and compensation would only occur in exceptional circumstances where all other recourse has failed. This is at odds with the current provisions of the Community Care Access Corporations Act that give government the ultimate authority for CCAC executive director employment and compensation.

Bill 8 provides for an opportunity to supersede those provisions of the CCAC Act, 2001, that are contrary to the expressed intentions of this government and would greatly improve the policy and working environment as seen by CCAC boards and executive directors. An amendment would strengthen and clarify the accountability model for CCACs, provide greater stability, and provide an intensely satisfying morale booster. The bottom line is that boards cannot be held accountable for that which they don't control.

In conclusion, let me express my appreciation again for the opportunity to appear before this committee and share our experiences.

The Chair: Thank you very much, Mr Libbey. You've used up about 11 minutes. Each party will have three minutes. Ms Martel, you're first.

Ms Martel: Thank you for being here today. I see you're specifically recommending that section 10 be repealed. Section 10 deals with the minister's appointments of executive directors only.

You wouldn't be surprised to hear me as a New Democrat say that I think there are some other provisions that should also be repealed, specifically the provision where the minister appoints the whole board as well, and where the minister controls what kind of information is provided. We opposed Bill 130; I continue to. I think that other health care organizations elect their board under the Corporations Act, and the same thing should apply to CCACs. So I don't want to offend you; that's not my intention, but you need to know where I'm coming from. The government shouldn't just go partway. The government should repeal the bill, because it was clearly used as a mechanism to control CCACs and the flow of information.

So let me ask you this, given that you've talked about executive directors, and I agree: What do you think about going the whole nine yards and dealing with the repeal of the other sections that allow for appointments instead of election of boards and that allow for the minister to control the flow of information rather than having some of that information which is public actually be publicly disclosed again?

Mr Libbey: If I may, we're not asking for that at this point in time. Clearly, we used to operate under that model before Bill 130. My sense is that that's quite an acceptable way to manage health care governance. I think the OACCAC's position is that we need accountability for health, and we'll stand behind that, regardless of how the government chooses to arrange the governance.

Ms Martel: But surely accountability has to do with reflecting the positions and the values and the input from the community, and it's hard to argue that that is happening if the minister, sitting in Toronto, is making

the appointments. I think if you really want to talk about accountability at the community level, that also has to mean having an election, having a general meeting, selling memberships, allowing people to participate and come forward and try to get on the board. Do you agree?

Mr Libbey: I can support your position, but also recognize that the Lieutenant Governor in Council appointments are members of the community, and so they do bring some of those values to the table.

Ms Martel: They do, but forgive me; what I saw happen in our community was that everyone who was appointed essentially ended up having a Conservative membership. I remain unconvinced that that was the best way to proceed. Yes, they might have held different positions in the community, but it was hard to argue that they had been democratically elected on any level.

If we're talking about a bill that talks about medicare and accountability—and there are a lot of sections I disagree with in this bill—I think we should be moving that other step to make sure that your organization, like other health care organizations, has a democratically elected board and an annual meeting and disclosure of information under the Corporations Act.

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The Chair: Thank you, Ms Martel.

Mr Heinz Schweinbenz: If I may answer that question also.

The Chair: Very, very briefly.

Mr Schweinbenz: In our particular case, both governments, the previous government and this government, looked to the chair for nominating people who would be acceptable to the government. I know in the ideal world it didn't always happen that way, but in our particular case, in both governments, we did get the people we nominated.

Ms Wynne: I suspect that some of this conversation goes beyond the bounds of Bill 8, so I'd like to ask you a question, because there's been a lot of talk about the silos of health care and the fracturing of health care in our communities.

You make a comment about coordinated access to health care, and certainly that's one of the things that we're interested in. Can you talk about, from your perspective, how that coordination could be better? How could we better coordinate all the services? My understanding from some of the delegations we've heard is that there actually has been a fracturing over the last eight years; it hasn't become more coordinated and the silos haven't broken down. Certainly putting this accountability framework in place is part of what we're trying to do to rein some of that in and make sure that the health care dollars go where they're needed, and in order for that to happen, there has to be coordination. Can you talk about, from your perspective, how things could be better coordinated?

Mr Libbey: A couple of ways. The first is that one of the things that's vested with community care access centres is case management—or care management, if you like. So that particular service that we provide for clients in the community is a way of connecting or providing the system navigation that I referred to earlier in the report to help those people move seamlessly through the various aspects of health services that they need. That's one of the ways.

The other way is that I think we're starting to find that many of the community care access centres are now starting to look at the more advanced management techniques of balanced scorecarding. By doing that in conjunction with other similar-minded organizations, they start to find that they're talking the same language. Those objectives that come through balanced scorecarding are not just the financial ones, but are the ones that talk about the clients and the quality of care. So those are the kinds of things that are happening.

Ms Wynne: Do you see an opportunity with this framework to possibly have accountability agreements with a number of providers or a number of organizations that would have agreements that would have as their goal improved coordination? Is that even a possibility from your perspective? I'm not sure what balanced scorecarding is.

Mr Libbey: For example, that's one of the objectives that our community care access centre from the eastern counties has put in place, that and improving our dialogue with physicians. Those are the kinds of things—whether you want to put them in an accountability agreement or not is hard to say, but essentially the objectives of system-wide coordination are things that CCACs, just by their general nature and where they are positioned, always want to do and get involved in. So anything you can do to make that easier for us, I think, is better for the client.

Mrs Witmer: Thank you very much, members of the CCAC, for being here today. I just want to make a comment. I would disagree with what Ms Wynne has just said. I think in recent years the government has made a tremendous effort to break down the silos and move toward a continuum of care, starting, obviously, with the provision of services to keep people healthy such as introducing the universal flu vaccine, free to everybody, introducing primary care family health networks, then moving into the hospital sector, then moving into the home care sector, the CCACs and long-term care. Certainly the investments that have been made in long-term care and home care in recent years are far in excess of what we've seen in the rest of Canada. So I think we need to continue, and I hope this government will continue, to move forward in providing that continuum of care.

Your concerns about the appointment of the executive director make me a little bit nervous as to the power that the minister is going to have under this new Bill 8. In some respects, the problems that you've had with your executive director and the lack of accountability that he or she has to you are what the government is envisioning is going to happen by the new CEO of the hospital having this accountability arrangement with the minister. I guess I hear you saying it didn't work, it doesn't work, and yet the government almost seems to be going that

way, where the CEO would have to be accountable to the minister. In some respects, this would mean that the voluntary governance structure in hospitals would no longer have the same relationship with the CEO.

Mr Schweinbenz: To answer that specifically, we're here to see that Bill 8 might be an opportunity to correct a flaw in Bill 130.

Mrs Witmer: Right.

Mr Schweinbenz: The appointment of the executive director, sometimes without consultation with the board as to who their choice is and so on—in Niagara it has taken a long time to fill that vacancy, partly because they couldn't attract the person, but partly because they had no say in the end. So we're seeing Bill 8 as correcting a flaw in some other legislation. And yes, we're an example of what other people have been saying to you.

Mrs Witmer: Yes. And do you know what? I don't disagree with what you're asking for. I think we should give serious consideration to taking a look at making sure that individual is appointed or hired in a different manner, and I would support you in making the board much more responsible and making sure that position is more than just advisory.

The Chair: Thank you for coming today.

We've had a little change in the schedule. Instead of coming back at 2 o'clock, we don't need to be back until 2:20.

The committee recessed from 1248 to 1421.

ONTARIO ASSOCIATION OF MEDICAL LABORATORIES

The Chair: Ladies and gentlemen, if we can come to order again. Our next delegation is from the Ontario Association of Medical Laboratories: Paul Gould, chief executive officer; and Ken Kirsh, board member and executive vice-president of Gamma-Dynacare Medical Laboratories. Come forward and make yourselves comfortable. You get 20 minutes to make your presentation, and you can use that time any way you please. If there's any time left over after the presentation, we would use that time for any questions that members of the committee may have. We do that on a rotational basis. The floor is yours.

Mr Paul Gould: Good afternoon. My name is Paul Gould. I am chief executive officer of the Ontario Association of Medical Laboratories. With me today is Ken Kirsh, a member of our board and co-chief executive officer and executive vice-president of Gamma-Dynacare Medical Laboratories.

I should like to begin by expressing my appreciation to the members of the committee for the opportunity to speak to you today on behalf of the OAML and its members, Ontario's community laboratories. Our member laboratories help serve the diagnostic needs of over 15,000 physicians, practical registered nurses and midwives by performing diagnostic tests on more than 14 million patients annually through our network of more than 400 patient service centres throughout the province. We provide services to residents in over 500 licensed long-term-care facilities and we provide in-home services coordinated through the community care access centres.

The OAML supports the principles underlying Bill 8 and the government's intent to develop a transparent and accountable health system for Ontario. Our members pay taxes too. We want to know that our taxes are spent in such a manner that we have the best health system for dollars spent in the world. The people of Ontario deserve nothing less.

The OAML is supportive of the creation of a quality council to provide the people of Ontario with an assessment of the performance of the health system as a whole and believes the government has made a wise decision in establishing such a body. We agree with the principles of mutual accountability and transparency within the health system. We as an industry have entered into funding and service agreements with the Ministry of Health for the last decade. Each of these agreements has specified annual amounts that community laboratories will be paid for the delivery of all OHIP-insured laboratory services. Each has also specified certain initiatives that the OAML and the community laboratory sector as a whole must undertake to promote best-use testing, codified service delivery or to participate as an active partner in the laboratory reform process.

More recently, as part of the laboratory reform process, our members have committed to entering into laboratory provider service contracts with the ministry. These contracts reflect much of what is being contemplated in the accountability agreements described in Bill 8. Service expectations, service standards, accessibility of services and reporting requirements are all among the elements contained in these contracts.

Ontario's community laboratories have been at the forefront of the reform of the health system. We have worked with successive Ministers of Health to ensure that the laboratory services available to patients in their own communities are of the highest quality, reliable and accessible. During the SARS outbreaks of 2003, community laboratories demonstrated that we are the surge capacity in the system by providing testing to hospital outpatients when hospitals were forced to close. We were approached by the Ministry of Health to help and we stepped into the breach, no questions asked. Such is the nature of our relationship. We are partners with the Ministry in the delivery of health services.

We support the minister's decision to expand the application of accountability agreements to other designated health resource providers. There are several sections of this bill, however, that are a cause of concern to us. We are pleased that in his address to this committee on February 16, the minister recognized some of our concerns, and we look forward to seeing the specific amendments that will be tabled on March 9. We understand and support the government's need for accountability for health dollars spent, but we are disturbed at the extent to which the bill, as currently drafted, seeks to impose ministry micromanagement of the health system.

We have concerns with the provisions of section 14 respecting the role of the general manager of OHIP with

respect to the information he or she might decide to collect. There is no limitation on the generality of the power delegated to the general manager of OHIP. This is particularly troublesome since this section requires that providers report data on uninsured services that they provide to insured persons to the general manager of OHIP. Community laboratories are licensed to provide services that are not insured by OHIP. It is already a condition of our licensing that we report annually to the ministry the total numbers for each uninsured service that we provide. We view this section as overly intrusive. It allows the general manager of OHIP to access proprietary financial information as well as personal information about health services provided which are not reimbursed by OHIP.

We are concerned at the provisions of section 21 that allow for ministerial imposition of accountability agreements which will be deemed to have been arrived at mutually. Section 24 allows the minister to terminate or vary the terms of any accountability agreement.

We are concerned with the provisions of section 22 respecting compliance directives. These sorts of provisions might be necessary in a state of declared provincial or local emergency, but we are concerned, once again, that there is no limitation on the generality of ministerial power. We are concerned that section 29 of the bill would allow the minister to collect and disclose proprietary financial information.

We will be reviewing the amendments tabled on March 9 to be assured that our concerns are addressed. The minister has declared to this committee that Bill 8 will be subject to the provisions of the Health Information Protection Act, Bill 31. This will impose severe limitations on the ability of the general manager of OHIP to collect personal health information. We have been told that the minister will not be permitted to collect personal health information. We are pleased that the minister recognized the need for changes to these sections and we welcome the promised amendments.

We also welcome amendments that reflect that the ministry does not intend to micromanage the delivery of health services through the imposition of accountability agreements. We appreciate the minister's clarifying comments with respect to responsibilities and accountabilities of CEOs and the boards of directors.

I will conclude by saying that success in addressing the challenges facing our health system today requires mutual accountability and transparency on the part of both providers and government. The accountability framework, however, must be fashioned within a partnering, not an adversarial, paradigm. The minister rightly pointed out that the tone of certain sections of Bill 8 must change. We would suggest that the detailed elements of Bill 8 must also reflect the partnering paradigm.

Thank you for your time this afternoon.

The Chair: Thank you, Mr Gould. You used up about eight minutes, which has left us with 12 minutes. That'll be four minutes for each party, starting with Ms Wynne.

Ms Wynne: I'm hoping that a number of the amendments that come forward will meet your requirements, sections 21 and 22 in particular. I just wanted to make you aware of what we're proposing.

Under section 21, we're suggesting that the independence of the governance structure would be maintained. So the health resource provider could be required to have a performance agreement with its CEO that's consistent with key performance requirements contained in the accountability agreements. So the accountability agreement would be between the ministry and the board, and the performance agreement would be between the board and the CEO. So that will be clarified.

In section 22, we're going to clarify what the procedure is by which that accountability agreement is put in place. You talk about mutuality and the need for a discussion, and that's exactly what we're proposing. Is that the kind of amendment you're looking for?

1430

Mr Ken Kirsh: Let me just clarify the point about the boards and the CEOs. A lot of the health providers in the province, including our members, are private corporations. So the boards of directors and CEOs often sit in the same shoes, and I don't quite understand how that's going to affect us or why it should affect us. There should be an accountability contract between the corporation directly and the ministry. It really has nothing to do with the CEO. I think that's something from another sector of the health care system that shouldn't affect us and really has no place within private corporations. I'm not sure the amendment deals with that.

Ms Wynne: So, in terms of an accountability agreement, what's the framework, then, you're looking for?

Mr Kirsh: We think the accountability contract should be directly between the ministry and the corporate entity. It has nothing to do with the board or the CEO; that's not the paradigm we live in. The board of a corporation may or they may not fire their CEO over meeting the accountability contract, but that's up to the corporation to decide. It's up to the ministry to decide whether or not it wants to penalize in some way shape or form that corporation for not meeting the accountability. It has nothing to do with the CEO directly.

Ms Wynne: Even in the paradigm that I was talking about, the accountability agreement doesn't have anything to do with the CEO directly. The CEO is not the person who has the accountability relationship with the ministry.

I think one of my colleagues has a question.

Mr Bob Delaney (Mississauga West): I have a question for you on your brief. You state on page 4, "The minister has declared to this committee that Bill 8 will be subject to the provisions of the Health Information and Protection Act.... This will impose severe limitations on the ability of the general manager of OHIP to collect personal health information." On page 3 you say, "There is no limitation on the generality of power delegated to the general manager of OHIP." Could you explain for me this apparent discrepancy?

Mr Gould: I'm making the distinction between the way the bill is currently drafted and the comments of the

minister when he appeared before the committee on the 16th. In his remarks he made reference to the fact that the minister himself would not be able to access personal health information.

Mr Delaney: Thank you for the clarification.

Mrs Witmer: Thank you very much for your presentation. I see that in the case of your association this bill does have some negative implications and that you would ask the minister to address these. You talk about section 14 and the role of the general manager of OHIP. I wonder if you could just explain to the committee why this is so troublesome. I know there is a paragraph here, but maybe you could just give us some examples of what you mean here.

Mr Kirsh: The uninsured services would be the critical issue. We are licensed to perform uninsured services, but they are uninsured. We do submit the total number of services rendered that are uninsured to the ministry so they know what's generally happening. They can do broad-based studies of what kind of testing is going on in the community. But, on the other hand, the proprietary information that's generated for the physicians that order that service, as well as the financial information that goes behind that, is not paid for by OHIP, has nothing to do with OHIP, and those are direct decisions of the ministry not to have OHIP involved in those. There don't appear to be any limitations on the general manager in terms of collecting that information. So there's a disconnect there, a direct disconnect. That's the example.

Mrs Witmer: Why do you think the ministry would have written section 14 in this way to also apply to uninsured services? If I take a look at the amendments proposed thus far, it doesn't seem that the ministry has yet recognized that this is troublesome.

Mr Kirsh: I honestly don't know what they were after. We just think it's a definite overreach, from our perspective.

Mrs Witmer: If there were one section contained within this bill that you find more troublesome than any other, which one would you be most concerned about as it relates to your association?

Mr Gould: I think the access to information outside the health insurance scheme.

Mrs Witmer: So the section 14 that I've just referred to? Are you satisfied, after you've listened to the government, with some of the changes they're saying they're going to be making to sections 21 and 22?

Mr Gould: We're certainly encouraged to hear that the process will be dramatically changed. Until we see the specific amendments, I can't comment further, but it seems to be moving in the right direction.

Mrs Witmer: I guess once the amendments are going to be introduced, if that's the direction we take, do you believe that an association such as yours should have another opportunity to review the bill, as it is amended, before it would proceed any further?

Mr Kirsh: We would always be happy with a second crack, if there was one given, absolutely.

Mrs Witmer: What about the regulations? Do you have concerns about the number of regulations, that obviously we have no idea at the present time what they may or may not look like?

Mr Kirsh: It's always the detail, the devil is in the detail, and it's true, vis-à-vis regulations versus legislation. For sure we would be going over it with a fine-tooth comb and hope to have some method of speaking to the government on that issue.

Ms Martel: Thank you, both of you, for being here today. I want to begin with your laboratory provider service contracts. Are those actually in place now, or are they still being negotiated?

Mr Kirsh: They were negotiated through the laboratory reform process. The board of our association actually agreed to the format and form of those contracts about two years ago. They still have not yet been finalized with the other members of the reform process; that would be the Ontario Hospital Association and the Ontario Medical Association. Our board is on record as approving those contracts.

Ms Martel: What's the government's role, then?

Mr Kirsh: The government's role, I assume, at this point—again, just an assumption—is to get the OMA and OHA to agree to those.

Ms Martel: So they're not a direct signatory themselves?

Mr Kirsh: No, in that case they're not. In fact, the OAML is not either; it's the individual providers. But to be fair to that process, it is wrapping up in the next three or four months. The final regions of Ontario, the last three regions—there were nine regions dealt with in the reform process—are now wrapping up, so I would expect that in the spring those contracts will be signed.

Ms Martel: I'm interested because you said—

Mr Gould: Could I just clarify for a moment, just in case you didn't understand? The final signatories to the contract will be the Ministry of Health and Long-Term Care and the provider directly.

Ms Martel: But are there terms and conditions for the ministry that are outlined as well? Do they have terms and conditions that they have to meet as part of this? Or are they setting out essentially your obligations and responsibilities?

Mr Gould: The ministry will be committing to a level of funding.

Ms Martel: Will that be articulated right in the agreements, the funding level?

Mr Kirsh: No, there may be cross-reference to the funding agreement but not directly within the provider contract that we talked about, the service standards and accessibility.

Ms Martel: OK. So this process has been negotiated, not imposed?

Mr Kirsh: That process was negotiated, yes.

Ms Martel: Right. The reason I ask that is because you said these contracts reflect much of what is being contemplated in the accountability agreements in Bill 8. You would hope that.

Mr Kirsh: We would hope so. I think we're leading the wave of accountability, and when we saw the bill, we had actually hoped to have some method of showing those provider contracts to the government and saying, "Does this meet with your criteria?" It certainly met with the criteria of the ministry itself when we negotiated them, and knowing that accountability was a critical issue down the road a couple of years ago, I believe that's what they were contemplating. Our view is that they are good contracts. We did agree to them, and we would hope other people would go as far as we went, in fact. We think we've gone quite far. Our view of it would be, here it is, it's a shining light of what we think should be there.

Ms Martel: The reason I raise that is because I think if that's a model that can be looked at, it should be, especially if it was one that was negotiated by the parties, not imposed.

The concern I continue to have has to do with the lack of clarity that I think the minister has provided around the sections that Ms Wynne referenced. I think it's important that I read into the record the rest of the piece that she didn't, so that you will understand the concern. I don't know if you got a copy of this February 19 document that the minister provided through the parliamentary assistant to members of the committee. It came because the minister said last week he was going to try to give us some sense of where he was heading with amendments.

Perhaps, if you didn't see it, you would want to take a look at page 2—actually the third page, section 22, is the one I'm most interested in. It says, "Include notice and other due process provisions"—this, by the way, is with respect to the accountability agreements, all right?—"including time frames for notice, to address development of accountability agreements, issuance of compliance directives and orders (eg discussion process, meetings, exchange of documents/information, representations"—and here's the key—"that the minister has to consider before issuing a compliance directive or an order)." So there's nothing in there that suggests to me that these are going to be negotiated—quite the contrary. The same concerns that we've been hearing so far, that the minister can issue orders and compliance directives, still seem to be in place. The only difference seems to be that he can consider a few more facts before he does that. Does that section concern you?

Mr Kirsh: This is the first time we've seen this, but our agreement itself, our accountability contract if you want to call it that, talks about negotiation and binding arbitration. It does not talk about directives.

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

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ONTARIO ASSOCIATION OF OPTOMETRISTS

The Chair: If I can call forward now the Ontario Association of Optometrists, Dr Shirley Ha and Dr Christopher Nicol. Make yourselves comfortable. You have 20 minutes. You can use that any way you choose. Any time that's left over will be split among the parties.

Dr Shirley Ha: I'd just like to start by thanking everybody. Thank you so much for allowing us the opportunity to present before the standing committee today. My name is Dr Shirley Ha. I'm an optometrist in practice in St Catharines and vice-president of the Ontario Association of Optometrists. With me today is Dr Christopher Nicol, an optometrist in practice in Bolton and a policy consultant with the OAO.

We welcome this chance to provide the members of the committee, and ultimately the Ministry of Health and Long-Term Care, with our input on Bill 8, the Commitment to the Future of Medicare Act, 2003, as it affects the delivery of and payment for professional eye care services for Ontarians.

Optometrists are front-line, primary eye care practitioners who are responsible for most primary eye and vision care in Ontario. More than three million patients visit an optometrist in Ontario annually for services that include comprehensive eye examinations and treatment in the areas of refractive status, oculo-motor status, sensory status and the physical health of the eye. Patient care also includes the diagnosis and management, in cooperation with physicians, of the ocular manifestations of certain systemic disease, including diabetes and hypertension.

The OAO is a voluntary professional organization that represents over 1,000 registered optometrists in every region of Ontario. In addition to providing resources and continuing education to its members, the OAO is committed to raising awareness of optometry and educating the public about the importance of professional eye care.

Let me give you a little bit of history about the funding of eye care services in Ontario. The provincial government, through a funding agreement under OHIP, currently pays for the majority of diagnostic services provided by optometrists to Ontario residents. The OAO is the organization responsible for negotiating the fee schedule with the Ministry of Health and Long-Term Care on behalf of the profession. OHIP funding for the provision of comprehensive eye examinations has not increased in 15 years. During that time, there have been significant advances in technologies and testing to diagnose eye conditions and diseases, the costs of which the profession is subsidizing out of its own pockets.

The fee for service paid to the optometry profession no longer comes close to covering the cost of providing eye care, and the profession is increasingly concerned about the ability to maintain the standards of care set out by the College of Optometrists of Ontario.

Over the past 15 years, the Ontario government's approach to the issue of funding for optometry services has been frustrating, ineffective in meeting the needs of patients and unfair to the profession.

Currently, Ontario optometrists are operating without a signed funding agreement with the provincial government, the most recent of which expired March 31, 2000,

and the optometric fees for OHIP-insured services are unchanged since 1989. The fees for minor assessment, currently frozen at $19.25, have not for several years covered optometrists' overhead costs. The fees for oculo-visual assessment, currently frozen at $39.15, do not provide for fair or reasonable compensation for optometrists' professional services once overhead is calculated.

When one considers inflation, optometric fees in Ontario have not only been steadily declining over the past 15 years, they are now the lowest in the country. As the population grows and ages, the demand for optometric services will only increase and it will become more and more difficult for optometrists to put the required investment into new capital equipment to keep them current with the college's rigorous standards. The OAO is not suggesting that standards should be lowered, but it is unfair to penalize Ontario optometrists for ensuring that they meet or exceed patient care criteria. This is not being asked of other health care practitioners.

Optometrists, unlike, for example, chiropractors, cannot bill any portion of their expenses for an insured service to their patients. And unlike physicians and dentists, optometrists are not afforded the protection of provisions in the Canada Health Act which guarantee reasonable compensation for insured services. You may say that optometrists are in a unique bind. They are caught up with physicians and dentists in the Health Care Accessibility Act, without having the protection of the Canada Health Act.

This brings us to a consideration of the bill before you and the provisions made in it with respect to the profession of optometry. The OAO is currently concerned with Bill 8 as it relates to funding issues for optometry. Accordingly, I will begin with the comment on those aspects of Bill 8 that are most important to this profession and found in part II.

Part II, health services accessibility, sections 7 and 9: For optometrists, the present Health Care Accessibility Act is the most draconian of any legislation to ever affect the profession of optometry. For the past 15 years optometrists have been in a virtual state of bondage to the provincial government and forced to accept insufficient payment for services that the public regard as vitally important. Despite years of attempts at negotiation, the amount payable for an optometric insured service has not changed since 1989.

Presently, the amount payable for insured optometric services does not provide fair or reasonable compensation for those services, as the amount payable no longer covers the cost of providing the insured service.

The lack of any fee increase for 15 years has created a crisis situation for optometrists with respect to acquiring and maintaining the specialized instrumentation necessary to provide the appropriate quality and standard of eye care required of optometrists by the College of Optometrists of Ontario.

Under present legislation, the Health Care Accessibility Act, optometrists are explicitly prohibited in the statute from billing in excess of OHIP rates, or what they call balance-billing, and receive a fixed payment for any and all services defined as insured services by OHIP. Optometrists, like physicians and dentists, cannot balance-bill or charge a patient more than the amount payable established by regulation. Physicians, unlike optometrists, have had periodic increases in amounts payable for insured services since 1989. Very few dentists receive payments from OHIP. Non-designated practitioners like chiropractors and physiotherapists can balance-bill and are able to offset rising practice costs with private fees.

This inability for optometrists to balance-bill has prevented optometrists from maintaining a sufficient income to adequately cover practice costs.

With the proposed changes under Bill 8, optometrists will no longer be specifically designated as practitioners that cannot balance-bill. The proposed changes in sections 7 and 9 of Bill 8 will provide an opportunity to permit the designation of optometrists as non-designated practitioners for the purposes of accepting payment.

The OAO supports sections 7 and 9 of the bill. Furthermore, the OAO recommends that once Bill 8 becomes law, an optometrist will assume the definition of non-designated practitioner for the purposes of the act, at least until such time as outstanding funding issues have been resolved to the mutual satisfaction of all parties.

Section 10: While this section states that the minister may enter into fee negotiation agreements with associations for determining amounts payable under OHIP, there is nothing in this section that compels a negotiated agreement or provides for recourse if negotiations break down. Consequently, health care practitioners, like optometrists, may never obtain an increase in the amount payable for an insured service, despite increases in cost of living and practice expenses.

The OAO recommends that section 10 be amended to permit some form of recourse, like compulsory arbitration, should fee negotiations fail to result in an agreement.

Sections 11 and 12: Subsections in this part permit the general manager to recover monies from an optometrist without the benefit of a hearing under the Statutory Powers Procedure Act, the SPPA. The OAO opposes any requirement to repay unauthorized payments and to pay administrative charges without the ability to request a review under the SPPA.

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Section 14: This section provides authority to the general manager to require any person or entity that renders an uninsured service to an insured person—this is virtually everyone in Ontario—to submit any information to the general manager. The requirement to disclose information on uninsured services seems unreasonable in legislation that deals specifically with insured services. Furthermore, failing to comply with a request for information on an uninsured service is subject to a suspension of payments for insured services under the plan. Health care professionals should continue to have autonomy over the establishment and application of fees and

charges for services that are in the public domain and not designated as insured services. Additionally, "uninsured services" is not defined for the purposes of this part and could mean anything that the minister decides. The OAO recommends that any requirement for the disclosure of information be limited to information related to insured services. This section should be completely removed from the bill.

Section 15: The prohibitions contained in subsections (1)(a), (b) and (c) are not matters of patient health and safety and should not be subject to mandatory reporting requirements. The OAO suggests that mandatory reporting requirements in this section are unnecessary and should be removed.

Section 16: The definition of a block fee could include uninsured services that optometrists routinely provide to their patients. Contact lens fitting fees and fees for orthoptics or vision training procedures are global fees that are set fees, regardless of how many services are provided. Presently, the College of Optometrists of Ontario regulates fees and charges through professional misconduct regulations specific to the practice of optometry. Uninsured services are not subject to prohibited fixed-fee regulation. Furthermore, the possible penalty of imprisonment for charging a block fee seems excessive, considering the offence. The OAO recommends that for optometrists any regulation of block fees should remain within the authority of the College of Optometrists of Ontario.

Going back to part I, the Ontario Health Quality Council, the OAO supports the establishment of a health quality council. The minister should have timely access to information on the availability of health care resources in order to make informed decisions. Once established, the council could commission appropriate research on public eye care needs amid health human resources in the eye care professions.

Part III, accountability: While accountability is an essential component in the delivery of health care, for optometrists and other regulated health care professionals, accountability is the responsibility of the profession's regulatory authority. Optometrists are accountable to the public through registration with the College of Optometrists of Ontario.

A "health resource provider" is defined as "any corporation, agency or entity that provides directly or indirectly, in whole or in part, provincially funded health resources." This definition does not appear to include optometrists; however, the inclusion of "entity" and "any other prescribed person" in the definition of "health resource provider" could be interpreted to apply to a non-individual like an optometric practice or clinic or partnership. The OAO recommends that accountability agreements under this part should not apply to optometrists, either as individual practitioners or as group practice under a clinic designation. The relevant sections should be amended to clearly identify the intended parties.

Part IV, amendments to Health Insurance Act, section 40(2.1): This section gives authority to the minister to arbitrarily and unilaterally amend a schedule of fees in any manner considered by the minister as appropriate. The order could remain in effect for 12 months. While this authority is contained in present regulatory powers, the authority to unilaterally change a negotiated fee seems unfair. The OAO recommends a change to this section to permit an order to amend a schedule of fees for an amount not less than the amount established by either agreement or negotiation.

In conclusion, the OAO has offered nine recommendations for your consideration. Most important, we believe that the introduction of this bill allows the government to change the basis upon which it funds the services of optometrists, which would allow the immediate redress of a 15-year funding freeze. Thank you.

The Chair: Thank you, Dr Ha. We've got just over four minutes left, so I'm going to turn it over to Ms Witmer. Would you use up that four minutes?

Mrs Witmer: Thank you very much for your presentation. It looks to me like, in some respects, the lack of clarity in this bill doesn't reassure you that you're going to be covered, and yet in some respects, if you are going to be covered in certain sections, that's a cause for concern as well.

Block fees: Is this a big issue for you, the fact that that responsibility for the regulation could well be taken away from the college and given to the minister?

Dr Christopher Nicol: It's not a problem right now, although we do have regulations in the professional misconduct regulations at the College of Optometrists. We normally and usually provide services that would be considered to be block fees under this legislation. However, it leaves itself open to recognition of that; perhaps not a control of that, but at least of having the ministry identify that. We are concerned that there may be controls over that.

Mrs Witmer: How do you see this bill allowing for an immediate redress of this 15-year funding freeze?

Dr Nicol: Right now we are designated in the Health Care Accessibility Act as a practitioner that must only bill OHIP and receive the amount payable. Under Bill 8, that designation will be by regulation, so it will be out of the statute. If we are then by regulation not defined as a designated practitioner, we will be able to balance-bill. That would allow us, at least in the interim, to bill something in addition to the minimum amount that we receive now.

Mrs Witmer: However, not having seen the regulations, you're not quite sure how they're going to read.

Dr Nicol: That's correct. We would hope that this committee would recommend that in the regulations we be defined as non-designated practitioners.

Mrs Witmer: Thank you very much. I see that we haven't made much progress since 2001.

The Chair: We still have about two minutes left. Ms Martel?

Ms Martel: Can I ask you a question about how, right now, if you have a concern about having to repay money—I gather there's a provision for you under the

Statutory Powers Procedure Act. Is that an appeal mechanism? Can you explain that to me?

Dr Nicol: I'm not a lawyer—

Ms Martel: Neither am I.

Dr Nicol: —and I'm not totally aware of that, but it wasn't in the previous legislation. It's being introduced now. It appears, as I read it, that it will remove the ability of a practitioner to have due process in that it would allow for repayment without a review under the Statutory Powers Procedure Act.

Ms Martel: Tell me, what do you have in place right now yourselves, as an association? What is your recourse at this point if the general manager wants to recover monies? The fee schedule is in place; I don't know how you could possibly get around it. But what is the mechanism right now if the general manager would say to you that he feels there are billings that are inappropriate? What is your appeal mechanism now?

Dr Nicol: I understand that there is a review by the Optometry Review Committee that was established under the Health Insurance Act and then there is an appeal mechanism if the application of that review finds that a member has billed inappropriately.

Ms Martel: Is the Ministry of Health a party to that? Is the Optometry Review Committee outside of your own college?

Dr Nicol: That's a committee of the college.

Ms Martel: Let me ask a question about coverage, because I didn't understand this very clearly. I apologize. This is on your page 4, near the bottom, your second sentence: "And unlike physicians and dentists, optometrists are not afforded the protection of provisions in the Canada Health Act, which guarantee reasonable compensation for insured services."

Dr Nicol: As I understand, in the Canada Health Act there is a requirement that physicians and dentists receive adequate remuneration, and optometrists are not included there.

Ms Martel: Not listed in some way?

Dr Nicol: That's right.

Ms Martel: I'm sorry, I don't—

Dr Nicol: In the Canada Health Act.

Ms Martel: OK. I think that's it.

The Chair: Thank you, Dr Nicol and Dr Ha. Thanks for coming today. We appreciate it.

Ms Wynne: Mr Chair, I know that the time was used up, but I just wanted to clarify something because I didn't want people to leave with the wrong impression.

The Chair: OK, very briefly.

Ms Wynne: Yes, very briefly. As I understand it, you're assuming that this bill allows you the designation of non-designated practitioner. Is that right? As I read it, as I understand it, it may open the door for you to ask for that, but it isn't automatic.

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Dr Nicol: That's right. Under the present legislation, we are specifically identified and under this bill we wouldn't be. Therefore, by regulation we could be defined as a non-designated practitioner.

Ms Wynne: Right, but that would have to be another step. As I read your brief, I was worried that you thought that you would be automatically.

The Chair: I think we're all on the same page now.

Dr Nicol: Again, we would hope that the committee would recommend that.

Ms Wynne: It's absolutely your right to say that.

The Chair: Thank you for coming today.

COTA COMPREHENSIVE REHABILITATION AND MENTAL HEALTH SERVICES

The Chair: Our delegation who was scheduled for 3:20 has been kind enough to move up to the 3:00 slot. That is COTA Comprehensive Rehabilitation and Mental Health Services, Sandra Hanmer, who is the president and CEO.

Welcome. Make yourself comfortable. You've got 20 minutes to use as you see fit. Any time that is left over will be split amongst the three parties for any questions.

Ms Sandra Hanmer: OK, great. I'll just wait a moment as my brief is going around, if that's all right.

The Chair: No problem. Any time you're ready.

Ms Hanmer: Good afternoon, Mr Flynn and fellow committee members. As introduced, I am Sandra Hanmer and I'm the president of COTA Comprehensive Rehabilitation and Mental Health Services. Unfortunately, my colleague Mark Schroeter is ill today and not able to accompany me. I am, however, pleased to have the opportunity to provide you with our thoughts and ideas on Bill 8. Our intention today is to provide you with a brief background of our organization and share the unique perspective of a leading community-based provider on this proposed legislation.

COTA is a not-for-profit, accredited community health and social services organization. Established in 1973, we are a proven leader in providing comprehensive rehabilitation, mental health, and support services to people of all ages throughout the province of Ontario. Last year, we delivered client-centred care to over 21,000 individuals, enabling them to achieve greater independence by remaining in the community setting. While most of our programs are based in the greater Toronto area, we have recently extended our scope of service to London and Ottawa. This makes us one of the largest direct providers of community-based health care services in the province.

COTA interacts with all other parts of the health care system. Our rehabilitation services are delivered through our contracted partnerships with nine community care access centres across Ontario. The CCAC system represents 4.2% of Ontario's $28-billion health care budget. We also provide services to society's hardest to serve, such as those living with mental illness. COTA delivers site support, court support, hostel outreach, case management and aftercare programs that are all funded either through the Ministries of Health and Long-Term Care, Community and Social Services, or Children's Services. These transfer payments to organizations such as ours

represent an additional 1% of the provincial health care budget.

We are pleased to see the government recognize that in order for our health system to remain relevant and function as a system, it must encompass a full continuum of care, including home care and community services. National research studies continue to provide evidence that home and community care is a cost-effective alternative to hospitals, nursing homes and emergency rooms. Yes, we must keep our hospitals functioning to provide important acute care services, but we also require appropriate public policy and sufficient funding to support home and community care services. They play a critical role in assisting patients discharged from hospital and reducing readmission rates.

COTA supports a public policy that provides Ontarians with the right services at the right time. Our current health care system operates in silos, and we need to change that. Nowadays, there are many places other than hospitals where people receive health care: in homes, community organizations, workplaces, schools, and local clinics. An ideal system would deliver value for money by encouraging innovative local health care initiatives that create a seamless continuum of care for people living in local catchment areas.

Relatively speaking, COTA provides value for dollars by helping clients stay in the community longer and avoid more costly stays in hospitals and other institutions. Studies have shown that the average cost of one day of care in a hospital is $812, $117 for a nursing home, yet only $44 for home care. Evidence-based research has also demonstrated that when services such as community mental health, for example, are funded adequately, hospital visits can be reduced by up to 80% for that particular population.

COTA welcomes the government's support for an integrated, consumer-centred health system that ensures access is based on need and not on an individual's ability to pay. We strongly support the overarching principles and key provisions of the bill, including establishing the health quality council, embracing the five principles of the Canada Health Act, and adding accountability as a sixth principle.

I would now like to share our viewpoints on Bill 8 as it pertains to entrenching accountability, strengthening prohibition of two-tier medicine and establishing a provincial health council.

COTA supports the government's intent to strengthen the principle of accountability within our health care system. However, Bill 8 appears to be largely one-sided. It focuses on how to make health care providers more accountable to government, yet does not provide similar details on how the government will meet its obligations of ensuring the provision of health care. We feel that the accountability provisions of Bill 8 do not sufficiently recognize the interdependent nature of the relationships between all key players within the health care system and the government. We are, however, encouraged by the minister's recent admission that accountability is a collective responsibility that the government is prepared to share.

COTA already is a leader in accountability within the community health sector. We are committed to improving service delivery through ongoing research and quality improvements. We have invested in new technology to integrate our information management systems more efficiently, and we continue to build effective partnerships with other organizations—like the CCACs, the Ministry of Health and Long-Term Care, the Centre for Addiction and Mental Health, school boards and others—to develop health care solutions that are integrated, measurable and cost-effective.

We demonstrate accountability through our own performance. Last year, we were accredited for the second time by the Canadian Council on Health Services Accreditation. COTA was one of the first community-based organizations to receive CCHSA accreditation, reflecting our ongoing commitment to best practices and quality improvement in our service delivery. These performance indicators are also a measure of how we can share, in the community sector, standards that the government is looking for.

The government believes that the future strength of Ontario's health care system depends on all key players sharing responsibility and working together. However, the current provisions do not provide for shared accountability, and in fact appear at the moment to reduce the government's legislative accountability. Bill 8 must provide for more government accountability.

For example, there is no reference in Bill 8 to the minister acting in the public interest when implementing performance agreements. Yet it allows the minister to order fundamental changes in the health care system and issue compliance orders with little, if any, public consultation, procedural safeguards, transparency or other checks and balances. This is inconsistent with the commitment to a shared approach to accountability, as outlined in the November throne speech. We propose that if the government is serious about supporting the key tenets of medicare, this legislation needs to provide clear definitions of "accessibility," "universality," "quality" and "medically necessary." For a point of clarification, COTA also requests elaboration on the definition of "rehabilitation." It's our understanding that this includes case management but does not automatically apply to our rehab health care practitioners in the community.

We believe the health system should be accountable to the people of the province and not just the minister. An accountable health system must include diverse board representation governing health care sectors; full public reporting on health care finances; whistle-blower protection; public consultation and debate about changes to the health care system; and finally, stable, multi-year funding for all aspects of the health care system.

This last point is particularly relevant for COTA and other community-based organizations. Currently, there is no mention of the ministry's overarching duty to fund the system adequately, as set out in the Canada Health Act.

While Bill 8 purports to enshrine the accessibility criteria under the health care act, the government makes no reference to providing stable, multi-year funding for health organizations. For the last several years, funding for the community health sector has not been stable, nor adequate, and certainly not predictable. For example, reductions to funding for assistive devices have left many unable to access the tools they need to live independently. Inadequate home care budgets have led to harmful cuts in service and instability within the community sector.

This situation could become more critical if, for example, hospitals are required to meet specific service level targets in their performance agreements. Many of the clients we now serve have been recently discharged from hospital. If there are unexpected increases or or decreases in visit volumes, organizations such as ours may not have sufficient resources to recruit and retain qualified health professionals to meet the demand.

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Furthermore, home care budgets may not be sufficient to sustain the service increases. COTA recently experienced the aftershocks of CCAC cost containment strategies and knows only too well the challenges that visit volume fluctuations can pose. We therefore urge the government to revise the legislation to address the sustainability of the community support sector through stable multi-year funding.

We also request clarification on how this proposed legislation impacts governance. As a contracted partner with various CCACs, we expect our service agreements to reflect the accountability agreements the CCACs and the Ministry of Health and Long-Term Care will enter into. However, as mentioned earlier, we are also a transfer payment program. Will COTA be expected to enter similar accountability agreements directly with the ministry? If so, we feel this would seriously undermine the role of our board and be detrimental to good governance in our area. We therefore ask the government to clarify how this bill might impact community-based transfer payment programs.

We are encouraged by the minister's recent comments that Bill 8 is subject to the privacy protections in Bill 31. Currently, Bill 8 contains a number of provisions that permit the minister to collect, use and disclose personal information. This is a breach of privacy rights in Ontario and we recommend its immediate withdrawal.

COTA has some concerns around the current wording of Bill 8 to prohibit two-tiered medicine. This may prevent organizations from developing innovative and value-added solutions to address existing gaps in service delivery and create a more aligned and efficient health care system.

Again, for example, COTA currently receives transfer payment funding to deliver a mental health aftercare program and a geriatric mental health aftercare program. Both programs have been in existence since the mid-1970s and address an unmet need in our community. Our preventive services successfully target a non-acute client population no longer eligible under the existing visit cap set by the community care access centres.

The transfer payment dollars are not sufficient to cover the full costs of these programs, so, as an organization, COTA supplements the payment to our health care practitioners—the therapists. Individuals utilizing these services are not charged extra, but the health care practitioner does receive more money than what is available in the transfer payment funding. You might say that one solution would be to cap the number of people we serve and create waiting lists. However, I'm not convinced that's the intent of the proposed legislation. If the government is serious about recognizing home care as an essential part of our health care system, it needs to reconsider putting such legislative barriers in place that prevent future improvements to the system.

COTA supports the creation of a health quality council for Ontario and believes that it could play an integral part in enhancing the accessibility and accountability of our health care system. However, COTA is concerned with the proposed membership of this body. By prohibiting key players within the health care system from participating, the council may be denied critical knowledge and expertise required to understand the complexity of health care issues facing Ontarians. We would like to see this council comprised of all key players in the health care system such as patients, advocates and health care providers, obviously including the overlooked community and health care support sector.

We do not agree, as the minister has recently stated, that such a council membership would advance individual stakeholder agendas. Instead, we feel it would reinforce and support the government's position that our health care system is the whole of its complementary parts. COTA has over 30 years' experience delivering community-based health care and evaluating outcomes of our services. Organizations like ours could therefore offer a unique and necessary perspective to propose innovative solutions to improving and monitoring our health care system.

COTA would prefer to see the proposed role of the council strengthened. Currently, the council may make recommendations to the minister, but only in regard to future areas of reporting. We believe the council could be more effective by amending provisions in Bill 8 which narrowly limit its function and reporting powers. We propose that the council investigate how well the health care system conforms to the principles of the Canada Health Act. It should conduct its operations in a completely transparent manner and make recommendations to hold the government accountable.

In conclusion, COTA fundamentally endorses the intent of Bill 8 to enhance accessibility and promote accountability within the health care system. However, we take issue with the way in which these proposed changes place a disproportionate share of accountability on health care practitioners and limit their involvement in the health quality council. We propose that Bill 8 be amended to ensure that both providers and government

are held accountable to Ontarians for the health care they receive. We welcome and support the minister's suggestion of a 60-day consultation period on regulations.

Ontario is well positioned to introduce new ideas and models for health care whereby primary care, institutional care and community care all work together in a fully integrated, cost-effective health care system. We look forward to working collaboratively to begin repositioning our health care system for the future.

Thank you for your time today.

The Chair: Thank you, Ms Hanmer. We appreciate it. You've used up about 15 minutes, so why don't we start this time with Ms Wynne.

Ms Wynne: I just have a couple of quick comments and then my colleague Ms Mitchell has a question. Thank you for your presentation. On page 4 of your presentation, you talk about the public interest. One of the amendments that's being suggested is that public interest be put into the preamble of the bill so that it becomes one of the underpinnings. Would that go—

Ms Hanmer: Perfect. That would be great. Just the flavour of the tenets of "in the best public interest" was missing from the legislation, as we read it.

Ms Wynne: You talk about compliance orders and so on. Section 22 is going to be amended, and the general direction we're going is on more transparency and more clarity and what that process is going to be in terms of developing the accountability agreements and what the steps would be leading up to the issuance of a compliance directive or an order. So that's our attempt. A copy of the outline of the amendments is over on the other table if you want to take a look at it.

Ms Hanmer: That's great.

Ms Wynne: I'm going to let Ms Mitchell ask her question so we don't run out of time.

Mrs Carol Mitchell (Huron-Bruce): Thank you very much for the presentation. I have a very quick question, and it's on one of your comments: "If the government is serious about recognizing home care as an essential part of our health care system, it needs to reconsider putting such legislative barriers...." I would ask for further explanation of what you consider legislative barriers. It says, " ... in place that prevent future improvements...."

Ms Hanmer: One theme, as we were reading through the legislation, was the inability to continue providing solutions that we are currently providing by using some government dollars to provide a service and partnering with other parts of the health care sector to provide resources that aren't currently funded. The confusion seems to stem from where our practitioners, who are all therapists, fall in the definitions of what's covered by the legislation and what's not. They are self-employed, contracted with us, and we provide them through monies we receive through the CCACs or through our transfer payment programs, or direct private-pay opportunities that exist. There's some confusion in whether we're going to be able to do that kind of partnering in the future, with the legislation. Does that help?

Mrs Mitchell: It helps.

Ms Wynne: Do I have another sec?

The Chair: You've still got about a minute.

Ms Wynne: My understanding under this legislation is that the accountability agreement would be with the CCAC.

Ms Hanmer: This is part of our confusion. We have contracts with the CCAC, and we understand they will have accountability agreements. We also, as a transfer payment program, have service agreements currently with the Ministry of Health, with the Ministry of Community and Social Services and with Children's Services. It's confusing where those service agreements are going to fall and how we'll be held accountable with those.

Ms Wynne: So we need to clarify that, but as it stands now it would be with the CCAC and you would be delivering to them under their accountability agreement.

Ms Hanmer: Under their accountability agreement. That's correct.

The Chair: Thank you very much for coming today. We certainly appreciate it.

I'm not sure if our next delegation is here yet. If not, if you had a brief question of this delegation, Ms Witmer or Ms Martel, I'd entertain it.

Mrs Witmer: Thank you very much, Sandra. It's good to see you here. If I take a look at your presentation, it's obvious that you've not had an opportunity to become involved in any personal dialogue or consultation with ministry staff on this bill.

Ms Hanmer: Not yet, no.

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Mrs Witmer: Because you still appear to have some questions that probably could be answered if that dialogue did to take place.

I guess as I look at it, your emphasis, the area that gives you the most concern, is the whole issue of accountability and the need for not only the providers but also the government to be held accountable. If you've listened to the other presentations, that certainly is a huge bone of contention and concern, particularly because this bill is stressing this need for accountability, this need for almost a sixth principle to the health care system. There was a suggestion made this morning that part III, which is the accountability section, really should be entirely rewritten. It's so badly flawed that it would be impossible to make amendments with what's there. What would your preference be? Would you prefer that it would be totally rewritten based on the information we've received from the stakeholders?

Ms Hanmer: I would agree with the comments you're making regarding the accountability section being probably the most problematic for providers. We certainly would support rewriting that section, based on the feedback that you have, and making sure that you're utilizing the expertise of individuals that you've heard from with respect to outcomes, performance indicators, those kinds of things. There's already a lot of work that has been done that I think could parachute it much further. But it would be very problematic trying to work

with what's there or putting it into regulation at this point.

Mrs Witmer: Thank you very much. I guess that's what we've heard. In the case of hospitals, there are performance agreements that are being worked on and we've certainly heard that from some of the other stakeholders. Thank you very much.

Mr Ernie Hardeman (Oxford): Just very quickly, we've heard a lot, as we just did in the exchange with Ms Witmer, about the accountability part of this. I've been listening to the presentations and have come to realize—on page 5 of your presentation, the first line: "We believe the health system should be accountable to the people of the province and not the minister." It seems that all our accountability that's built into Bill 8 reflects on how we're going to make the providers of the service, the providers of our health care, responsible to the minister, who can then direct the activity of the providers in a way that he or she believes is most appropriate. None of it seems to deal with being accountable to the people we should be accountable to: the people who are using the system. I commend you for that line in the presentation, because as we've heard today in the concern expressed about the accountability in the act, the providers seem concerned that they're putting too many guidelines in place, too many restrictions on how we provide the service, but no one really seems to be talking about being accountable to the people who need the service. So thank you very much for that part of the presentation.

Ms Martel: On your page 5, the start of the second paragraph, you said, "Currently, there is no mention of the ministry's overarching duty to fund the system adequately as set out in the Canada Health Act." I wanted to focus in on that, because the preamble is great. Who could not support this preamble, really? But there's a big gap between the preamble and community agencies on the ground, in particular, receiving funding to deliver some of those very important services that are listed. What do you think you need to see in Bill 8 that would give some legitimacy to accountability by pointing out what the government is responsible for and how the government has to be accountable for the provision of health care services?

Ms Hanmer: Thank you for your question. The key things that we have talked about from a sustainability and accountability standpoint deal with planning and the ability to have the resources—ie funding—to make our plans for year over year. When we've only got funding based on a yearly allocation it's very difficult to make sure that our services that are needed are available. Because we contract with the community care access centres and don't always control or have an idea of what their budgets are going to be, if there is a budget shortfall, for example, then all of a sudden services are cut, which makes it very difficult to keep providers, which makes it very difficult to service the clients, and you're making tough ethical decisions around who's receiving service and who's not. So, multi-year funding, for sure, would be a good piece to be able to incorporate. I recognize it's difficult to do, but I think we need to look at the mechanisms of how we can go beyond just one-year planning for finances.

The Chair: Thank you, Ms Martel. Why don't we all have a little break, five or 10 minutes, and grab a coffee until our next delegation gets here. You can join us if you like.

Ms Hanmer: Thank you.

The Chair: Thank you very much for coming today.

The committee recessed from 1525 to 1538.

REGISTERED PRACTICAL NURSES ASSOCIATION OF ONTARIO

The Chair: If we can call back to order, ladies and gentlemen, I'd appreciate it. We're actually still a little bit ahead of ourselves here, but our 3:40 delegation is here from the Registered Practical Nurses Association of Ontario. Joanne Young Evans is the executive director and Gabrielle Bridle is the president, if they would like to come forward and take a seat at the end of the table.

Make yourselves comfortable. I don't know if we have any clean glasses down there or not; if not, maybe we could get you some. Are there? Are they clean?

Ms Joanne Young Evans: We'll be good health professionals and—there we go. Thanks.

The Chair: It depends how thirsty you are.

You have 20 minutes. You can use that 20 minutes any way you like. At the end of your presentation, if there is any time left over, we'd like to use that time to ask you some questions, and that will be on a rotational basis among the three parties.

I've got exactly 3:40, and the floor is yours.

Ms Young Evans: Thank you very much. My name is Joanne Young Evans and I am the executive director of the Registered Practical Nurses Association of Ontario, which is also known by its acronym, RPNAO. With me today is the president of our association, Gabrielle Bridle. Gabrielle is also the president of the Canadian Practical Nurses Association and is a practising RPN.

It is a pleasure to speak with you today and to offer the advice and recommendations of our association that we believe will greatly improve Bill 8, the Commitment to the Future of Medicare Act, 2003.

The Registered Practical Nurses Association of Ontario is a voluntary professional association that has represented registered practical nurses, RPNs, in the province since 1958. Our association represents nearly 5,000, or 14%, of the 32,000 RPNs registered to practise by the College of Nurses of Ontario. Our members work in a variety of settings, including acute care facilities, long-term-care facilities, community health, occupational health, and a plethora of other venues such as physicians' offices and educational institutions.

Let me begin by saying that RPNAO supports the intent behind Bill 8. We believe that Ontarians deserve a universally accessible, publicly funded health care system based on the principles of accountability, transparency and accessibility. We do not believe that this bill, as it is currently written, achieves these principles.

Let me say, however, that we are very encouraged to hear that the Minister of Health and Long-Term Care will be tabling amendments with the committee in early March that will hopefully address our deep concerns with parts of Bill 8. We look forward to reviewing those amendments when they are made available.

Bill 8, as you know, touches on a number of areas. First, it establishes the Ontario Health Quality Council. The mandate of this council will be to measure the effectiveness of the health care system in Ontario. The council is designed to ensure accountability in our health care system, to ensure that money is being spent where it should and to ensure that the greatly needed improvements in the system will be made. The RPNAO looks forward to the council's implementation and we look forward to working with it in order to achieve the desired results of improving Ontario's health care system.

Bill 8 also addresses the issue of prohibiting two-tier health care. In principle, we support this part of the bill as well. However, we do have a major concern with sections 13, 14 and 29, relating to the collection, use and disclosure of personal health information. We believe that every attempt by the government should be made to define by statute, not by regulation or otherwise, how personal health information is collected, used and disclosed. To avoid confusion and to reduce costs of implementation and enforcement, we think there must be a single piece of legislation for the protection of personal health information in Ontario.

The RPNAO supports Bill 31, the Health Information Protection Act, which is currently before another committee. We believe that Bill 31 should have primacy, not only over Bill 8 but also across all provincial legislation concerning the collection, use and disclosure of personal health information. We are pleased that the Minister of Health respects this position as well, and we understand that he will be tabling amendments to these sections of the bill to achieve these objectives.

Part III of the bill deals with accountability in our health care system. It also happens to be the source of great anxiety amongst many health professionals and the organizations that represent them, such as ours. Let me be clear: Our concern is not over the principle of accountability per se, but rather with the draconian and one-sided approach the bill has taken. In fact, one of the principles that guides the RPNAO and one that our members strive for, is the principal of accountability.

Does Ontario's health care system need to be more accountable and transparent? Absolutely. Does Bill 8 achieve accountability and transparency? Absolutely not. In fact, if Bill 8 is passed as it is currently written, it will have accomplished nothing more than the drawing of the battle lines between the provincial government and health care organizations and service providers. Obviously, we do not believe this was the intent.

To be frank, part III has gone too far. It has given extraordinary powers to the minister to direct an organization to fire, demote or otherwise sanction any person in an organization without the right of recourse; in the words of the bill, "change in a person's terms of employment, including a reduction or variation of the compensation payable to, or benefits provided to a person"—subsection 27(1).

Part III allows the minister to direct any individual, organization or entity to enter into an accountability agreement or issue compliance directives. It also allows the minister to terminate or vary the accountability agreement for any reason whatsoever as he or she sees fit and at any time of his or her choosing.

The bill goes further by stating that any accountability agreement entered into by one person automatically applies to that person's successor, regardless of whether the successor has any knowledge of this agreement or was involved in its negotiation.

Part III will also allow the minister to vary private employment contracts retroactively. Further, it specifies that any changes or variations in an individual's private employment contract ordered by the minister are "deemed to have been mutually agreed upon between" the individual and the employer. As well, the change does not entitle the person to any sort of payment or compensation, despite any provision to the contrary in labour law, collective agreements or in his or her personal contract or agreement of employment.

Ms Gabrielle Bridle: As currently written, Bill 8 completely ignores the Employment Standards Act and labour laws in general, as well as any collective agreements and individual employment agreements. The RPNAO is of the strong belief that the government has been overzealous in its desire to create an accountable and transparent health care system in the province by the draconian and heavy-handed approach that the ministry has taken through the provisions outlined in part III of Bill 8.

Having said that, we understand that the Minister of Health and Long-Term Care will be presenting for the consideration of this committee a number of amendments that are to address many of these issues that we have mentioned to you today, particularly with respect to part III. We look forward to reviewing these amendments with the expectation that they will greatly improve this bill.

Transparency and accountability are crucial to the success of our health care system. As we have said, the RPNAO is supportive of the concept of accountability and the overall intent of Bill 8. What we cannot support are some of the measures and the approaches this bill proposes in order to achieve accountability.

We are concerned that the elements of this bill will simply polarize the government and health service providers in this province, which would be beneficial to no one.

The initial steps the government has already taken by its willingness to listen, to take advice, and its flexibility to change have been encouraging to us. As always, we appreciate being included in these discussions to provide our input.

Those conclude our formal comments. Thank you for your attention. We will take questions.

The Chair: That's wonderful. Thank you very much. You only used up about eight minutes, which leaves us with 12. We will give four minutes to each one of the parties. We will go back to the rotation we were on before, and that would be starting with Ms Martel.

Ms Martel: Thank you, both of you, for being here today. I appreciate it. I appreciate the focus on part III of the bill as well. We've heard from many parties, many sides, that this is a rather draconian bit of business and far beyond the current provisions the minister would now have under the Public Hospitals Act, for example, to use the public interest to have a supervisor—this goes far beyond it. No one seems to really know why the government and this particular minister think they have to go to these lengths to deal with whatever issue it is that he wants to deal with.

You may know that last Thursday the minister, through his parliamentary assistant, gave us a copy of some of the areas that he proposes for change. Those are being made available over here, so before you leave, please do grab the February 19 memo. It's addressed to the chair, Kevin Flynn.

I want you to take a specific look at some of the proposed changes around sections 21, 22 and 23, some of the ones you've highlighted. I'll ask you to do that because my concern is that there has been very little change in terms of what is in the bill now and what the minister proposes by way of amendment. For example, although many groups have said an accountability agreement is one that has to be negotiated, it cannot be imposed by the minister; in fact, the changes in section 22 still allow for the minister to issue compliance directives or orders, regardless of whatever the negotiation has produced or failed to produce.

Also, it's very clear in section 23 that the minister still is allowed to change, for example, benefits, wages and salaries of the CEO. There is provision for a compensation clawback or other financial remedies that have yet to be defined.

Please do take copies of those, because my concern is that the government really hasn't heard the concerns that were raised repeatedly as we've gone through this process, and we are in the same position where the minister is essentially in the position of, at any point in time, bringing forward compliance directives or orders that would have a dramatic impact on hospital boards, on workers, on CEOs etc.

You might look for one other thing, and maybe you can comment on this now. I appreciate that it doesn't impact your workers in the same way that it might with respect to CUPE workers, for example, but let ask you this question as well. I think the compliance directives could also have the impact of doing around-the-door changes that would also impact on people's employment. For example, if through a compliance directive the minister ordered amalgamation of cleaning services or contracting out of cleaning services, of food services, of any number of services within a hospital, that could have an impact on people's employment and certainly on their compensation benefits, wages etc, if they no longer have employment. That's not a frontal assault on their collective agreement but it certainly is a way around the back door to achieve something else.

Although I appreciate where most of your folks work, and it's not in those sectors, do you have some concerns that there could be other ways, through a compliance order, not through a change in a collective agreement per se, that your members could either have their positions directly affected or their compensation affected as well?

1550

Ms Young Evans: Many RPNs are represented by CUPE. We have thousands, actually. RPNs are in service unions such as this; they aren't represented by ONA. We have about 100 who are represented by ONA; the rest are in about 15 to 20 different service unions across this province. So in effect, some backdoor things could be done. But the only instance I could think of, Ms Martel, would be if somehow the collective agreement was such that they contracted out, and if they did that and they went to an agency for nurses instead, they'd actually be paying more than what they'd be paying those who are in the collective agreement. So it would end up costing the hospital more for RPNs if they did something like that.

Ms Martel: Which is what they were doing during SARS. I appreciate that a number of folks might be organized through CUPE, but generally RPNs wouldn't be involved in food services or laundry provisions. That's the point I was trying to make. So an amalgamation of those services would not directly impact RPNs.

Ms Young Evans: Not unless they're working as a unregulated care provider.

Ms Martel: OK, thanks.

Ms Wynne: Thanks for your presentation. I'm just going to make a couple of clarifications and then Mr Duguid has a question.

I'm glad you agree with the notion of increased accountability, because I think this bill comes from two places. There's a lot of money going into the health care system and people feel that it just isn't working the way it should. What we're trying to do is get a handle on why that is, how we can help institutions to move in the direction that we all want to go, which is healthier people in a healthier community. So that's where this comes from.

The second place it comes from is a desire to start to shift the focus on to community health as well as hospital provision of health care. So what we're trying to do is get a sense of where those dollars are going and how they might better be spent. So that's underpinning this. There's absolutely no intention to vilify anybody or to pick a fight. As you heard from the minister's remarks, the language that seems to do that is going to be modified. I just want to be clear about that.

On some of the specific pieces that you identified, sections 13, 14 and 29 relating to the collection, use and disclosure of personal health information: First of all, there are going to be amendments to sections 13 and 14. The reason there is reference to the collection of health

information in this act as well as in Bill 31 is that the collection here is for specific purposes around the queue-jumping and extra-billing. So the need is to be able to access that information to figure out exactly what's going on. That's why it's in here. There may be further refinements that we need, but that's the explanation.

Section 27, just to be clear, deals with CEOs. We're not talking about individual nurses.

Then the other sections that you referenced, section 21, section 22, what we've tried to do there—and the amendments will come forward—is to bring some clarity to what the procedures are. So, yes, there may be the ability of the minister to enforce an order as the final step, but there's a whole lot that leads up to that in terms of what has to be done, what he or she has to consider, and that being available to people so they know what the procedures are.

Those are the changes that we're going to try to make. I hope they jibe with what your concerns are.

Mr Duguid had a question for you.

Mr Duguid: With the few minutes remaining—

The Chair: A minute or so.

Mr Duguid: A minute or so? That's OK. The question I have is on accountability within the system, to ensure that we can bring the significant changes that we want to bring to the system, changes such as ensuring that there are more full-time nurses as opposed to part-time, changes such as ensuring that the resources are going more into community-based than institutional-based initiatives and delivery. It's going to be difficult to do that. I think the accountability agreements may be one of the tools through which we may be able to start making some of those changes.

You indicated that you had some difficulties with the methods being used to ensure compliance. Do you have any suggestions as to how we can ensure that we have compliance with these agreements?

Ms Young Evans: If I can make a comment, and it goes back to some of Kathleen's comments and then into yours with regard to accountability, we have been talking to the ministry for the last three and a half years with regard to accountability. One of our main concerns, particularly with hospitals, is the hiring of RPNs and RNs. There are publicly funded facilities in this province that do not hire both categories of nurse, nor do both categories of nurse work to full scope of practice. You talked about nurses working to 70% full-time; this system can start saving hundreds of thousands, toward millions of dollars, if all nurses work toward full scope of practice and all those hospitals that are publicly funded are encouraged to hire both categories of nurses as well.

Nurses are overworked; they're burned out. What we want to see with this government is more accountability in how those health dollars are spent. We truly do not believe that more money needs to be infused into the system and that we can use that money much more wisely. We can even hire more nurses if the nurses that are there are used much more effectively.

Mr Duguid: But we need an effective way of making the stakeholders comply and be accountable.

Ms Young Evans: Yes. You should be looking at the Ministry of Municipal Affairs and Housing. When they deal with municipalities, they do a line-by-line budget, not global budgeting. We think that's one of the issues as well.

Mr Hardeman: Good afternoon, and thank you very much for your presentation. I just want to say that even before I had the opportunity to totally read Bill 8, I got a call from one of your members who was a member of CUPE. So I understand that you are represented by CUPE and concerned with the provision of being able to strip the contract and actually replace certain people with other people and so forth. That was in the bill.

Ms Wynne just mentioned the fact that this isn't about vilifying anyone, this isn't about a negative reaction to anyone employed in the system. This is about making sure that our money is properly spent in the health care system to make sure we're getting value for money. I wonder why the minister would introduce a bill—and maybe you can enlighten me—to provide the provisions for vilifying someone when we find them, rather than finding them first or looking at the system to see where the inefficiencies are and where we can make better use of registered practical nurses, as opposed to having all RNs; where we can find a better way to make our system work before we look at penalizing people.

The other thing I want to touch on I find very curious, and maybe you could help me. You've done a very good job of making a presentation. In most cases, a minister introduces a bill and then puts it out for public consultation. With this one, I have to commend the minister; it was put out to public consultation after first reading rather than second reading. It had more to do with timing in the Legislature than it had to do with when we heard the public presentations. But what's interesting about it is that it's not very often that a minister would introduce a bill, first or second reading, and then in between the time the bill goes to committee and before we hear the deputations, the minister comes forward with all the amendments he's going to make after we hear what the public has to say about it. It would seem to me to be more practical to wait for the public presentations and then, from what they've said, tell us what we need to modify in the bill in order to make it useful.

I find it very hard to understand why we would have a process that says, "Here's a bill. Come and make your comments on it. But incidentally, make sure you watch the news because you're really going to be making comments about a totally different bill than what is before you, because I am going to totally amend it. I realize there are a lot of problems in it and you're not going to like it, so we're going to do something totally different. But make your comments."

Ms Wynne: It's a work in progress.

Mr Hardeman: Yes. I was just told that it was a work in progress, but it wasn't very well founded in principle. It would seem to me that the minister must have read the bill before he introduced it and he must have had some idea of what he hoped to accomplish with that bill. When

you take whole sections of the bill prior to second reading—he's going to take out whole sections of the bill because he knows it's not going to do what the public will accept—I have to believe he was trying to slip something through to do things and hopefully it wouldn't get caught.

Did you find it difficult to make a presentation and to tell us what was good about this bill and what needed changing, recognizing the fact that what you were commenting on was not what needed changing? I don't know what the amendments were because I wasn't here for that part of the committee, but there's a whole new ballgame with all the amendments the minister is putting forward. Did you find that difficult?

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Ms Young Evans: We wanted to make sure that our comments were known on the original writing of the act. As Ms Martel has suggested, we are going to pick up and see some of the amendments. We had actually talked to the minister about some of those amendments, so we knew some of the things that were coming down. I think a lot of this is perception; a lot of this is explanation. As we work with our own bodies in nursing, I think sometimes intent is one thing and what actually is meant is something else. So I would hope that what the minister is trying to do is to put things out, see how people are understanding this, and further clarifying from there. I'm not defending his position. As I indicated before, I think there are some other issues that need to be dealt with in the accountability section as well.

The Chair: Thank you, Ms Young Evans, and thank you, Ms Bridle, for coming today.

CARE WATCH TORONTO

The Chair: Our next delegation is from Care Watch Toronto. We've got Bea Levis, Judy Jordan-Austin and Bernie Berger. Please come forward and make yourselves comfortable. You've got 20 minutes to use any way you see fit. It's entirely up to you. After the presentation, if there's any time left over, we will use that time among the three parties to perhaps ask you some questions. I'd ask that you identify yourselves for the Hansard record. The floor is yours.

Ms Judith Jordan-Austin: Thank you very much, Mr Chairman. My name is Judith Jordan-Austin. I'm a past president of Care Watch Toronto. To my left are Bea Levis, the present chair of Care Watch Toronto, and Mr Bernard Berger, who is a board member, and we have a few cheering people in the back. We're very appreciative of being able to speak with you this morning—this afternoon. I'm sorry; it's been a long day—and would like to express our thoughts and concerns about Bill 8.

I would like to make something abundantly clear at the very outset. Care Watch Toronto is a voluntary organization. Although some people have been professionals in the past, we work as volunteers and try to give a strong consumer voice to the whole matter of health care. We are deeply concerned about the quality of care and social services in Toronto and in Ontario.

We are also very concerned about the organization, delivery and quality of community-based long-term care. We want to improve the quality of life for care recipients and family caregivers. We want to ensure that such care is comprehensive, responsive to the needs of the individual, equitably accessible and of the highest quality. To this end, we endeavour to influence public policy regarding the development and maintenance of high-quality, publicly funded programs and services that allow the frail elderly, the chronically ill and the disabled to remain in their own homes as long as possible.

This said, we have some concerns about Bill 8, which does nothing at the moment, since we don't know the amendments, in our view to increase democratic input or improve accountability to the people regarding our health care system, so valuable to us all.

It has been presumed, and it makes sense in relation to Liberal campaign promises—although we don't expect all 243 to take place immediately—that this bill was intended to enshrine the Canada Health Act in Ontario law, create a health council to monitor health services and provide accountability which prohibits the development of a two-tier health care system.

The bill, while it contains a few important provisions, does not accomplish these objectives. That is our feeling. For instance, it does nothing to enhance the possibility that our constituency, namely today's seniors, who are growing in number, or future generations as they age, will be able to age in place with dignity and the greatest possible independence.

More specifically, we are concerned with the following sections of the proposed legislation. In the preamble, on first reading, this section appears to support all the positive features of our publicly funded health system, but it does not mention or make any commitment to reduce or eliminate the negative features such as the steady encroachment of P3 hospitals, use of for-profit services, private MRIs, delisting and user fees.

As an example, the statement "Recognize that access to primary health care is a cornerstone of an effective health system" we believe should read, "Recognize that primary health care reform must be the cornerstone of an effective health system."

Home care is mentioned, along with pharmacare for catastrophic drug costs, as though it is a secondary issue. Home care must be recognized as a vital component of a community health care system and must be funded as such. If you're concerned about dollars, I'm sure you're aware of the research that has been done that shows that home care in effect costs much less than institutionalized care and allows people to live in their homes in dignity.

Part I, the Ontario Health Quality Council: The council, as set out in part I, does not appear to have the right to make recommendations. One wonders why it is even considered. The process of member selection should be defined. The council should be at arm's length from the government, as is the national health council. We believe that half of the council membership should be from the community as defined in part I, clause 2(3)(c). The

process of selection of community members should be outlined. For-profit service providers should be excluded.

Part II, health services accessibility: To a large extent, this part incorporates the pre-existing provisions of the Health Care Accessibility Act, which forbade extra-billing by physicians. The issue of block fees charged by physicians is raised, but it is not clear whether the intention is to ban or regulate them. Our position is that they should be optional and regulated.

Part III, accountability: A number of people seem to feel that this is totally unacceptable because of the almost unlimited power it gives to the minister and the government. The opening sentence of the preamble to the bill reads, "The people of Ontario and their government...." This section, at the present time, effectively deletes the people of Ontario. We're sorry to say that the resemblance of this section to the omnibus bill passed by the previous government is rather alarming.

Thank you for inviting us today. If there's anything further we can do in helping your deliberations, please call on us. We congratulate you on beginning to address the health care needs in Ontario. We hope that our concerns and suggestions will be carefully considered. If you have any questions?

The Chair: Thank you very much. You used up about eight minutes, leaving us with 12, starting this time with Ms Wynne for four minutes.

Ms Wynne: Thank you for coming here today. Just so we're clear, the amendments are not finalized. You made a comment about not having seen the amendments yet. The reason for that is that they're not finalized. We're still in process. We've got three more days of hearings. So as I said earlier in a side comment, it is a work in process. The fact that we brought the bill out after first reading means that there is a large window of opportunity to make changes.

On the issue of the health quality council, the idea is that there would be a reporting to the public of the direction that we're going, how we're doing against standards that have been set. You said, what's the point of having the health quality council? I guess the point, as we see it, is that there would be this gathering together of information and it would be quite clear whether we're achieving the goals that we set out or not.

1610

Ms Bea Levis: We feel that the health council could have a very valuable function, as does the national health council, in being able to monitor and to keep a tab on and make accountable the steps the government takes in relation to this provision of service.

Ms Wynne: And for you, that would be the ability to make recommendations? Is that what you're—

Ms Levis: Without the ability to make recommendations, it seems that it's quite toothless.

Ms Wynne: OK. I think the idea is that there would be pressure that would be applied because of the information that was gathered, but we take your point. Thank you.

I wanted to make another point about the reference to home care in the preamble. I think it's important that we all understand that this bill is not meant to do everything that we promised, obviously, in the health care section of our platform. This is a step. The reason that home care and catastrophic drug care are mentioned in the preamble is that this is the future of medicare act and we all know that provision of adequate home care is a huge part of what we must do. That's why it's there, because this bill sets a framework for what needs to be put in place. The point of the bill is to get a handle on where those dollars are going and to begin to shift the emphasis, because we know that the provision of community health care is inadequate.

Does it make sense to you that this could be a first step to get a handle on what it is we're doing, how the money is being spent, how it could be better spent and to start to make that shift? We just heard a presenter say there are hundreds of thousands of dollars that could be saved in the system. That's the kind of thing we're looking at, because our focus is on that community care.

Ms Levis: Yes, we're very glad to hear that.

Mr Bernard Berger: I think one of the things that troubles us is that what began some years ago—not that many years ago; I think with the NDP government—as a program of home care, it made sense to help individuals who were disabled either by age or physical disability in their homes—home care services such as cleaning house and cooking, taking people to the doctor and so on. Because of the pressure put on these services by hospitals that are discharging their patients while they still need intensive care, that program is gone and a lot of people have been warehoused who could have stayed in their homes.

I think everybody here probably understands that the process of deterioration that takes place with aging intensifies in a warehouse, in an institution, and it's much slower when you're living at home among familiar things and so on. That's what our concern is. Our major concern is the well-aged who are living in their homes and are going to be kicked out because they don't have services.

Ms Wynne: That's the culture shift we're trying to begin. Thank you for your comments. I've probably gone over my time.

The Chair: No, there's about a minute left for Mr Duguid.

Mr Duguid: I just wanted to make a comment. I wanted to really thank you for coming here today. We hear from a lot of people and we have a lot more to hear from on this bill, but people who directly represent just the consumer, which is your mandate, are few and far between in the system. Your input is extremely valuable to us. I just wanted to say to you, please stay engaged in the process on this bill and on others, because there are far too few voices for the consumer in this process. I guess that's what our job is, for everybody around this table, but we rely on you to help us in fulfilling those duties. So I thank you for your efforts. They are very much appreciated.

Mrs Witmer: Thank you very much for your presentation. It appears to me, based on your comments, that this bill has not met the objective of the original press release the government issued saying that this bill was to outlaw two-tier health care in Ontario and stop creeping privatization of health care, because in your preamble you speak to the fact that you don't see any evidence of that.

Every time I listen to the government I hear there is a new reason, another reason why this bill has been introduced and I ask myself, if the objective is to use taxpayers' dollars in the best way possible, which I agree with, why didn't we have a consultation before we introduced a bill? I think we all support best use of tax dollars and we support accountability, but certainly this was a pretty draconian bill to introduce if that was its objective.

I would just ask you about your position on block fees. You have stated here your position would be that they would be "optional and regulated." So you don't support the elimination of block fees?

Ms Levis: Many of our members, because they are very clearly dependent upon their family physician and because there are very few community health centres around that provide salaried physicians and also make provision for all the extras—which, by the way, we're also concerned about—felt they couldn't put themselves in the position where the physician would refuse to serve them if they refuse. However, there are problems with people who can't afford to pay the block fees. It's all very well for middle-class and other, wealthier people to be able to do it. That's why we feel it should not only be optional but regulated, so people who cannot pay, for one reason or another, would be allowed to continue having their service without payment.

Mrs Witmer: I appreciate that explanation.

On the issue of accountability, you mentioned that many people have said that section is totally unacceptable because of the unlimited power it gives to the minister and the government. We know that that power is unprecedented and never seen before. Then you say there needs to be a change because you're concerned about the word, "the people of Ontario and their government." What type of change would you make to that in order to ensure accountability to the people of this province and the need for the public interest to continue to be protected?

Ms Jordan-Austin: I don't want to get into a debate with anyone today; I don't think that's our purpose here. But you had said it's never been seen before. The reconstruction of the CCACs deliberately did away with any community input. Our feeling is that community input is extremely important. We feel, as the recipients of home care and as the people who have to do something about home care, that we should be involved in the process of deciding what, how, when and where.

Mrs Witmer: How would you change the preamble? It's in your last part.

Ms Jordan-Austin: The preamble?

Mrs Witmer: Yes. It says, "The people of Ontario and their government...." Then you say, "This section effectively deletes the people of Ontario." I guess I'm asking you, how would you change that to make to sure it reflects what you think to be important?

1620

Ms Jordan-Austin: I don't know that we'd change the preamble. We might wish to change some of the other parts of the bill. Bea, do you want to speak to this?

Mrs Witmer: I'm not sure what your line means when you say, "This section effectively deletes the people of Ontario."

Ms Levis: I think we're dealing with here, although we didn't spell it out, the unlimited power that is given to the minister in many respects. Some of those respects have been spelled out by people such as the last two presenters I heard here this afternoon.

The thing we want to make sure of is that there is input from various sections, providers and consumers into the various aspects of providing health service that we felt this bill didn't provide, as it reads now.

Ms Martel: Thank you for being here today. You said, "The bill, while it contains a few important provisions, does not accomplish [the] objectives." Let me give you my take, for what it's worth.

I think the preamble is great—who could not support a preamble that talks about our most cherished institution, medicare?—but it was done as a public relations exercise. I don't think it's an accident that this bill was introduced on the first anniversary of the release of Mr Romanow's report. I also don't think it's an accident that many of the things he talked about in his report make their way into the preamble. I only wish that some of the details to put it into effect actually appeared in the bill.

I'm quite worried about the contradiction between the preamble and what is or isn't in the bill. For example, the preamble talks about continuing to support the prohibition of—one of the examples is user fees. Except that we have the Minister of Finance right now openly musing about the possibility of changing the universal Ontario drug benefit plan and perhaps implementing a means test so that more wealthy seniors can actually pay for their own drugs. Do you see the contradiction between what the preamble says and what the government is currently involved in?

Mr Berger: Maybe this is sacrilege, but we seniors—at any rate, those of who are in Care Watch—see nothing wrong with increasing taxes, because taxation is a progressive movement, not regressive. User fees are regressive.

Ms Martel: Thank you.

Mr Berger: Those that got, pays, and those that ain't got, don't pay. That's the way we would like to see it.

Certainly we are concerned, as the government is, about the billions of dollars in deficit that they've inherited. But taking it out on the backs of the citizens is not the way to proceed, by introducing user fees or delisting services. We really feel very strongly—and none of us are millionaires—that the way to overcome this deficit is to increase taxes, run a deficit for a little while, and eventually you pay off your debt. That's the way we feel.

Ms Martel: Also in the preamble, it says, "Recognize that access to primary health care is a cornerstone of an effective health system." Yet the bill is silent, for example, on the establishment of more community health centres, which have proven to be a very effective, cost-efficient manner to provide primary health care. Are you concerned at all about the preamble that talks about primary health care and the body of the bill that doesn't reference primary health care or CHCs, anywhere?

Ms Levis: We are certainly concerned, but we did try to address just the points that were in the bill. We do make representations to the government on primary health care and on the establishment of community health centres, but we did not put it in this.

Ms Martel: It points out the problem of what's not in the bill, so it's hard to comment on those things.

The Chair: Thank you for attending today. We certainly did enjoy and appreciate your input.

Ms Jordan-Austin: Thank you very much for having us. We appreciate the consultations and we hope we'll have more.

The Chair: We will.

CANADIAN AUTO WORKERS

The Chair: Our next delegation comes from the Canadian Auto Workers. Paul Forder, director of membership mobilization, is with us, and Nancy McMurphy and Corey Vermey. Please come forward and make yourselves comfortable. Same rules as everybody else. You've got 20 minutes. You can use it any way you see fit. At the end of the presentation, if there's any time left over, we'll be sharing that time among the three parties. You've got the floor.

Mr Paul Forder: Thank you very much, Mr Chairman. I want to bring you greetings on behalf of our president, Buzz Hargrove, the quiet, soft-spoken leader who has a real sensitivity to health care issues these days. He slipped and fell on a recent trip to the Northwest Territories and is laid up for four or six weeks with torn ligaments and muscles, and he's just being cranky, or he otherwise would have been here himself. So it kind of takes on more meaning for us.

Nancy McMurphy is our executive board member and also president of her local union—28 years' experience in the health care field. Corey Vermey is one of our researchers, who has spent 14 years working with this issue, and health care is part of his assignment. We welcome this opportunity.

It's nice to be back in the Legislature, having some meaningful dialogue. Eight years—it's been kind of cold out there, I can tell you, and we start to feel a little bit more appreciated as we do have some dialogue. We think it's important to keep things fluid. We're not going to tax the committee's time by going through our presentation word for word. We trust the members will do their work, and the staff, to look at our more detailed suggestions. We do have a couple of key points we'd like to make with the limited time that we do have.

We welcome the minister's commitment to amend various sections of Bill 8 based on the concerns expressed. The amendments are significant and address many valid concerns about the scope of Bill 8 and its intended impact on health care workers.

Expressing our public commitment to the future of medicare requires that we move forward in a positive, co-operative spirit with workers in health care and equal partners in pursuing quality, improvement and patient and worker safety in our public health care system.

We notice the whistle-blower protection section. The minister has addressed that today. We appreciate that and I'll skip that paragraph. We're comfortable with what appears to be an honest and direct amendment to protect workers from any reprisals for coming forward.

The greatest threat to public health care, as recognized by the minister in his November 27 statement to the Legislature—"The pursuit of corporate profits weakens, not strengthens, health care by taking dollars and resources out of medicine"—is the creeping privatization of health care that the minister proclaimed would be ended by Bill 8. We think we have some room to grow here and to ensure that this in fact does occur.

Private health care threatens quality for the sake of profit, rationing access based on ability to pay and revenue generation. We believe it subverts accountability for the sake of commercial confidentiality and proprietary rights. But Ontarians need to ask themselves, does Bill 8 end the creeping privatization of health care?

Under part I, health quality council, the bill only provides for annual reporting on access, resources and outcomes with no mandate to assign responsibility or to offer assessment or prescription on improvements. I did hear some of the comments of the members about what they felt the intent was, but we think it has to be fairly explicit, and they have to be empowered to do so.

We require a competent and credible watchdog, a public agency that is able to offer a description, as well as a prescription, for change. The mandate of the quality council needs to, at a minimum, also include reporting on the impact and outcomes of for-profit health care delivery in Ontario. The health quality council should be the primary means for ensuring the social accountability of the health system, including the Minister of Health, in terms of access, quality, outcomes and resources to the people of Ontario.

1630

Under part II, health services accessibility, the bill largely incorporates the Health Care Accessibility Act provisions enacted in 1986 regarding extra-billing, as well as new provisions prohibiting queue-jumping and regulating block fees. We quite frankly suggested recommendations about reducing the fines and don't feel that is an appropriate way to go when you think about the fines in 1986 now being even lower. One has to question whether that is going to be the necessary disincentive to protect the system. We think the fines should be rethought and looked at, being at least equal to the 1986 provisions of the Health Care Accessibility Act.

The core issue surrounding block fees remains the adequacy of physician remuneration systems and the need to regulate non-insured services under the accessibility principle of the Canada Health Act. Of course, we vehemently oppose block fees. We see that as part of the problem and if we can address the stagnant income of physicians in a constructive way, that, we believe, will help resolve that particular problem.

Under part III, there's a typo here. You'll note on the bottom of page 1, it should say part III—we say "part II"—accountability. We welcome the commitment to provide for substantial amendments to the more contentious provisions dealing with accountability agreements and compliance directives. We expect the minister to amend the bill to make that explicit, and he has, from the notes that we saw today on his intention to table those amendments. We appreciate that wholeheartedly.

We support the intent to provide that accountability agreements will be negotiated, not imposed, on boards of designated health providers: hospitals, long-term-care facilities, independent health facilities—clinics—and CCACs. But we ask why the minister, in his remarks, did not include or specify for-profit private providers such as the public-private partnerships—P3s—home care agencies or commercial laboratories. Those were not listed.

There has been no open, public debate on the merits of proceeding with P3 deals. The continuing lack of transparency and disclosure surrounding the P3 arrangements in the Brampton and Ottawa areas is lamentable. The public must rightfully ask, where is the accountability to the Liberal campaign platform to close the door to private hospitals? We know you didn't open it, but we know you have the power now to close it, and we urge you to do so.

We submit that the proposed penalties under this section again should not be less, as we mentioned, than in the Health Care Accessibility Act of 1986. We also support the intention to require a 60-day consultation period, including legislative debate, of course, on the accompanying regulations to the bill to ensure full public and stakeholder input. While we welcome the legislation as a demonstration of the commitment to the principles of medicare, as with medicare itself, there are obvious and immediate areas where we need to strengthen and reinforce that commitment.

I'm going to ask Corey to deal with a couple of issues in the time we have left, maybe the preamble, and also, if we have time, the accountability question.

The Chair: You've only used up about eight minutes, so you've got lots of time.

Mr Corey Vermey: Thank you. What we are suggesting by way of the text in the preamble is to redraft that language. We believe that the language can be strengthened and our comments are directed at the context in which those remarks are made, where those statements are recorded in the preamble. By and large, there are some textual issues that we would have with, for instance, a consumer-centred health care system. Our union represents 180,000 members in Ontario; 20,000 are health care workers and 160,000 are workers in other sectors. They do not see themselves as consumers. They see themselves as citizens and as patients, or residents, if they are retirees in facilities or receiving services in their homes. So we take exception to that.

Given that the Romanow exercise was to begin with a health care covenant, we think this preamble as drafted should be strengthened in light of the spirit of that covenant and, in fact, the spirit of the entire commission's findings, and put in as a statement of purpose, thereby giving the public and others, including the judiciary, a sense of the legislative purpose and intent behind this legislation to clarify the uncertainty as to what the transfer of power to the minister is all about.

So we had a few points in regard to the language of the preamble, but speaking to the council, we certainly join with those who would advocate for the council as contemplated by this draft legislation to be strengthened considerably, insofar as it becomes a primary vehicle for social accountability to the public in Ontario. Largely, significant sections of this bill are about the vertical accountability of providers to the Minister of Health, and rightfully so; there is that obvious accountability relationship. But we think what this legislation strongly requires is a very effective council that is able to ensure social accountability to the people of Ontario. To begin with, we would urge that one of the key functions of the council is to report to the public of Ontario on the extent of for-profit, investor-owned health care in Ontario: What are the number of clinics, what are the number of services, what is the billing in dollar terms that is occurring in the province and, as well, what are the impediments to access, what are the deficiencies in quality that we are encountering as a province?

We think that in order to achieve that end, of course, one has to look critically at the composition of the council. We advocate for increasing the size of the council. Most hospital boards in this province are in excess of the size contemplated for this council, which obviously has a very critical role to play—not that local hospital boards do not—given the jurisdiction they are contending with. We would specifically ask for two exclusions. One is already there in the legislation in terms of excluding the senior management of health care providers. We would also urge the exclusion of those who are on the public record as having attacked and continuing to attack the principles of medicare or who have a financial stake in investor-owned delivery of health care. We think that in order to be credible and to enjoy the respect of the people of Ontario, that is a very important exclusion from the council.

In addition to that, we would suggest that seats at the table of the council be reserved for representatives of the public. We think the experts, for instance, should be attached to the council by way of consultative mechanisms, subcommittees etc, at the reach and disposal of the council, but not on the body of the council itself. That would provide for far more effective accountability to the people of Ontario through a body that the people will see as being representative of the spirit of medicare.

Our view on this piece of the legislation is obviously to begin to develop in Ontario a mechanism by which the public can directly deal with the many policy issues and complexities around the provision and delivery of health care in Ontario. Obviously, as this area grows as a spending program and as a social need in our province, these policy debates need a forum. There is not, to the best of my knowledge, certainly over 15 years, a forum in Ontario where all stakeholders can present these matters and where a consensus can be reached in terms of which way to go forward on the many challenges we face.

Editorially, one very specific piece in terms of the bill: There is a reference to continuous quality improvement, which we understand as CQI in our union. I think this is brand versus generic. This is a very specific approach to quality. One can obviously find many consultants engaged in the implementation of continuous quality improvement, and it is a brand. We would urge that there be a commitment to quality. Our union is certainly committed to quality workplaces and quality products, but we have made the suggestion that instead of the reference to continuous quality improvement, the reference be to improving patient safety, enhancing workplace health and safety, and improving quality of service and outcome. We think that is far more specific and deals with the issue at hand, as opposed to promoting one particular approach of many that have some dubious record in terms of health care delivery. Thank you.

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Mr Forder: I'll call on Nancy to conclude our presentation.

Ms Nancy McMurphy: In conclusion, we commend the government for its commitment to securing the future of medicare in Ontario through adoption of several of the recommendations of the Romanow Commission. As the Minister of Health stated to the Legislature on November 27, 2003, in presenting Bill 8, the Romanow report came to one pivotal and irrefutable conclusion: "The pursuit of corporate profits weakens, not strengthens, health care."

The test of Bill 8 in recognizing the legacy of the deep and profound commitment of Canadians to medicare is the ability of the people of Ontario to hold their government and health care providers accountable for strengthening health care and resisting the creeping privatization that threatens access, quality and sustainability of universal public health care. The challenge for Ontario is to build an integrated, comprehensive public health care system, capable of delivering quality services and improvements, to ensure continuing accountability to Ontarians for their investment and commitment to medicare.

Mr Forder: We'd be happy to take your questions, the hard ones for the staff and the political ones for me or Nancy.

The Chair: OK, very good. It appears that we've got about six minutes left, so they're going to have to be brief questions from each, starting this time with Ms Witmer.

Mrs Witmer: Thank you very much, Paul and the other members of your delegation. You mentioned here on page 13 that you feel the general tone of the bill in part III is adversarial in prescribing powers to the minister and that it allows the ministry to act with total impunity, regardless of the consequences. What type of amendments would you like to see that would eliminate that adversarial position that has been enunciated in the bill? What are the key types of provisions that you'd like to see changed?

Mr Vermey: I think it's fair to say that the case needs to be made by the government as to why the powers of the minister need to exceed the existing powers of the Minister of Health. We haven't been party to that conversation as to why additional powers are required beyond those that are current. We know of hospitals in Ontario that have been brought under supervision; we know of long-term-care facilities that have been brought under supervision. If the intent is to extend to other sectors, we certainly would take note of that, but there is no discussion that precedes this legislation in its draft form to warrant a significant extension of power to the minister, through the normal process of the minister being accountable to the public in Ontario.

It is as much its presentation as its obvious drafted provisions—and others, obviously—that gave us concern. We have only begun now to look at the amendments in context of the draft legislation to see where the new line, the bright line, is being drawn in terms of the powers of the minister.

Mrs Witmer: You've had no discussions with the minister or ministry on this bill, then? Or you have?

Mr Vermey: We have brought our concerns to the attention of the minister's office but we've had no direct discussion with the minister.

Ms Martel: Thank you for being here today. Let me deal with your summary, second page, where you said you "support the intent to provide that accountability agreements will be negotiated, not imposed, on boards of designated health providers." Before you leave, Paul, I want you to grab a copy of the February 19 memo from the minister to Mr Flynn. We got it in Windsor last week. Take a good look at sections 22 and 23. Those are the proposed changes. I don't think you'll get any great comfort that these are going to be negotiated, because the words "compliance directives and orders" still very much appear as part of the minister's ability. So you'll want to take another good look at that. Despite what he said, I don't think they got the message.

Let me deal with privatization, because this, for me, is key. We've got a preamble that talks in glowing terms about publicly funded health services, and yet there is nothing in the bill that stops the P3 hospitals, there is nothing in the bill that ensures that technology in the private CAT scan and MRI clinics goes into the publicly funded, publicly administered hospital system; there's nothing that stops competitive bidding in home care. Given that there is nothing in this bill to support the provisions in the preamble, are you worried that in fact

there's quite a disconnect between what the government pretends it wants to do in this bill and what the government is actually doing with respect to private health care services in the province?

Mr Forder: For us, it's a major weakness. We feel the minister, the cabinet and the members have to address this frontally. This is our opportunity to do something about it. Suffice it to say that we didn't start it. We know who started it, and now we have to fix it. If there is a consensus across this province—and we believe there is a strong consensus to fix it, to stop it dead in its tracks—then there should be no room for P3s in our system. That is just the opening of the door. We have to find a way to make sure our elderly and someone who's in that baby-boom bulge who is going to need all these services down the road—it's imperative that we fix it now, before the bulk of the boomers start to move through the system and be savaged by what we would see as unfair treatment in terms of the ability to pay, in terms of access and in terms of block fees etc.

Ms Wynne: Very quickly, because Mr Craitor has a question: On the P3 issue, I just wanted to cite the language that's being used right now in terms of moving forward. The ministry is working with the Ministry of Public Infrastructure and Renewal on a framework that would be based on public ownership, public accountability and public control. I'm not going to ask you to comment on that, but that is what we're working on.

In the reporting process, what the council will report on, I just want to be clear. Are you suggesting that there also be a report on privatization, on for-profit? I wasn't clear on that piece. What are you looking for?

Mr Vermey: That would be an absolute. We would expect that actually should be written into the act. That would be no greater an obligation than is currently in legislation under the Canada Health Act, although we're not aware that the province of Ontario has reported in recent years to the federal government under the terms of the Canada Health Act on the extent of privatization in health services delivery as well as funding.

Ms Wynne: Do you put specific language for an amendment in your report, or have you done that? Could you provide us with some language that you might suggest? Mr Craitor has a question.

Mr Kim Craitor (Niagara Falls): Thank you. I would be remiss if I didn't say hello to my brothers and sisters, especially my good friend Paul. It has been a while since I saw you. We were on the OFL together when I was president of the Niagara Falls labour council. First of all, let me just say—and I'm certain my colleagues feel the same way: excellent presentation, great suggestions. The one thing that caught my eye—and I think you know it would—was the whistle-blowing aspect of it, which I always felt strongly about, even when I worked in the federal government. Paul, the comments you had: Can you just go over them again with me in terms of how you feel we can improve that section of the bill?

Mr Forder: We could file an elaborate suggested amendment to try to incorporate our view. In the minister's statement dated the 19th, his intention seems to be very satisfactory, but you always have to make sure, as you know, that the legal people have an opportunity to do a cut, give a cut. As long as people are not subjected to any form of reprisals for coming forward, that is so commendable, it's so important, it's so necessary. We can see and we know the consequences for people coming forward when they don't have those kinds of protections. I would be happy to provide the committee with some of the suggestions from our legal department, who are much more adept at doing such a write.

Mr Craitor: I would like to get that.

Mr Forder: Good to see you, Kim.

Mr Craitor: You're still a good dresser; you're still a good speaker. You're just a little greyer. That's the only thing I noticed.

The Chair: On that note, thank you for coming today. We did appreciate your input.

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INDEPENDENT DIAGNOSTIC CLINICS ASSOCIATION

The Chair: Our next delegation is from the Independent Diagnostic Clinics Association. Neena Kanwar is the president, and she's joined by Teresa Kapitor, who's on the board of directors. Make yourself comfortable. OK, same rules as everybody else: You've got 20 minutes. You can use that any way you like. Any time left over, I'll split evenly amongst the parties. If you would introduce yourself for Hansard.

Ms Neena Kanwar: My name is Neena Kanwar. I am the president of the Independent Diagnostic Clinics Association. Joining me today is Teresa Kapitor. She's one of the members of our board of directors. I'd like to thank the members of the committee for allowing us to make this presentation.

I'd like to start off with a little bit of an introduction regarding the IDCA and then talk about Bill 8. The IDCA was founded in 1989 when the Independent Health Facilities Act was first introduced by the Liberal government. Independent health facilities are community-based clinics. They offer public access to diagnostic and ambulatory surgical services. Community-based clinics have been in existence in Ontario for over 40 years. Many of the current clinics that are licensed were in existence prior to the implementation of the Independent Health Facilities Act.

The IDCA is an organization whose membership is open to all owners and operators of independent health facilities. Since its formation, the IDCA had been primarily involved in the area of quality assurance and in assisting both the government and independent clinic owners in the effective implementation of the Independent Health Facilities Act.

Independent health facilities have been an integral part of the publicly funded health care system, as I mentioned, for over 40 years. There are approximately 1,000 independent health facilities licensed by the Ministry of

Health and Long-Term Care in Ontario. Approximately 50% of the diagnostic services provided in Ontario are provided in independent health facilities, which is equivalent to about five million diagnostic procedures on residents in Ontario annually.

There are independent health facilities in under-serviced areas, in rural areas, for example, where hospital and physician resources may be limited or unavailable. Independent health facilities provide patients with an alternative to driving to large urban centres to receive needed services.

The IDCA is supportive and has always worked to improve and protect the public health care system. We recognize and support the Ministry of Health and Long-Term Care's efforts to ensure that the principle of accessibility contained in the Canada Health Act is protected and enforced here in Ontario. We are also supportive of the ministry's and the minister's efforts to entrench accountability as a cornerstone principle of Ontario's health care system.

We acknowledge and are encouraged by the minister's comments on the opening day of public hearings on Bill 8 one week ago and the draft amendments that followed last Thursday. We applaud Minister Smitherman on his commitment to a collaborative process, open dialogue and meaningful and responsive stakeholder consultations.

Despite our agreement in principle with the goals of the Ministry of Health and Long-Term Care in developing Bill 8 and with many of the draft amendments, we would like to outline some of our concerns with respect to Bill 8. We will address our concerns in the order that they appear in the bill.

Part I, the Ontario Health Quality Council: The first section of Bill 8 describes the purpose and composition of the Ontario Health Quality Council. The council is mandated to monitor the state of the health care system and report annually to the minister. Bill 8 prohibits board members and "senior staff" members "of a health system organization" from being members of the council. While the minister has agreed to define the term "health system organization" in the legislation rather than waiting for the regulations, it is still unclear which stakeholders will be excluded from participating on the council. The wording of the bill seems to suggest that any provider of insured health services in Ontario, including IHFs, would be considered to be a health system organization and therefore excluded from participating on the council.

In the minister's comments on February 16, he expressed concern that if health organizations were represented, they would merely represent their respective silos. Having sat on many committees, we agree that there are silos in our health care system and that in order to ensure that the council achieve its mandate, this silo mentality must be eliminated. However, health care service providers such as IHFs are uniquely qualified to identify and help solve problems in the health care system. Since IHFs deliver services directly to patients across Ontario on a daily basis in their local communities, they have the skills and the experience necessary to advise on the current state of the health care system.

Our recommendation is that Bill 8 should be amended to allow senior staff members of health system organizations to be members of the council, not as representatives of their particular organization's or group's interests but as individual members of the council with the appropriate knowledge base and skill set. The fact of the matter is that health care service providers such as IHFs are uniquely qualified to identify and help solve problems in the health care system. We strongly believe that Bill 8 should be amended to allow health system organizations to be members of the council. In the alternative, a structure or mechanism should be developed that will provide IHFs and other health system organizations with an opportunity to be consulted and to provide feedback or recommendations to the council.

There have been examples in the past where consultation did not take place and decisions were made. Two examples come to mind. First is the case of bone mineral densitometry, where independent health facilities were not consulted when this service moved from being listed under one section of the schedule of benefits to another section of the schedule. This resulted in an increase in utilization of over 100% within a one-year period. If we had been asked, we could have predicted that particular increase. This is all history; it was a while ago. The most recent example would be scintimammography, where a service that was initially not in the schedule of benefits is now in the schedule of benefits, but only the professional fee, and thereby access to the service has been affected. There are other examples that I could quote, but I'll stick to the two and move on to part II, health services accessibility.

In the second part of Bill 8, subsections 9(1) and 9(2) state that physicians and designated practitioners shall only accept payment from OHIP or in accordance with an agreement made under subsection 2(2) of the Health Insurance Act and that they may not charge or accept more than the amount payable under OHIP. This is inconsistent with existing provisions of the Health Insurance Act, which allows facilities to pay physicians directly for services performed by the physician to such person or entity as may be prescribed. The inconsistency has also created some confusion, and the IDCA has concerns about whether Bill 8 will prohibit IHFs from paying physicians directly for their services, as well as paying amounts for administrative services, quality control etc, in addition to OHIP billings.

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To give you an example, if a physician was to report a study, OHIP is billed and that physician gets paid, but for quality control reasons that study may be reported by another physician. It's not billable to OHIP, but the physician needs to get paid for looking at the study again. This is to determine the quality and inter-observer and intra-observer variability. That's just one of the examples where the IHF would directly pay the physician.

We recommend that the bill be amended to address this ambiguity, either by including a specific exemption or by revising section 9 accordingly to clarify that IHFs

may pay physicians directly and that payment for administrative services, quality control etc, in addition to OHIP billings, is permitted.

Under the minister's proposed amendments of February 19, payments are permitted by public hospitals and mental health facilities for insured services rendered in those facilities. However, there is no mention of IHFs, and we would request that we be treated in a similar manner to the public hospitals and mental health facilities.

Subsection 9(4) of the bill prohibits any person or entity from charging or accepting payment for the rendering of an insured service to an insured person except under the conditions provided or unless permitted to do so by the regulations. The term "designated practitioner" is left to be defined in the regulations. It is unclear how this provision will affect IHFs, since we're not sure if IHFs will be included as designated practitioners or as non-designated practitioners. Therefore, in our reading of this section, it appears as though they would prohibit the charging of facility fees by IHFs to the Ministry of Health under section 3 of the Independent Health Facilities Act.

Leading from that, since it becomes then an unauthorized payment under Bill 8, it would give the power to the general manager to recover amounts for unauthorized payments. All of the things that follow after that section would then apply to IHFs. So the lack of clarity of section 9 with respect to facility fees means that unless IHFs are categorized as non-designated practitioners or a specific exemption is included under section 9 for facility fees, the fees paid to IHFs will be considered unauthorized payments.

Therefore, we recommend that the terms "designated practitioner" and "non-designated practitioner" be defined in the bill. Either IHFs should be classified as non-designated practitioners or this section should be amended to include an express exception permitting IHFs to continue to charge facility fees under the Independent Health Facilities Act.

Despite section 25 of the Statutory Powers Procedure Act, subsection 11(4) of Bill 8 allows the general manager of OHIP to take steps to enforce his or her decision regarding the accessibility requirement by deducting future payments owing to a health care provider even where the health care provider has not yet exhausted all available appeals. There is a similar section in the Independent Health Facilities Act where the director of an independent health facility may withhold payment, but in that process it is only after the appeals have been exhausted. It is also a departure from the general principle, as set out in section 25 of the SPPA, where the enforcement of a decision is stayed until final resolution of the matter.

While a minor amendment has been proposed in this regard, our opinion remains that the general manager should begin to enforce a repayment decision only once the appeal process is complete, as is the current process under the Independent Health Facilities Act. This would avoid situations where funds have been wrongly withheld when a health care provider is ultimately successful on appeal or found not guilty.

The initial inclusion of imprisonment as a penalty for individuals convicted of an offence under this section was draconian and unacceptable and we're glad to see that the minister is proposing to remove the potential for incarceration. The maximum penalties for offences as they currently appear under Bill 8, however, are significant and, in the context of IHFs, prohibitive. The proposed penalties exceed the annual net revenue of many IHFs, and in some cases actually probably exceed the gross revenue as well.

The IDCA has similar concerns about penalty amounts set out in subsection 29(4) and section 31. We are encouraged by the minister's intention to reduce the maximum penalties. However, since they are not yet defined, our comments stand.

Furthermore, we believe that Bill 8 should contain an exemption-from-liability provision which protects individuals such as directors and officers from liability as long as they are acting in good faith in the scope of their authority.

I'd like to move on to part III, accountability. Under part III of Bill 8, the minister has the right to require health resource providers and their executives to enter into accountability agreements, issue compliance directives to providers and health resource provider executives, and unilaterally alter the terms of employment, the terms of funding, of HRP executives.

In his February 16 remarks, the minister stated that he intends to include IHFs in the definition of health resource providers. The IDCA feels that this part of the bill gives the government the power to micromanage the operations of every IHF and to provide directions to the executives of IHFs. In addition to creating a very unstable working environment, these changes interfere with fundamental principles of corporate governance. Furthermore, in light of the highly regulated nature of IHFs, subjecting IHFs to accountability agreements and compliance directives is both extreme and unnecessary. IHFs are already highly accountable to government as a result of the licensing regime and the provisions of the Independent Health Facilities Act, which governs how IHFs must conduct their affairs.

In addition to the licensing, service and billing requirements contained in the Independent Health Facilities Act, the Independent Health Facilities Act also allows the director of independent health facilities to investigate and assess IHFs to ensure that the IHF regulations and limitations and conditions of their licences are being respected. If they are not, the IHF stand to lose its their licences.

The registrar of the College of Physicians and Surgeons of Ontario—I'll break down the accountability for IHFs into two sections; one is the quality section—has the mandate under the Independent Health Facilities Act to assess and set standards for independent health facilities.

In partnership with leaders in medicine, the CPSO develops clinical practice parameters and facility standards, and assesses all IHFs in Ontario on a regular basis against these standards to ensure that the best care and services are provided to patients. So in terms of quality, they check the quality of the images, the quality of the reports, the billing that is being done—everything, basically—with a fine-tooth comb. If the IHFs are not in compliance with any of these clinical practice parameters and facility standards, the director may revoke the IHF's licence at any time if the IHF violates the terms and conditions and fails to provide an acceptable standard of care, or otherwise fails to comply with the terms of the IHFA.

The Chair: You have about a minute left. Perhaps you can start to summarize.

Ms Kanwar: OK. In terms of financial accountability, the IHFs represent less than 1% of the total health care budget, and we are accountable financially to the Ministry of Health.

I think you have my presentation, so I'll leave the 30 seconds for questions.

The Chair: I would as soon you'd finish. I haven't heard a 30-second question yet. I think we'll pass on the question. If you do have anything to summarize, though, take the time.

Ms Kanwar: No, I pretty much said what we came here to say.

The Chair: Wonderful. I appreciate that. Thank you very much for coming today.

1710

ROBERT CAMPBELL

The Chair: Our next delegate is Robert S.W. Campbell, who is shown as being here on behalf of the Toronto Health Coalition but is actually here on his own behalf today.

Mr Robert Campbell: Good afternoon, Mr Chairman and honourable members. Yes, that is correct. I am a member of the coalition, but the official presentation was made, I believe, last week. So I'm presenting as a member but on my own behalf.

The Chair: No problem at all. Thanks for noting that. You have the same rules as everybody else: 20 minutes to use any way you see fit. If the presentation does not take 20 minutes, we'll use up that remaining time to ask you questions. The floor is yours.

Mr Campbell: Thank you. The copy of the bill that I have does not have a title, but I gather from the related material that the title is actually the Commitment to the Future of Medicare Act. I have read the draft bill and I have some comments about it. It seems to me to fall a good deal short of what should be present in essential legislation of this sort.

The principle of such a bill, of course, is without question one of the most important subjects that exist in the health care field, but there are some aspects of the actual drafting of the bill that I think, unless I'm mistaken—this is entirely my own view—are not adequate for the objective of legislation of this kind.

One troublesome feature, in my view, is the preamble of the bill. It appears in the copy that I have of the draft Bill 8 as the initial—it is contained in the body of the bill, but under the heading "Preamble." Of course, it sets out some extremely important principles that are fundamental in the health care system. I believe they are reasonably comprehensive and accurate in the statement, with one or two exceptions, but the difficulty I have with this preamble, as it presently appears in the draft bill, is that it really has very little effect. It does not achieve an affirmative and legal status by reason of its allocation in the bill as a preamble.

In statutory draftsmanship—I think I'm correct in this—if I could just refer to the Ontario Interpretation Act, it states that a preamble "shall be deemed a part thereof," meaning the bill or legislation, "and is intended to assist in explaining the purport and the object of the act," which is clear enough. However, the preamble that is stated in this bill, in my view, is really a crucial definition of the purpose, the objects and the principles of the legislation. If that is so, then it is far too crucial to regard merely as a statement in a preamble.

With regard to the courts with respect to preambles of statutes, the preamble has a very qualified effect. It really is not much more than a general expression of the direction of the legislation. It has very little interpretive significance or value. The result is that a preamble cannot change the fundamental enacting provisions of the statute itself. Consequently, if the legislation is put into force as it presently exists, it seems to me that we're working almost in a kind of vacuum.

The solution, in my submission, if it has not already been suggested as an amendment, is that the preamble be brought into the enacting part of the legislation and made part of the statute. In that way, it serves a number of functions. For one thing, it gives the health care council that is established by the legislation the crucial statutory definition, standards and the criteria that it requires in order to carry out its functions, one of which of course is reporting. That, I think, is one of the main preliminary comments that I would have in connection with that part of the legislation.

The next impression I have with respect to the legislation is the functions of the health quality council. Its principal function is to report periodically on the status of the health care system. However, it seems to me that the functions of the council should go well beyond this.

The council should, in my submission, also be given investigative power, not just, as the legislation states, to monitor and report, but to investigate, because it may well be one of the most elementary difficulties that the council encounters, not to have the ability to carry out its own inquiries as to compliance with the standards of the system.

1720

There is one very general aspect, but perhaps I could deal with it now. While it is not strictly, I suppose, within

the confines of this bill, it's certainly the basis of the whole health care system, and that really is the matter of the financing of the health care system. As I gather it, the government is encountering financial difficulties and is suggesting a great many, I think, crucial changes in the system to deal with this conundrum in the way of suggested reductions and delisting of various services, various devices of that sort.

The question, of course, comes down simply to a matter of funding. As I conceive it, the situation is that the cupboard is bare financially and there has to be some way of making ends meet with respect to providing the means for the health care system to carry on.

The one solution that seems to offend the government is the matter of taxation. The suggestion I have is very obvious: We've got to raise taxes in order to fund the system. Taxes, in my opinion, are the price we pay to live in a progressive democracy. I don't think the general populace would shrink from agreeing with some general increase in taxation. The other aspect of course is that the Romanow commission made quite plain that the system as a whole depends on progressive public taxation. This, I think, should be the whole basis of Canadian health care. It has been in the past, but that has certainly been compromised through the years in a great many ways.

The one aspect with regard to funding of the system that I think should be touched on, if it has not already been done, is the question of capital financing. My suggestion—it's certainly well known as a method—is to make use of the Bank of Canada. The Bank of Canada Act, clause 18(j), contains the ability and power of the bank and the provincial government to negotiate loans for the purpose of public expenditures. Certainly this, I suggest, is one of the main ways in which the system could be helped over difficult periods.

Another suggestion—I don't know whether this actually has been carried into effect but I believe the suggestion has been made—is that with respect to the financing of public accounts and accounts with respect to the health care system, resort be made to the modern and intelligent way of accounting, I would say, which is accrual accounting or capital accounting. In this way, at least we would know how the system is doing. As it stands now, I believe there is a transition going on, if I'm not mistaken, in that respect.

These two aspects of financing, I think, are part of a system that was part and parcel of Canadian financing in the past. We financed World War II entirely through the Bank of Canada at the end of the Great Depression and not only managed to come out on our feet, but we were able to finance the transition from a wartime to a peacetime government through the same method.

There is one other aspect, I would suggest: the matter of audit. I think there is a reference in the bill to this, but I don't see anything that would require the council to carry out audits or require audits of the private sector part of the health care system and report to the Provincial Auditor. If that's not in place, I certainly think it should be. Not only that, I think any report that is made in that fashion, if it were, should be submitted by the Provincial Auditor to the federal Auditor General. I don't see anything in the bill about that.

A subject that's very bothersome, especially for some groups, is the matter of free-standing clinics and the method of privatizing, in effect, part of the health care system by allowing these entities to come into being. This seems to me to be quite contrary to the thrust and spirit of the health care system, which is essentially a public system. Yes, there are private providers, of course, but the system has been privatized well beyond anything that existed in the early stages of health care. The trend toward intensifying that kind of transformation in the system, I submit, is unsound. It's certainly destabilizing. We have a kind of chaotic situation now, with the disparities in the state of provincial health care systems and the federal government. The right hand doesn't seem to know what all the left hands are doing. It seems to me that much of this is the pressure that has been building up for many years to allow a privatization of the health care system, which I submit is entirely wrong.

The people who I think are most emphatic with respect to that process are the ones who have the most privatized system presently in place, and that of course is the Americans. The American health care system is a glaring example of what could happen in Ontario. They have problems of almost insoluble difficulty—

The Chair: One minute.

Mr Campbell: Thank you.

There is no real end in sight. Some of the critics of the system—and I have no doubt this has been referred to before the committee. The article in the February 2 issue of Time magazine about the crisis in the American health care system over the cost of pharmaceuticals and drugs, that kind of thing, clearly states in so many words that this is a crisis and that the American public is being left to a kind of game of chance, which is really something I think should be a salutary warning to legislators in this province. I don't think we should go further in that direction, and I don't think it's necessary. There have been many studies carried out that indicate, for one thing, that in comparison we have a much superior system in Ontario, dependent on the fact that it is a public one, not a private one. Consequently, the notion that private health care is superior is exploded in many American studies by authorities from Harvard and Yale University. It doesn't exist in that form.

The Chair: That would be a wonderful note to end on. Thank you very much. We appreciate your coming. Unfortunately we have no time for questions.

1730

TORONTO DISTRICT HEALTH COUNCIL

The Chair: If we can move on to our next group, the Toronto District Health Council, we have Scott Dudgeon here today, the executive director, and Mimi Lowi-Young, who is the chair. You have 20 minutes to use as you see fit. Any time that is left over from your

presentation will be used by the other members of the group to ask you any questions they may have. If you would introduce yourself for Hansard, the floor is yours.

Mr Scott Dudgeon: Thank you very much to the standing committee for the opportunity to present to you. I want to introduce Mimi Lowi-Young, the chair of the Toronto District Health Council. I'm Scott Dudgeon, the executive director.

I'll tell you a little bit about district health councils. I expect that some on the committee have intense knowledge of the health care system from the perspective of a user and some from a more concentrated view of the health care system. District health councils have been around for 30 years providing advice to the Minister of Health on the health needs of their respective communities. There are 16 in Ontario now. Toronto District Health Council is the smallest in area, but it's a fairly complex city and it has some very complex issues. Our job is to make sure that whatever changes take place in the health system make sense for the people of Ontario, that whatever issues emerge in the delivery of health care are brought to the attention of the minister and solutions are provided. We do our work through extensive relationships we have with providers and consumers throughout the breadth of the system and through a board that's comprised of equal measure of providers and consumers. It's kind of a unique arrangement; an excellent tool for governance. We do it through the hard work of a very small staff of professional planners and epidemiologists who have expert knowledge of health system planning. So that's who we are.

We are happy to have this opportunity to talk to you about our views on Bill 8 and to offer you some advice from our rather unique perspective. We want to start by applauding the government for Bill 8. We think that the commitment to the future of medicare in Ontario, as expressed in Bill 8, is solid, noteworthy and commendable. We think that accountability is vitally important and that putting instruments in place that reinforce accountability is similarly important. We have an accountability agreement at the district health council that was an agreement between the district health council and the then Minister of Health, Honourable Elizabeth Witmer, that stipulates what's required from either party. It stipulates the roles of the minister, the ministry, the chair, members of council and the executive director in very clear language. It's clear about the length of the term of the contract and other arrangements. We think it serves as a reasonable model for accountability agreements with other elements in the system.

In the situation we're in today, we need to have absolute clarity as to what is expected of health care providers and others in the system and what is expected in terms of what can be delivered for the amount of money that's being spent in pursuit of meeting service objectives. In any agreement of that sort, there needs to be a clear definition of what the rewards and consequences associated with the delivery of the items in the agreement are. We think it's commendable that the government intends to proceed in this fashion. We're going to come back to accountability in a moment.

The second thing I wanted to comment on was the advent of the quality council. We think this is absolutely essential, and it's tied very closely and logically to the notion of accountability, because there is too little intelligible information on the performance of the health system that would allow you to monitor the performance through the accountability agreements. I'm thinking particularly in the community sector, where the metrics are just not solid enough to be the basis for very rigorous accountability agreements.

We need to have a quality council that identifies what the measures are that need to be put in place to make sure the system itself is delivering what it needs to in the form that it needs to be delivered in to the people who require it. We think that it fits quite nicely with the national quality council, and we're seeing a sort of cascading of measurement responsibility from the federal to the provincial to the more local geographic unit, which at the moment is district health councils. We're quite happy to continue to play a role in this.

A few years ago the Toronto District Health Council played a leadership role in creating the first local health system monitoring project. We did this because our council took the view that it couldn't adequately report to the minister on the performance of the health system unless it had a good sense itself as to what the impact of the reforms that have been taking place so far has been. Are those reforms being enjoyed by the entire population to the same extent? What are the areas that we should focus on to plan for further system improvements? We commented on about 70 performance indicators that identified issues of health care utilization, issues of health status and descriptors that set the context so that you understand the basis of the population on whose behalf the health system is arraying its services.

Since that time, we have worked with district health councils across the province to similarly develop local health system monitoring projects, which allows government and providers in various communities to get a handle on the context for what's going on in their areas on the basis of performance in other parts of the province.

Currently the people involved in this project are developing measures of inequity, in terms of measuring the extent to which services in Ontario are accessed evenly and equitably and in relation to people's actual need for those services. We're looking at such areas of equity as geographic distribution of services. Do people in the north have the same utilization rates for certain services as people in the more urban parts of the province? Do women have different issues with respect to accessing services than men? Do aboriginals have particular access issues relative to the rest of the population? We're going to be happy to be reporting on that in the fall of this year.

We think we can play a very vital role in supporting the work of the quality council. What distinguishes

district health councils and their work in this area is the rather unique blend of highly analytical work performed by our planners and epidemiologists and our highly consultative approach to planning, where we work with experts in the field to develop consensus on what's important and how to go about measuring it. So we're putting that on offer as something that will support the good work of the quality council.

The third point I want to raise is back to the issue of accountability. You will have heard by now, I expect, from many of the silos that characterize the system about what interests those silos in the area of accountability. What concerns me about moving forward in developing the system is, how do we break out of the silo orientation, and who's going to take responsibility for the delivery of health care at the system level? If I can take Toronto as an example, you're going to have accountability agreements with the 24 hospitals in Toronto, with the 22 community health centres, with the five community care access centres, and as this unfolds with the many hundreds of other agencies that exist in Toronto, who is going to be responsible for ensuring that the volume of activity that's described in accountability agreements is actually required? If you have a number of hospitals, for instance, that are making agreements with the province to deliver X volume of services on behalf of the residents of Toronto, how is government going to know that X is the right number of services required for the city of Toronto?

1740

Our job, our mandate and our responsibility is to make sure that there is a plan, and that's what we're working on right now: to develop a service plan that identifies for you what the needs are in Toronto between the years 2008 and 2016, to give us a reasonable planning horizon. On the basis of that plan, we're also providing for government's consideration a plan for reshaping the decision-making structure for the health system at the Toronto level. What we're going to be proposing is that there be a body that's responsible for planning, for negotiating agreements with the various agencies and for making sure that those agreements are done on a multi-party basis to make sure that for geographic units inside Toronto, hospitals, community health centres, long-term-care facilities and primary care physicians all have a way of binding their mutual obligations together on behalf of the residents of that geographic area and with the people of Ontario through the government. We think that something this committee is going to want to consider is, across the province, how are we going to make sure that there are mechanisms for system-wide accountability at the local level?

I want to finish on that note. I think that's maybe the most critical bit of advice that the Toronto District Health Council would like to offer you. I want to make sure that there's room for discussion. Thank you, and I'll take whatever questions you might have.

The Chair: That's wonderful. Thank you. You used up about 11 minutes. You've left us with nine, starting with Ms Wynne.

Ms Wynne: Hello. How are you?

Mr Dudgeon: Hello again.

Ms Wynne: I haven't seen you since 7:30 this morning. We have to stop meeting like this.

You talked, Scott, about the breaking-out-of-the-silo mentality. Can you talk a little bit about what the mechanism would be? How would you actually insert yourselves into that process if offered the opportunity?

Mr Dudgeon: That's an excellent question. I think people in the system look to us to take a system orientation. We've had an honest-broker role for years that only works in the current circumstances because we neither fund services nor provide services; we're noted for our objectivity and our skills in planning. People trust the district health council, and they work with us. I'm continuously impressed with the extent to which people are willing to give up their evenings and their family time to come and sort out how to improve access to neurosurgery, how to improve the delivery of palliative care or whatever issue we might be working with. So building on the trust that exists and our planning strengths, we're in a position to help government achieve that breakaway from the silo orientation.

What's really important, though, is for government to have the will to do that. It's not an easy matter. The system was not designed as a system. The silos evolved quite naturally and have pretty rigid walls around them. It's going to take tremendous will, effort and concentration on the part of government to break through that. I'm offering our assistance. We certainly wouldn't be in a position to do it without tremendous support from the government.

I think the most important step for government to take in that direction would be to focus on population. So the starting point of the discussions has to be, what does the population of that area—say, Toronto—need in the way of service? How do we know this? Can this be backed up with sound evidence? Then move from there toward the delivery of service. Prior discussions have focused on what additional services are needed. I'm suggesting that if we start with population and move toward service, that would be a corrective that would be very helpful.

The other thing—and I'll finish with this—is that we need to move the whole system at once. Through the last effort to restructure the health care system, the starting point was hospitals. The restructuring commission had the legal power to direct hospitals to do things. It had the force of law. The commission only had the power to make recommendations to government to change the other elements of the system, and those didn't happen as a single effort. There were delays in getting to the community pieces and there was a mismatch between getting objectives met because of the difficulty of addressing the whole system at once. So I'm suggesting you start with the population and use the system as the vehicle instead of the individual delivery units.

Mrs Witmer: Thank you very much for your presentation. I've always appreciated the work of the health councils in the province. I think they have a very import-

ant role to play. I guess part of what you've indicated here is that you see a unique role for yourself as far as supporting, for example, the creation of an Ontario Health Quality Council with a mandate of ensuring accountability in our health system.

When you talk about this, do you envision other councils in the province also supporting the government in this respect, or are you focusing solely in your remarks on the Toronto District Health Council?

Mr Dudgeon: I'm not in a position to speak on behalf of the other district health councils, but if you're asking if that's something that's conceivable, I think that we've demonstrated, through the last couple of years, a collective will to increase the level of intelligence that's available for government to make decisions by working together in data collection, analysis and interpretation. I think that district health councils—and this is my opinion—would welcome the opportunity to support the health council through their skills.

Mrs Witmer: Are there any priorities that you would see for a health council? We've seen that it's taking a long time for the federal council to get underway and what have you. What would you see a provincial council doing? What would be some of the first priorities?

Mr Dudgeon: My sense is, a high priority—I don't know that it's the first priority—has to be the development of meaningful metrics for measuring system integration. We all want system integration, but would we recognize it when we see it, and how do we measure progress in that direction? I don't think there is substantial agreement in any kind of finite way of measuring that. I think that would be my first priority, if it was my call.

Close to that would be just getting simple performance measures in place for the community sector, which is struggling to demonstrate its worth. We all know that the community sector does tremendous work, but how do you measure the value of keeping the frail elderly at home and autonomous and aging in place? How do you measure, then, the efforts that are taken by those agencies to accomplish that? How do you measure it in a way that gives them the tools to better manage their work and to look for opportunities for integration in support of doing that? So those are two areas that I think would be important.

Ms Martel: Thank you for being here so late in the afternoon. We heard the same in Ottawa, that there is a sense that district health councils want to provide support in whatever way, shape or form that may be to the council. You have set out where you have been heading. Clearly a great deal of work is being done on the local health system monitoring project and then in the process of developing a health system plan for Toronto.

My question would be, what is the status with respect to other district health councils? I'm not trying to undermine you by asking you to comment on the others, but I wouldn't have any clue of what the capacity would be of other district health councils to respond in a similar fashion where they are in terms of planning for health care services in their own regions, which in many cases would be a lot bigger than yours geographically and present some unique challenges that way in terms of the delivery of services.

1750

Mr Dudgeon: Thank you very much for the opportunity to amplify a point that was maybe hidden in some of my earlier remarks. I think that in pursuit of government's agenda to improve on the delivery of health care, one of the things we need to do, whatever the goal is—and I assume the goals are all lofty—is to recognize the need for different starting points across the province.

Toronto's health system plan is predicated on a set of institutions and a set of agencies and organizations, some skills that we know to be on the ground and available for retooling, in pursuit of a better system. I know that in Sudbury you'd have a different configuration of services and a different set of skills and capabilities, just as I know that the issues confronted by the system in Sudbury or Kingston or Kitchener, or in Kenora for that matter, all have different priorities. I think we can all move to a more integrated system taking those different starting points into account.

District health councils are meeting tomorrow and are going to be looking at a common approach to take to government that would say there are fundamentally four sets of starting points that need to be considered: one would be urban, and that's the point that I was referring to for Toronto; one would be a starting point that deals with matching the capacity of the system to the rapid growth experienced in the greater Toronto area; a third one would be northern communities and the unique challenges they face, particularly with dwindling populations and an eroding resource base; and the fourth one would be rural populations.

What I'm suggesting to you is that in moving toward a single, very solid view of a more integrated system, let's take advantage of the different skills, the different resources available to district health councils and the different starting points available across the province.

The Chair: Thank you, Mr Dudgeon and Ms Lowi-Young. Thanks for joining us here today. We appreciate it.

MEDICAL REFORM GROUP

The Chair: Our last delegation of the day, the Medical Reform Group: Aaron Rostas, a member of the steering committee, and Bradley MacIntosh, another member of the steering committee. Make yourselves comfortable. The same as all the other groups we've seen today, you get 20 minutes. You can use that any way you see fit. If there's any time left over at the end of your presentation, we'll use that amongst the three parties to ask you any questions that we may have, up to the 20-minute limit. The floor is yours.

Mr Bradley MacIntosh: To start, I just wanted to describe the Medical Reform Group. It's an organization that was formed in 1979 and it's a group of approxi-

mately 300 practising physicians, medical students and other health care advocates. The MRG represents the views of its members on health and health care matters through research, public statements and consultation with other groups who share our aim of maintaining high-quality, publicly funded, universal health care.

The Chair: I've made an error. I forgot to ask you to introduce yourselves for Hansard.

Mr MacIntosh: OK, I'll get to that. But first—

The Chair: I think you probably should do it now because they're trying to record what you're saying and they don't know who's saying it.

Mr MacIntosh: OK. I'm Brad MacIntosh and this is Aaron Rostas. We're very pleased to be able to present our brief on Bill 8. As I was going to say, Aaron and I actually bridge over two parts of the Medical Reform Group because we're also founding members of a student chapter. We recognize the benefits of open discussion, political awareness and diversity, and we hope to share that with you today.

We're very pleased that the government is explicitly stating its support of medicare through Bill 8. Our presentation today will focus on areas where we believe Bill 8 can be strengthened and ensure that Ontarians receive the best health care possible.

Now Aaron is going to talk about parts I and II, and I'll finish with some comments on part III.

Mr Aaron Rostas: As you're aware, part I deals with the implementation of an Ontario Health Quality Council. We have a number of thoughts that we'd like to share on that. The Medical Reform Group strongly supports the development of a council to report back to Ontarians on the state of their health care system. We also agree with the proposed size of the group and we definitely support the notion of diversity among council members.

However, we believe that the appointment process as it's currently structured could potentially lead to the formation of a partisan council that is not sufficiently independent from the government. We go on to suggest a number of possible alternatives for that, and I'll allow you to look through those.

In general, we feel that the appointment process should attempt to mimic the appoint process of the national health council in Ottawa. The Medical Reform Group was happy to be involved in the process of implementing the national health council, and several of our suggestions were followed.

We also strongly recommend that the council's power to make recommendations not simply be limited to reporting needs. The Ontario Health Quality Council, as it's immersed in research in the health care system, is in a strong position to make non-partisan recommendations regarding health care system structure and function. For political reasons, as I'm sure you're all aware, governments must often focus on short-term cost containment goals instead of looking at longer term cost-effectiveness. An example that comes to mind is the previous government's attempt to palliate the problems of physician shortage by increasing the number of positions in medical schools, but not following by increasing the number of residency positions in proportion to that. Currently, an article that just came out in The Medical Post states that this year, for the first time, there are in fact more people applying for residency positions than there are actual positions, forcing medical graduates to have to leave and go to places like the States. We're hoping that a strong Ontario Health Quality Council could make recommendations to look a little further down the road and help overcome some of these shortcomings.

The second part of the bill deals with health services accessibility. The Medical Reform Group strongly supports the notion that health care practitioners such as physicians only be permitted to charge OHIP for insured services. The Medical Reform Group strongly supports the right of the government to regulate block fees for non-insured services. However, we believe that the government should go one step further. We feel that the government should go beyond simply regulating block fees and ban them entirely. Recent news reports have highlighted instances where doctors have circumnavigated the College of Physicians and Surgeons of Ontario's block fees policy. For example, a recent Globe and Mail article reports that two doctors are charging their patients $2,500 per year to receive care. This practice, which is reasonably common in the United States, is known as "boutique medicine" and has come under intense criticism across the border. The CPSO's own magazine reported that patients in one Ontario town were told by their physician's office that the doctor would not return phone calls unless they paid a block fee.

There are several important reasons why block fees should be banned. With thousands of Ontarians unable to find a family doctor, it's both irresponsible and unethical for physicians to limit their practices to those who will pay for their care. Furthermore, the number of physicians in Canada is significantly lower than almost all other G7 countries; Ontario specifically has the lowest number of family physicians per capita out of every single province in the country. The financial incentives that block fees provide further discourage physicians from taking on new patients.

Many of the items for which some physicians charge fees are in fact medically necessary. What are called "necessary adjuncts" in Bill 8 are essential to the doctor-patient relationship and we feel should in fact be insured services paid for by OHIP. These include such responsibilities as acting as a patient advocate, giving customized advice, renewing prescriptions and providing adequate transfer of care when a patient needs a new doctor.

A block fee will inevitably open the door to some form of boutique medicine. Non-paying patients may receive less of the doctor's time at appointments or less advocacy when they need an important diagnostic test. Due to the difficulty in monitoring block fees, as well as a natural reluctance of patients to complain about their

doctor, any block fee policy designed to simply minimize harm is unlikely to be successful.

If block fees are to still be allowed, the government should still ensure that necessary adjuncts, as defined by either the Lieutenant Governor in Council or the council itself, be excluded. Block fees should include only truly optional services, such as forms for summer camp, non-insured vaccinations etc.

Other recommendations to minimize harm include: Doctors who charge patient block fees should be required to post a government-designed poster in their office outlining what services cannot be included in the fees. The poster should explain to the patients how they can file a complaint if their doctor is violating this policy. The government should clearly state that doctors must not discriminate between patients who pay a block fee and patients who don't, neither in terms of accepting them in the practice nor in terms of the quality of OHIP-covered care that's provided. Finally, the government should permit itself the right to specify a maximum allowable block fee.

1800

Mr MacIntosh: The third item that we were going to speak to is the issue of accountability. In principle, the MRG is encouraged by the introduction of such an idea. However, we found it difficult to actually make recommendations in light of some contrasting initiatives. So there's the issue of accountability—which is nice—the language of which we support wholeheartedly. However, in Ontario, we feel that there's a commitment to finding new ways to pay for or deliver services.

So I call your attention to two examples where the MRG basically has a question to you, and we're wondering how these two examples fit into the context of accountability. The first example is the mortgage-to-own hospitals, which were previously called P3 hospitals; and the second example is the private MRI and CT scanners. We don't understand how these two items are incorporated into the context of accountability.

In the first case, mortgage-to-own contracts are still in negotiation. So the MRG recommends that you clarify how listed issues such as transparency, public reporting and trust get translated into practice in this context.

As the MRG has previously stated, we are opposed to governments embarking on temporary cost-saving mechanisms or means of delivering some sort of health service. One of our members, Dr P.J. Devereaux, has published several papers articulating the difference between private for-profit hospitals and private not-for-profit hospitals. In several studies he found, for example, an increased rate of mortality in private for-profit hospitals or increased mortality in hemodialysis centres. So with that as sort of the backdrop, we find it difficult to understand how this evidence will be incorporated into the accountability. That's a question we present to you.

The second item is the private CT and MRI scanners. That story is also quite telling, because as we've heard from the current scanners that are operating in Ontario, the issue of accountability is already missing. So how is this proposed act going to affect the services, which I understand are currently in the form of renegotiation? Issues like documented adverse drug reactions or breaching of rules, protocols, such as administering contrast agents: These represent breaches of this bill. We're not sure how this would then be reflected. So that comes back to a problem with the bill in this section, and that is, the definition of a health resource provider is general in the sense that it could be a doctor, a community centre, a long-term-care facility or, as I've said here, these particular examples. So it may be useful to decide whether the issue of accountability is going to be generalizable to all the circumstances.

In closing, despite election promises by the Ontario Liberal government stating that they were not going to outsource health care services, this is not the reality. So we wanted to just introduce that as a glaring problem with this bill. We're disappointed in these steps, and we'd just like to acknowledge that in the context of accountability.

To summarize, we support the idea of an Ontario Health Quality Council, although we recommend some modifications as have been listed here. To ensure that all Ontarians have equal access to medically necessary care, the MRG recommends that the government ban all block fees. Finally, to ensure transparency, the MRG recommends that all accountability agreements that are drafted in part III be made public.

The Chair: Very good. Thank you very much, Mr MacIntosh. You've left us about six minutes, so we can probably get three questions in, three final questions of the day, starting with Mrs Witmer.

Mrs Witmer: Thank you very much for your presentation and your review of Bill 8. I'm not quite sure, though, of your position on block fees, because on the second-last page you come back and say that perhaps they should be allowed for non-insured vaccinations. I guess the truth is, if doctors aren't going to be reimbursed for these, how are they going to be paid?

Mr Rostas: There are certain medical processes that physicians do that I guess they do need to be reimbursed for. Examples might be a plastic surgeon doing a cosmetic procedure or something like that. But we see those as different from something where every patient is required to pay as just an aspect of their care; block fees such as photocopying services and things like that and the example of doctors charging $2,500 per patient. Those were fees simply given essentially to belong to the practice under the guise of telephone costs and photocopying costs. We believe those sorts of fees definitely impair access to the physician.

Mrs Witmer: What about the non-insured vaccinations? Who pays for those?

Mr Rostas: In those cases, the patient would be paying for those, because I guess it's felt by the government that those are not medically necessary things. For example, someone travelling to a foreign country may need something. However, we're certainly not implying

that vaccinations that are medically necessary shouldn't be covered by the government.

Mrs Witmer: I think your points on the health council are well taken.

Ms Martel: Thank you for being here at the end of the day. We appreciate it. I'm just going to focus on your last point and relate a story to you that happened in Ottawa. When we were in Ottawa, I moved a motion to have the details of the lease agreement being negotiated between the government and the private consortium at the Royal Ottawa released so the public could have a sense of what was happening in that regard, because my concern is that if you don't release it now, once it's signed, sealed and delivered, there isn't going to be much anybody can do to change the details. One of the Liberal members argued against that motion, saying that would intrude upon confidentiality provisions and commercial confidentiality provisions and might cause the private sector consortium to flee. I would be very happy if they did because, quite frankly, if you're a supporter of medicare, you support publicly funded, publicly administered and publicly financed health care as well, something that is missing in the current P3 hospital proposals, both in Brampton and in Ottawa.

In terms of accountability and the lack of accountability of this government around those particular two mortgage arrangements—they used to be lease arrangements; now we call them mortgage arrangements—what is your concern as we go down the road when they're not included and we can't see the details of those commercial transactions, when we can't see the details of the commercial transactions involving the MRI and private CAT scan clinics? What is your concern about where we're heading with respect to medicare if we start to move in that direction and we can't see where that money is being spent or how much of it is being spent in a profit instead of on delivery of front-line health care services?

Mr MacIntosh: There are several components to answering that. The first one is that we know when we outsource services to the private sector, investor-owned businesses, that the service is not the same quality. In the case of the private MRIs, we know through anecdotal evidence, as documented by the Ontario Association of Radiologists, that patients aren't getting the same quality of care.

That's something that's happening at home in Ontario, but in general, the idea of privatization or P3 models, we know from the body of literature elsewhere—as in Britain, for instance, where they tried these financing schemes and they didn't actually work out well. The current government appears to be pigeonholed or backed into a corner based on previous governments finding ways or looking for ways for business initiatives, so unfortunately they're dealing with the previous government's laundry.

Ms Martel: But they made a promise to cancel them. Let's not forget that during the election in order to get votes this government said they were going to cancel the P3 hospitals and the private MRI clinics, please.

Mr MacIntosh: So, the question is, are they reading the contracts, and if so—I don't know that. I've spoken to people in the Ministry of Health and, to my knowledge, I'm not sure if this is something that is getting the attention it deserves. That right there is a bit of an insult, based on what their election mandate was. Second, if it is such a priority, then by all means go and take ownership of these hospitals. It's cheaper. It's safer. You just have to have the political will.

The Chair: Ms Wynne, last question of the day.

Ms Wynne: I just want to make a couple of points. Your point about the disentangling of previous agreements, I think, is well taken. Right now there are two ministries working on the going forward in terms of new infrastructure. The Ministry of Public Infrastructure Renewal and the health ministry are working on any building going forward being based on principles of public ownership, public accountability and public control. That's the commitment. But in every sector in this government in this province right now, we're looking at arrangements and deals that were made previously. We're trying to unravel that. This bill is a step toward cleaning that up and pointing ourselves in a different direction. In that context, is it reasonable that this is a first step? We're trying to get some sense of where the dollars are going, to refocus on what health care should be in the province and to put a mechanism in place—this is really a process bill—that will start to talk about the direction we're going in and make that public to citizens in Ontario. Does that seem like a reasonable thing to do? It's a small question.

Mr MacIntosh: It took a long time for me to actually deduce the context of the accountability, so I would say that if your message is what you're suggesting, then you should vocalize that.

Ms Wynne: The accountability mechanism needs to be made clearer, and that is one of the things that is going to happen in our amendments. So it will be much clearer how that accountability mechanism will work. Thanks.

The Chair: Thank you for coming today, gentlemen. I do appreciate it. We stand adjourned until tomorrow morning at 10 o'clock.

The committee adjourned at 1814.

Continued from overleaf

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