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Tuesday 24 February 2004

Journal des débats (Hansard)

Mardi 24 février 2004

Standing committee on justice and social policy

Commitment to the Future of Medicare Act, 2003

Comité permanent de la justice et des affaires sociales

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

Chair: Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

Tuesday 24 February 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE ET DES AFFAIRES SOCIALES

Mardi 24 février 2004

The committee met at 1003 in room 151.

COMMITMENT TO THE FUTURE OF MEDICARE ACT, 2003

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

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

The Chair (Mr Kevin Daniel Flynn): We're a few minutes after 10, ladies and gentlemen, if we can call to order again. I bring to the members' attention that you have an interim version of the summary of the witness recommendations before you this morning prepared by Ms Luski. It brings us, I think, up to Friday.

Ms Lorraine Luski: Thursday.

The Chair: I'm sorry, Thursday of last week.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Chair: Our first delegation this morning is from the College of Physicians and Surgeons of Ontario. If the three delegates would come forward and make themselves comfortable, I'll just briefly explain the rules to you. You have 20 minutes to use any way you see fit. At the end of your presentation we'll take the time remaining and share it proportionately with the three parties represented here this morning. It would be appreciated if you would introduce yourself before you speak, for Hansard. I've got 10:04 and the floor is yours.

Dr Barry Adams: Thank you, Mr Chair and members of the committee. On behalf of the College of Physicians and Surgeons of Ontario, I'd like to thank you for this opportunity to make this presentation to the committee.

I'm Barry Adams, the president of the college. I'm a practising pediatrician in Ottawa and I have done that for almost 40 years now. On my left is Dr Rocco Gerace. Previously he was an emergency physician in London, Ontario, and is now registrar of the college. On my right is Louise Verity, director of government relations and communications for the college.

The college governs the practice of medicine in Ontario in keeping with the overarching principle of the legislation that guides us, the Regulated Health Professions Act. The principle is "to serve and protect the public interest." The college's duties, in part, are issuing certificates of registration which permit physicians to practise medicine and ensuring the continuing quality of physician practice through peer assessments, education and remediation. We investigate public complaints about doctors, we address concerns about physicians who may be incapacitated and we discipline those who commit acts of professional misconduct or who are incompetent.

We congratulate this government for its commitment to ensuring the best quality of health care for the people of the province. The mission of our college is the best quality care for the people of Ontario by the doctors of Ontario. Therefore, I think both the government and our college are on the same wavelength. The principles of accessibility, accountability and collaboration are central to our strategic plan.

In bringing our views on the review of Bill 8 to this committee, we look at the regulatory perspective, and more importantly, the public interest perspective as encompassed in the bill.

We'd like to convey our support for the government's decision to conduct public hearings early in the legislative process. We feel this will be beneficial because we are concerned that some aspects of the bill will not meet the government's objectives. The minister has made a commitment to revise the bill significantly. We support many of the proposed changes that we've heard and look forward to continuing to work with all parties to achieve a common goal.

Our review of the bill is organized into five key areas: self-regulation, the Ontario Health Quality Council, health care resources and access, accountability, and regulation-making authority. For a detailed summary of our analysis and recommendations, please see our full submission and accompanying table.

As pertains to self-regulation: The government of Ontario has consistently supported this principle. Self-

regulation, also known as professionally led regulation, is based on the premise that where a very specific or technical body of knowledge is needed to assess a professional's behaviour, a central role in regulation must be played by the profession itself. This duty is given to the profession with the acknowledgement that the regulator must never put the profession's interest before that of the public. The college believes that self-regulation is the cornerstone of providing medical care that is responsive and sensitive to the public interest.

With respect to block fees in the bill, we understand from remarks the minister has made and subsequent meetings and discussions with ministry staff that the government does not intend to move the responsibility of regulating block fees from our college to the government. We are pleased that this is the case. Block fees are currently a part of our regulatory responsibility. We regulate block fees by ensuring that all physicians in Ontario are aware of our policy and require that any charges for uninsured services be reasonable. Patients—the Ontario public—must be given an opportunity to make an informed choice as to whether they wish to pay for services through a block fee or on a fee-for-service basis.

As you may be aware, we are currently reviewing our block fee policy. This policy, like all of our policies, is reviewed every three years. This regular review process ensures that our policies are current and meet societal and professional standards. As part of the review of our block fee policy, we will consult with all stakeholders. This consultation will include input from government, the public and the profession. An important component of this process is to ensure that new or revised policies are clearly communicated to the public and the profession.

We believe that this section of the bill should be eliminated. The legislation as currently drafted would establish a regulation to govern block fees. Currently, the block fee policy is not enshrined in regulation. This is our preference, as it allows us to review and change the policy in a timely way. We welcome your suggestions about improving the block fee policy.

We support the Ontario Health Quality Council, but we believe the council's policy objectives, as well as its functions and duties, should be set out in the legislation as opposed to being left to regulation. For example, section 4 includes as a function of the council the support of "continuous quality improvement." This is currently a mandate of the health professional colleges under the act. We are supportive of any initiative that would guarantee quality health care to the citizens of Ontario. However, we are unsure as to where the responsibilities of the college might end and those of the council may begin.

Given that health regulatory colleges are responsible to the public interest and that they have a legislated duty to develop and carry out quality assurance programs, we wonder why this group is to be excluded from membership on the council. It is our hope that at the very least a strong and effective advisory structure to the council will be established. We would be pleased to help identify candidates for the council, as well as advisers to the advisory committee.

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Health care resources and accessibility: In this area, the college is committed to working in partnership with government to find ways to make health services more accessible. We know we share this goal but we suggest that this part of the bill may have some unintended consequences to the contrary effect.

With respect to section 15 of the bill, we understand that the intent is to prevent queue-jumping by punishing those who pay or accept a benefit for moving up the queue. Queue-jumping is not the problem, but rather is a symptom of long waiting times. This provision in the bill focuses on the wrong issue. Queue-jumping only happens when there are queues. Many patients in this province are waiting for health care services. They are in pain, partially or fully debilitated, and may through no fault of their own have months and sometimes years of waiting in front of them. Let's work together to fix the system, rather than just address the symptom.

Years ago, when there were long queues for cardiac surgery and people died while waiting for their surgery, the government instituted a system whereby people would be put on lists according to their needs. If the service couldn't be provided in Ottawa but a space was available in London or Toronto, these patients would have the option of moving into those spaces and having their surgery earlier. I think the same thing could be done for hips and knees and the other areas where there are patients waiting for years to have the services done.

Accountability is a critical component of our health care system, and we are supportive of an accountability framework. The accountability proposed in Bill 8 is focused in one direction: from health providers to the government. We believe that just as health providers must be held accountable, so too must health care consumers and government.

This part of the bill gives power to the Ministry of Health to establish accountability agreements. Although drafted with the right intention, we are concerned that the provisions of this section are heavy-handed and have the potential to interfere with care. The college recognizes that the minister has made a commitment to negotiate agreements with hospital boards rather than impose such agreements upon them. We believe this approach is much more appropriate.

As to regulation, I'd like to speak briefly about the extensive regulation-making authority set out in the bill. As a result of this authority, it is very difficult to analyze the practical application of the bill. We understand the minister has indicated that he intends, through amendments, to beef up certain sections of the legislation rather than leave them to regulation. We support this move. Furthermore, we understand that the government has agreed to consider a 60-day consultation period for development of regulations. This, in our view, would be a very constructive approach if the consultation is broad in scope.

Thank you again for the opportunity to appear before this committee. The college and the government share a

common goal: providing the best quality of care for the people of Ontario. We hope our analysis of the legislation will be helpful to you as you move to the clause-by-clause deliberation stage of the bill. The legislation must be significantly amended. We welcome the opportunity to continue to work with government as amendments are developed and finalized.

Thank you for hearing us. We'd be pleased to answer any questions.

The Chair: That's great, Dr Adams. Thank you very much. You've used up about 11 minutes, which leaves us with nine. So we'll assign three minutes to each of the parties, starting with Mr Klees.

Mr Frank Klees (Oak Ridges): Thank you, Dr Adams, for your presentation. We've now completed almost a week and a half, I suppose, of hearings on this bill, and I have to say to you that we have yet to hear from any group that supports this bill. In fact, the minister himself, when he presented here at the opening of these hearings, was very apologetic for what he admitted was a very flawed piece of legislation, and undertook that there would be wholesale revisions and amendments to this bill.

You've effectively pointed out a number of areas of your concern. I'd like to follow up in one specific area, and that's related to block fees. I gather from your submission this morning that the minister has specifically undertaken to you that the regulation of block fees will be left with the College of Physicians and Surgeons. Can you confirm that for us, for the committee, this morning?

Dr Adams: I have to pass to Louise, as she has been in discussion with the ministry staff.

Ms Louise Verity: On that particular point, we have had a number of discussions with staff at the ministry, and we understand that the intention is not for the government to take over responsibility for the regulation of block fees. The discussions we've been having are really around how we can perhaps amend the bill. But I think the government's also looking for an assurance that the policy—and this is one policy that Dr Adams has mentioned we are currently reviewing—is not only strong and effective, and responds to the public need, but also that it's well communicated. That's an area that we have committed to also discussing with government. As a matter of course, any time college policy is reviewed, there is certainly discussion with government as well.

Mr Klees: I can tell you that there's very broad concern across the province from physicians, the way this legislation is written, that in fact block fees may well not be allowed, certainly not allowed the way they are now, because if the government was satisfied that all was well, this wouldn't be here, would it? Frankly, we don't trust a great deal of what the minister or this government is saying; they haven't done a very good job of keeping their promises, and we asked him to get to us in writing the areas where they're prepared to make some amendments. Interesting enough, section 16 wasn't one of them.

I say to you that if you're relying on the minister to work these things out in regulation, be very, very sure of what you believe the minister is telling you today. Certainly, we will be insisting that any regulations come forward to this committee for our review to ensure that in fact what the undertaking has been in the course of these hearings is reflected in those regulations.

Mr Rosario Marchese (Trinity-Spadina): Thank you, Dr Adams and Dr Gerace, for being here. I have a couple of things. This bill reminds me a bit of the old Conservative omnibus Bill 26, which had tremendous powers that it had given to itself, including introducing eight municipal bills, each one building on the errors of the first and lack of proper consultation. I don't expect you to comment on that, really, but do you think this Bill 8 was perhaps introduced with some haste—not consulting with some of the stakeholders wisely or properly? Just an opinion.

Dr Adams: I don't know if it was introduced with haste, but we know it was introduced with the intention of having wide consultation before going to third reading. We certainly appreciate that the government has asked for that consultation early rather than later.

Mr Marchese: Very well.

On the block funding, you review it every three years. In between, presumably you find abuses. How do you deal with that? Is it public? Do you deal with it expeditiously? Does the example that you deal with help the others not to perhaps continue with some of those abuses? How do you deal with that, in between?

Dr Adams: Probably the registrar can answer that more, but we do deal with it in a couple of ways.

Dr Rocco Gerace: There's a range of responses that we have. In the vast majority of cases, there are simply questions raised by either a physician or a member of the public. We educate them, and generally in that forum both parties are quite happy that it's been explained and we're comfortable that the policy is being followed.

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That being one end of the spectrum, the other end of the spectrum is a discipline hearing that was conducted—I don't remember exactly when—where a physician was simply behaving in an egregious fashion with respect to fees. A disciplinary hearing was held and he was found guilty of misconduct.

Mr Marchese: That worries me. I heard two examples that were given yesterday of two doctors charging $1,200, I think it was, of block funding. I'm not sure I've got the facts straight, but those were two kinds of instances that were offered. One worries about that kind of fee. Maybe some of those fees should be covered by OHIP, I don't know. While some of those are legitimate, you simply wonder about that kind of fee. If the college isn't dealing with it in a way that satisfies governments, in a way that is satisfactory, governments then say, "Maybe we should be regulating it."

Dr Gerace: We've not been told, leading up to the introduction of this bill, that we hadn't been managing it properly. I think if we had had concerns brought to us with respect to how we deal with our block fee policy, we would have addressed them. We deal with it on a

regular basis, and while we can't talk about cases currently being investigated because of the privacy provisions of the legislation, I can tell you that whenever a concern is brought to us, we will address it.

Ms Kathleen O. Wynne (Don Valley West): Thank you very much for coming here today and for acknowledging the process of consulting early on a bill. As you know, this is after first reading. There will be another opportunity after second reading to give input. I don't expect my friend across the way to understand consultation, because that's not how they ran government. So I do appreciate your acknowledging that this is a good process.

I want to ask about the review process around block fees. Who does a patient contact if they have a complaint regarding the appropriateness of a block fee? Who do they get in touch with?

Dr Adams: They get in touch with the college. We have intake workers who register the complaint and it then goes to the complaints committee. Or some of them are resolved just by discussion with the patient and the doctor and it can be resolved in that area. If not, it goes to the complaints committee.

Ms Wynne: So it's a complaint-driven process.

Dr Adams: It's a complaint-driven process.

Ms Wynne: OK. This review that you are undertaking, how is the review going to address the issues of better informing the public? I think one of the concerns about block fees is that it's a bit of a grey area for people. It's handled differently depending on where you are. I think what we're trying to get at is, how does this become a more open process? They exist, and they exist for all sorts of reasons that we could go into, but how is your review process going to deal with the transparency issue for patients?

Dr Gerace: With respect to all of our reviews, we will consult as widely as necessary to get as broad an input as we can to revise any policy en route to counsel. If there is a perception that patients are being hard done by, we can consult with patient groups, and we've done that in the past for some of our policies. I'm not sure anyone has told us that this policy is broken. I welcome input from all stakeholders to suggest that there are problems that are not being dealt with. We will consult with patients, we will consult with doctors, we will consult with government, we will consult with others who have a stake in this issue.

Ms Wynne: So there's a bit of a disconnect, because we have heard people come and say there is a problem with this, so we obviously need to continue talking about this.

The Chair: The time has expired. Thank you, Doctors, and Ms Verity. Your presence was appreciated here this morning.

NORTHUMBERLAND HILLS HOSPITAL

The Chair: I'd like to now call forward the delegation from Northumberland Hills Hospital, which had been a delegation of one but I understand now it has swollen—grown—a little bit. Greetings. Make yourselves comfortable. The same rules as the previous delegation: You have 20 minutes to use any way you see fit. At the end of your presentation we'll apportion that time as equally as we can among the three parties, starting this time with Mr Marchese. Would you introduce yourselves for Hansard, seeing as there are five of you. I've got 10:27 and the floor is yours.

Mr Don Morrison: I'm Don Morrison, chair of the Northumberland Hills Hospital. On my left are two of our board members, Bob McInnes from Port Hope and George Bonar from Cobourg. On my right is our CEO, Joan Ross, and on her right is Peter Delanty, our mayor in Cobourg. We're delighted to make this presentation to you this morning. I'm making the formal presentation here because our concern about this bill is concentrated in the governance area. That's what we'd like to concentrate our remarks on in the limited time available.

Let me give you a quick description so you'll understand where our hospital is coming from. We operate in the 401 corridor, between Oshawa and Belleville. Our hospital is the biggest hospital. It covers a 50-mile space down the 401 corridor, on the north shore of Lake Ontario. This area is growing at the provincial average, even though it's a largely rural setting. The area around Cobourg is actually growing considerably faster than that. With the movement out of the GTA, that certainly is expected to continue. We also have the fourth oldest population of catchment areas in Ontario, which causes us particular concern. The bottom line is, health care, which tops every election poll that you're so familiar with, is certainly the top priority in our community.

Five years ago, our board inherited one of the worst messes in Ontario. There had been a long-standing conflict between the two smaller hospital communities in Port Hope and Cobourg, which reached a point where the Port Hope hospital was ordered closed by the HSRC. The board of the hospital was essentially hijacked by the embittered Port Hope community, and as a result ultimately the HSRC dismissed the old board. It became necessary to appoint a new board, which was done through a community nominating committee, and we believe we're the only board that has a ward system to ensure that there is democratic representation by area. That became necessary to resolve that and that's the framework we inherited.

The board also inherited a position that the HSRC had mandated, a $17-million renovation of the old Cobourg site. The Port Hope hospital was ordered closed and we had to sell it. That was one of our first duties. The $17-million renovation frankly was completely inappropriate. We could not have funded that and we quickly proved that it would cost as much to do that properly, with the enlarged program that had been approved, as it would to build a new greenfield site. We had to make that case and we had to sell it to the community, which we did.

We've come a long way since that period. What we essentially did, in order, was that we had to dispose of the

Port Hope hospital, with all the turmoil that focused on and the community criticism from that part of the population, and we had to develop the case for the new greenfield hospital. What we did at the end of the day, with all of the work down the line in terms of selecting the site, redeveloping it, getting through the municipal approvals, raising the money, was that we built a $75-million, spanking new hospital that opened last October. It's been operating for three months now.

The result of all this has been simply an incredible success. We have raised $24 million in the community, including $6 million from the municipalities and an $18-million fundraising campaign. That amounts to over $450 per capita—I'm talking about public fundraising only, not the municipal money—which is what our residents have contributed to this hospital on average. It shows how much they value health care and what it means to them. With a good program, they endorsed it, they hopped on, and it has been completed. It was completed on time, on budget, but I can tell you it took a lot to get there.

Throughout the period, this was an incredible combination of teamwork from our great staff, our CEO, the planning team, the consultancy architects we used, but it was the community that made this happen and it was the board that led that. It could not have happened without the combination, but it was the board that sold the vision. We designed, for example, the financial plan, which was completed, as I say, on time and on budget. I think it is a textbook success in terms of how the system can work if it works properly, and that we did.

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The community acceptance and enthusiasm for this is such that we had 10,000 people tour the hospital in the first two days of our official opening weekend. It was just a happening, it was incredible. The enthusiasm for the services since has also been great.

One of the great concerns we had with the old hospital, being subject to the two smaller ones being divided, frankly, our services fell through the cracks. We didn't have the total service that we were entitled to and that is justified by the new central community hospital. It's in the right location, in the centre of the area, and it provides the services that we need to operate properly.

What we've accomplished now is to get us back to about where we should have been in terms of equity compared with other provincial peers. We have not got a Taj Mahal, as some people have said. It's not excessive. We ran a very Spartan operation, which is why we're on time and on budget. I think, if you know hospital construction, that's a pretty unusual event in both cases.

In any event, unfortunately for us, we opened the hospital a month before Bill 8 was introduced. We see it as a very serious threat. Bluntly, we do not think, as a board, that we could have accomplished what we have under this structure. We think that the attitude in Bill 8, above all, is very unfortunate, very destructive and unwarranted. We're very concerned about the mentality that permeates the whole legislation.

The most shocking thing about it is that it was introduced without any consultation. It's fine that we're having these opportunities to appear as we are today, but this is very late in the day. There are only a couple of weeks of scheduled hearings. We haven't got the details of the amendments. We haven't got the regulations. We don't really know what this means. Above all, I'd encourage the committee to extend the process so that we can see what we're looking at before this is finalized. I'm assured by the comment that we may have other opportunities at second-reading level.

Bluntly, in the interest of brevity, we see Bill 8 as a transparent attempt by certain bureaucrats to take over control and centralize the hospital system. It's very clear what the intent is. We think there's going to be a very substantial policy movement to increased regulation, amalgamation. At the end of the day, what that has meant previously is reduction of hospital services, not an increase.

We recognize there's a very serious fiscal problem, but we've always represented our community and we've done the right thing. We don't think we've been unreasonable or that we've asked for things that we're not entitled to. We know, because of the fiscal situation, that obviously we're all going to have to cut our cloth accordingly, but to have the kind of structure we're looking at now is simply very destructive of the whole system and the relationship that we must operate in. We frankly see a parallel to the consolidation of school boards that the previous government introduced, which I don't think most people feel has been successful. It has certainly been very destructive in communities like ours.

Our community wants to participate. We have thousands of people involved in this process in one way or another. We have an auxiliary that has over 500 men and women in it. It has increased by 25% in the last year. They come from over the whole catchment area. That's what it means to run something like this. They are there from 7 in the morning until 7 at night as volunteers to make this hospital work as well as it could.

We're of the view—and we've looked at the regionalization theme very thoroughly. There have been seminars and hospital circles. We have never, frankly, seen any documented evidence that regionalization is cost-effective. The bottom line on it, I think, is that it has done a lot of damage, it has caused a lot of upheaval, and I don't think it has improved the system. We would not like to see that direction followed, and I'll talk in a moment about more constructive directions in which we think we could go.

We note, for example, particularly in terms of the section of the bill that the minister seems determined to maintain—I think it's 26—that the CEO would report to the ministry as well as to the board and could be terminated unilaterally without any compensation. We see that as particularly destructive. We have a very fine relationship. The CEO is our only employee. That is an intolerable way to operate. The board would essentially be gutted in terms of its authority. The CEO would

always be looking down the rifle barrel and wondering where he or she should report. That's an ambiguity that the BC government and the auditor concluded was completely untenable and made strong recommendations about. I point that out because some of the models of this proposal seem to be taking after the BC system as a model.

On the other side of it, I point out that the title of the bill in itself is misleading. To term this thing a commitment to the future of medicare is simply deceitful. This does very little to improve medicare. As I've already said, it clearly threatens and destroys some of the things that are important to making it work. Much is made of the need for increased accountability on the parts of boards. Frankly, I've run major businesses, and I think there's all the authority and accountability in the present system that should be required to make this work properly. The minister has the powers to introduce an inspector, an investigator and, finally, a supervisor, which is like a trustee in bankruptcy. The board can be terminated at any time. You've got budget control. You've got funding approval for the dominant portion of our operation. There's moral suasion. There are all the stops along that way. Why should there be a need to single out and make such a major issue and, above all, a merit of accountability?

I heard this morning that it was news that hospitals are going to be accountable and forced to reduce waiting lists. Well, you've got to get there. We need funding and we need to be able to do that. This bill does nothing like that. It threatens our doctors. You heard something of that in the earlier presentation. That is a very fragile situation and that's been severely disturbed by the mentality in this bill to date.

We think there is a great deal of accountability. Not least, I point out to you that under the Public Hospitals Act all hospital board members are personally liable for what they do. That was always enough discipline for me, I can tell you. Our board worried long and hard about the major decisions we had to make, the risks we had to take. At the end of the day, there'd be no doubt, if it went wrong, who was responsible. I think that is the greatest guarantee you can have of good discipline, but we all know there have been other methods. What I'm saying is that, through a combination of good management in the ministry and working closely with the hospitals, I think the system can be made to work. Again, I think what we've accomplished has been exemplary, while it certainly hasn't been without difficulty and has required an awful lot of relationships and conversations to make work.

Constructively, what we'd like to see focused on, rather than the brutal risk of amalgamation, centralization, regionalization of hospitals run out of Queen's Park, is the communities. That dimension very much concerns us. We think we understand the local needs and we think we're sensitive to taxpayers' interests as well. We'd like to see concentration on so-called vertical integration. There is not enough linkage between the access centres, the long-term care centres, the medical clinics and other things that total the health care system. The hospitals wind up being the dumping grounds for things that happen in those organizations that we can't do anything about. It's a myth that there is very simple and easily negotiated accountability of the sort that I think is intended here. Frankly, that intention is naive. We don't control when doctors write medical orders to admit patients to hospital beds or to get X-rays or whatever. That has to be brought into the equation here. We can't control what happens to long-term-care beds—they're over the fence—but when there aren't enough of them, they back up and our hospital beds are full. When a doctor goes on holidays or after-hours, the recording, as any of you must know, is, "Go to your nearest emergency ward." Guess what that does to us in terms of controllability? Probably 80% of our emergency patients aren't really emergencies. They're there because there are no doctors and because their doctors aren't available. That, in terms of controllability and accountability, is very important.

If accountability is to be further strengthened, such agreements have to be very sensitive to these kinds of issues. Above all, they have to be discussed and mutually understood. Otherwise, you are just going to pass in the dark all over again. As our new hospital project has shown, a lot can be improved in the present system. We struggled with the silos in capital projects. You have to deal with one group for your bricks-and-mortar building, then you have to have another whole round with the equipment people. You're uncertain, and there are very fuzzy rules, as to what happens in terms of the transitional costs in terms of training and moving. The last thing you do is get approval for your post-construction operating budget. When I had to explain that to Lou Rinaldi, he couldn't believe it. He said you never should have started the hospital. It's impossible, and business people would have thought it was. Here, it's the way things operate.

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There's a lot that can be improved in this system. What we're worried about is that, while we've succeeded, there's $8 billion, as I understand it, of capital planning going on for other hospital projects. If this isn't well-thought-out and processed more efficiently, a lot of money is going to be wasted, because there's high risk of disasters in that structure. At the same time, if you turn off the community input and enthusiasm that we've enjoyed, you're not going to be able to collect the pledges on the existing campaigns that are out there. If we have a centralized service and let's say our obstetrical work goes to Peterborough or somewhere else, is somebody going to pay for their last tranche of the pledge? Not likely. What about the new hospitals? If you're talking $8 billion, you're talking from a third to 50% that has to be funded through the community or some other way. That's a lot of money, and it's not going to come under this kind of structure.

Frankly, if this bill were to go through, our board has already decided that it would resign and it would not

participate. That's how strongly we feel about it. We think this bill should be sent back to the drawing board, that full upfront consultation should occur. We'd be delighted to participate in it. We'd be delighted to be made accountable, but this bill does not solve our problems.

The Chair: Thank you, Mr Morrison. We've got about three minutes left. So let's start with Ms Martel.

Ms Shelley Martel (Nickel Belt): I very much appreciated your comments. You're right: The bill is very destructive. The powers are quite overwhelming, and the problem is that it doesn't look like there's going to be any change, despite what others may tell you.

Before you leave, you want to get a copy of a February 19 letter that the minister gave to this committee in Windsor last week outlining the changes that he intends to make as a result of concerns. I want to tell you that there aren't changes that are going to meet with your approval, because it's very clear in section 22 that the minister will still have the power to issue a compliance directive or an order. So at the end of the day, the minister can still drive it home with a sledgehammer.

Secondly, under section 23, the minister still has the power to deal with CEO compensation or any other financial remedies to be applied to a CEO as a last resort after due process, blah, blah, blah. So I don't think your concerns with the current bill are unfounded, and frankly, your concerns should still be much in existence with the proposed changes that the minister has put forward, because at the end of the day, the minister is still going to continue to have broad, sweeping powers. There's no mention of negotiation, and the minister still has the control at the end of the day with respect to compliance directives and orders.

Given that that is very clearly the case in terms of the direction, do you feel any differently in terms of what your board intends to do?

Mr Morrison: No, absolutely not. Frankly, the Ontario Hospital Association has been far too passive about this until recently, because they were optimistic that the minister's promise to make changes would occur. I think those of you who saw the presentation yesterday will know that they're certainly very critical and uncomfortable with the current state of those amendments. We don't find them satisfying at all. My comment was written with those amendments in mind.

Ms Martel: Very good.

The Chair: Thank you, Mr Morrison. Ms Wynne?

Ms Wynne: Actually, Mr Duguid is going to ask a question.

Mr Brad Duguid (Scarborough Centre): Just very quickly, because there's not much time left at this point. I served on a hospital board for nine years, up until last year, and I've got to tell you, if I thought this legislation was going to do anything to, as you say, gut hospital boards, I'd have concerns about it. It will not gut hospital boards in any way. Hospital boards will have to be accountable to government, and hospital boards that I know and members of hospital boards whom I know want to be accountable for what they're doing.

So I'm really concerned about comments like, "We're going to resign if this bill passes," or that somehow hospital boards are being gutted by this bill when, as you recognize, the Public Hospitals Act gives the government the only tool that they have right now when there is a rogue board or a rogue CEO to move in and put a supervisor in.

What this bill will do is give you some interim measures that we can take and a process that will be set up in the regulations and through the accountability agreements so that we don't have to go to that length, so that there are things we can do to work with the boards rather than just taking them over. The previous government, and probably rightfully so on a couple of occasions that I'm aware of, had to use those powers. Those are extreme powers, much more extreme than what we're talking about in this bill. So I'm curious as to why you would think this is in any way gutting the boards.

Mr Morrison: I've been on a lot of boards of directors, and there is no jurisdiction I know of where the CEO reports in two directions at the same time.

Mr Duguid: There's nothing in this bill that says the CEO reports to the government.

Mr Morrison: Essentially, if the CEO can be terminated without notice and without compensation, you've got all the power you want. We would worry about who the CEO looks to.

The Chair: Thank you, Mr Morrison and Mr Duguid. Our time has expired. Very, very briefly, Mr Klees or Ms Witmer.

Mr Klees: The fact is, if I was in your shoes, I would resign too. Don't believe—

Ms Wynne: Why don't you?

Mr Klees: —this minister. Because I'm not in their position. The fact is that this bill will do exactly what you say it will do. It puts all of the authority, all of the power, into the hands of the minister. As Ms Martel indicated, the indications we've had from the minister that they are going to make substantive changes—the letter proves that they have no intention of doing that whatsoever.

This is heavy-handed. It is draconian. There is an absolute disconnect between what the preamble, in lofty language, says it's going to do and the rest of the bill. That's why we've been calling on this government to scrap the bill and start over.

I can say to you that either the minister did not understand this bill when he read it before it was tabled with this committee or he didn't read it, because no one in their right mind would bring forward a bill that attacks every sector of the health care community in this province, every sector. You're not alone. We heard from unions. We heard from doctors who say they are going to leave the province if this bill goes through. We heard from nurses. We heard from the volunteer sector. There isn't a single sector in the health care field that believes there is anything in this bill that is productive and that will help health care.

The Chair: Thank you, Mr Morrison. We do appreciate your frankness and your input today.

ONTARIO PHYSIOTHERAPY ASSOCIATION

The Chair: I now call forward the delegation from the Ontario Physiotherapy Association, Signe Holstein and Caroline Gill.

Ms Signe Holstein: It's just Signe Holstein, due to traffic. I apologize to the committee.

The Chair: The last delegation grew; yours has shrunk. Same rules: You've got 20 minutes. You can use that any way you like. Any time that is left over will be split among the three parties, starting this time with the government side. If you would introduce yourself for Hansard, I'd appreciate it, and the time is 10:49.

Ms Holstein: Thank you. My name is Signe Holstein. I'm the chief executive officer for the Ontario Physiotherapy Association. Our president, Caroline Gill, who works in multiple sectors that could be affected by this bill, wanted to be with us today but is somewhere in traffic.

There are about 6,000 registered physiotherapists practising in Ontario today, and the Ontario Physiotherapy Association represents approximately 4,300 of those, or about 70%. On behalf of the entire membership across Ontario, we look forward to working collaboratively with this government to address some very serious challenges that face the health care sector which in our view are largely the result of misguided policies and chronic underfunding in our sector.

We decided to organize this presentation into five segments, each of which relates to specific provisions in the bill, some of which we strongly support, some where we suspect some oversight and some where we have major reservations. We are aware that the Minister of Health and Long-Term Care will be submitting to you a number of amendments that will address some of these concerns that we will be mentioning today. This is encouraging. However, we are not aware of the exact details and, as such, we can only comment as it is currently written.

Let me begin by saying that we appreciate the central thrust of accountability as one of the specific provisions of this bill.

Over the last five years or so, a number of publicly funded hospitals in Ontario have created within their precincts private rehabilitation clinics. By "private rehabilitation clinics," we mean clinics that offer services to the public for which either the patients pay directly or the costs are covered by extended health or other third party insurers. Put another way, these clinics do not bill through the government plan or through OHIP, whether in whole or part, for any part of that treatment; they bill privately.

1050

We don't know exactly how many hospitals currently operate such clinics. We suspect, from anecdotal evidence, that somewhere around 22 hospitals are doing so. Many of the hospitals that set up these clinics have tried to obscure their relationship with the clinics for reasons that I will relate. Some hospitals as well have decided recently to load-shed physiotherapy services by simply closing down their ambulatory care clinics for the same reason.

Rhetoric aside, the principal objective of the private clinics is to generate revenue to cross-subsidize the publicly funded operations of the hospitals. This is deemed necessary to offset inadequate government funding. In this respect, we are very sympathetic to the hospitals' plight. What the OPA takes issue with is the solution.

Physiotherapy, when provided in hospitals, is an insured service under the Canada Health Act. Accordingly, we believe it axiomatic that when a hospital provides physiotherapy services, it must do so within the publicly funded system. When physiotherapy services are provided by hospitals in privately funded clinics, we think this is a clear infringement of the Canada Health Act, but as I am sure many of you know who have looked at the Canada Health Act in terms of interpretation, it's very open to interpretation.

Furthermore, people are attracted to private rehabilitation clinics in hospitals because they can get faster treatment or because they think they can get a higher quality of care. This is the epitome of two-tier health care.

Finally, the existence of private clinics in public hospitals, from any of the evidence that we have been able to gather, has not reduced waiting lists for publicly funded services. In fact, it may actually have created a net reduction in rehabilitation services because some hospitals have shifted resources from the publicly funded rehabilitation clinics to the privately funded ones. A member of our association has been involved in a PhD study over the past two years trying to get better data on what is actually happening in the sector.

The OPA has raised this issue with the Ministry of Health and with successive Ministers of Health since late 1996, but no action has resulted. Bill 8 may provide some of the tools to address the problem.

The second issue we would like to address relates to section 10. We would ask whether physiotherapy was left off the list in error. If not in error, what is the reason for excluding physiotherapy? We have asked that question of the ministry but have received no answer. OHIP covers physiotherapy services provided by approximately 100 facilities and individual practitioners registered under OHIP schedule 5, and there is a fee schedule, negotiated with the ministry, which applies to the services rendered. As such, it is incomprehensible to us why physiotherapy should not be listed.

Our third issue relates to those sections of the bill relating to the collection, use and disclosure of personal health information; for example, sections 13, 14 and 29.

To avoid confusion and to reduce costs of implementation and enforcement, we think there must be a single regime for the protection of personal health information in Ontario. The OPA has supported the regime set out in Bill 31 that is currently being considered. We think

that Bill 31 should have primacy across all provincial legislation and that provisions relating to the collection, use and disclosure of personal health information should be made consistent with and subject to the provisions of Bill 31.

We are, as well, concerned about the prohibition against block fees in section 16. The prohibition would apparently apply to fees that are charged for health services that are not insured services as defined in section 1 of the Health Insurance Act. As committee members may know, there is a move toward block fees in several payer streams. Although we may take issue with the monetary value of some of the block fees—it's our job—the OPA very much supports the concept. Why? Because block fees give maximum discretion to the practitioner to provide the number and type of treatments that the practitioner believes each patient requires; because block fees keep insurers out of the micromanagement of treatment; because block fees reduce administrative costs; and because block fees can be used to emphasize prevention.

In the workplace safety and insurance stream, the WSIB hopes to have as many as 80% of WSIB-funded treatments provided through programs of care for which practitioners receive block fees. The OPA and several other health care associations have been deeply engaged in the development of the programs of care and the associated fees. The level of employer, employee and practitioner satisfaction is very high, and we are confident that this approach will result in better care at a reasonable cost. Accordingly, we are very opposed to any legislative prohibition against block fees outside the publicly funded system or that may be interpreted to impact on that.

Our biggest concern, however, relates to part III of the bill. The provisions of part III, to our mind, are very draconian and one-sided. The minister shall decide when, with whom or what he will enter into an accountability agreement. The minister may unilaterally terminate or vary an accountability agreement at will, with no provision for notice. An accountability agreement entered into with one person automatically applies to that person's successor. Where an accountability agreement results in a material change in a person's terms of employment, "The change shall be deemed to have been mutually agreed upon between the person and his or her employer and the change does not entitle the person to any sort of payment or compensation, despite any provision to the contrary, in his or her personal contract or agreement of employment," and the crown is relieved of any liability for anything done as a consequence of the accountability agreement.

From our perspective, in one fell swoop the Employment Standards Act and labour law in general, collective agreements and individual employment agreements are swept aside. It's breathtakingly heavy-handed and, with greatest respect, not particularly becoming of a Liberal government.

The final issue we would like to raise relates to part IV, amendments to the Health Insurance Act. Professions such as physiotherapy, medicine, optometry and dentistry negotiate their respective OHIP fees with the Ministry of Health and Long-Term Care. At the end of the day, however, it is accepted that the ministry negotiates only as a courtesy and may impose any fee it chooses. Subsection 40(2.1), which allows the minister to unilaterally amend a schedule of fees in whatever manner he deems appropriate, would be harsh enough in its own right. In light of the foregoing, it is not only harsh; it is unnecessary.

One of the OPA's priority objectives is to enhance access to publicly funded physiotherapy services across Ontario. We are further away from that objective than we were a decade ago. In 1990 or thereabouts, over 80% of physiotherapists were employed in the publicly funded system. Today that figure is less than 40%. The fact is that the publicly funded system has become increasingly unattractive as an employment venue and, where practitioners have the choice, they vote with their feet in favour of the privately funded system. The impact on access to publicly funded physiotherapy is obvious.

Provisions such as those relating to the accountability agreements and a unilateral amendment of OHIP fee schedules may be well-meaning, but they will have the contraindicated results of making the publicly funded system less attractive, thereby encouraging practitioner exodus to the privately funded system in direct opposition to what we want to achieve. Accordingly, we beg you to reconsider these provisions. They hurt us more than they can help.

Thank you for your attention. We would be pleased to answer any questions.

The Chair: Thank you very much. There are about nine minutes left, so each party will have three minutes. We'll go to the Liberal side first.

Ms Wynne: Thank you for coming down today to talk to us. I just want to address a couple of your issues, and then I have a question for you.

First of all, under section 10 you noted that physiotherapists are not listed. There are a number of organizations that are not. That wording has been lifted verbatim from other legislation. If you look at subsection 10(3), you'll see that you, the chiropractors and a bunch of other organizations are captured. So there's nothing there that would limit the ministry from dealing with your organization. I just wanted to make that clear.

1100

The other thing I wanted to acknowledge is that you've identified some sections—and I hope you'll pick up a copy of the framework of the amendments, which are not in their final form but that we're proposing to put forward. Just about every section you've named is an area where there's going to be amendment, specifically around accountability in part III, the accountability issue. We understand there needs to be more clarity, more specificity around what those accountability agreements will be and what the minister can and can't do. The amendments that are being proposed will address those issues, understanding that we're still in consultation and

that those things will change, which is why you don't have the final wording.

You've said that since 1990, things basically haven't been getting better. That's quite a while. I want to ask, if you were in the Minister of Health and Long-Term Care's seat, what would you do to improve accountability? There's a sense that there's a lot of money going into health care but it's not being spent in a way that's helping patients. What would you do to improve accountability?

Ms Holstein: Certainly in issues around the priorities of funding—the funding priorities have been to acute illness care; we're in the rehabilitation business. It's not that we aren't involved in acute care, from intensive care through palliative care, but the focus on continuing to fund the acute piece—we understand the rationale, but as budgets tighten, the things that are left by the wayside are rehabilitation, long-term care, wellness, prevention and health promotion. Those are all key elements of who we are and what we do.

Ms Wynne: Then I hope you'll continue to work with us, because that's exactly what we want to get at. We want to get at a shift away from institutional care and more into community-based, more into wellness-focused. That's where we want the dollars to go, but first we've got to figure out where they're going now. This bill is the first step toward that.

Ms Holstein: I would draw your attention in the future to submissions this organization has made to the primary care transition fund, because we are committed to health promotion and prevention and, within the primary care milieu, have been part of that process and have submitted projects.

Ms Wynne: Thank you. I hope the next 13 years are better than the last have been.

The Chair: We'll go to Mrs Witmer.

Mrs Elizabeth Witmer (Kitchener-Waterloo): Thank you very much for your presentation and for the services you provide to people in the province. I know they're very much appreciated.

This bill, despite what you're hearing, I believe, after hearing many presentations and reading many letters, is really a very shoddy piece of legislation. I think it's very poorly drafted. It has certainly raised the anxiety of health stakeholders, unions, health providers and individuals throughout the province of Ontario.

Many people are saying, for example, that the accountability provisions need to be totally withdrawn and rewritten. As I listen to individuals really tear apart this bill, because there was no consultation with any of the stakeholders prior to the introduction, I guess my question to you would be, what are the key amendments you need to see before your association would be able to support this bill?

Ms Holstein: I think you have to remember that most of our members in this particular sector are going to be in two places. One is they're going to be employees in hospitals. We have significant concerns about the impact of this bill on those members, particularly the accountability provisions. We have not seen the wording. I've received it. I haven't been able to go back through the legislation.

Mrs Witmer: The wording for?

Ms Holstein: The memo from February 19.

Mrs Witmer: The memo from February 19 is over there, and you're going to see that it will not address your concerns. There is nothing specific in there to allay any fears. We've had stakeholders in here. They've read it and don't feel comforted.

Ms Holstein: We do have concerns. When you put the kind of accountability of the CEO directly to the minister—I sit in a CEO's position, so I'm particularly sensitive to this, I suppose—it's like serving two masters. I think it's that concern, the serving of two masters, where whatever the CEO has to do to maintain that relationship may or may not be in the interests of the whole, that would be a major concern. So that is an area.

We are also very concerned—yes, the unions have spoken about some of their concerns. We also have a number of members in hospitals who are not unionized. They are professionals, not part of a unionized environment, and those protections need to be built in for them as well. They are already feeling very much undervalued, under-appreciated and overstressed. We can show you the research, and if you read the OHA human resources study, it's in there. They used our research. It's an area that concerns us terribly at this point in time: How do we ensure that physiotherapists are comfortable working in the public sector and stay in that sector? It's very necessary.

Mr Marchese: Good morning to you both. Sorry I missed much of your presentation. I had to do a conference on something else.

Ms Wynne talks about how proud she is of the consultations they have made, and presumably by the consultations they made, they mean to speak to these hearings. But normally what we mean by consultation is that before you draft a bill, you talk to people, so that by the time they come here, you find some supporters of the bill. Based on what my colleague Shelley Martel was telling me, because she is a member of this committee, most of the people coming before this committee are opposed to much of what is in this bill.

Good policy generally means that you talk to people and work some of the wrinkles out before you bring it here. Were you or anyone you are aware of consulted before this Bill 8 was brought before this committee?

Ms Holstein: Not prior to this piece of legislation, no. I would say that we're more than happy to consult on any component of physiotherapy services.

Mr Marchese: I'm sure you are. We have a new era, obviously. They love to work with people and consult. This is really great. It's very new. It would have been nice if they had started with talking to people prior to the drafting of the bill, is all I'm thinking.

The minister has talked about a particular aspect of people's concern. He says in section 19, in the definition of "health resource provider," to exclude solo physicians,

group practices and trade unions. I suspect some people might be comforted by that.

Section 22 of the bill, the compliance directives, says: "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."

That suggests to me that there is absolute power here that's still in the hands of the minister. Does that worry you at all?

Ms Holstein: Yes. The short answer is yes. Like anything else with legislation, the devil is frequently in the details. How that's interpreted, how it rolls out in regulations, who that really means and whether or not our members are actually protected by that wording, I don't know at this point, and I would be concerned.

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

CANADIAN UNION OF PUBLIC EMPLOYEES, ONTARIO DIVISION

The Chair: Our next delegation is the Canadian Union of Public Employees, Ontario Division. They are represented here today by Mr Sid Ryan, the president of CUPE Ontario, and Michael Hurley, president of the Ontario Council of Hospital Unions with CUPE. Doug Allan, I understand, is also with us as a research representative. Welcome, gentlemen, and welcome back, Mr Hurley. The floor is going to be yours in a minute. The rules are you have 20 minutes to use any way you see fit. At the expiry of the presentation, we will take any time remaining and split that among the three parties, this time starting with the official opposition. I've got 11:11 and the floor is yours.

1110

Mr Sid Ryan: My name is Sid Ryan. To my right is Michael Hurley, as you indicated, president of the Ontario Council of Hospital Unions and the first vice-president of CUPE Ontario, and Doug Allan, who is a researcher with CUPE National.

Just a little comment before I get into my presentation. A few moments ago a question was asked about consultation. Of course, we, the Canadian Union of Public Employees, were not consulted either. But then we only represent 50,000 members, so why would you want to talk to the people who represent 50,000 front-line workers?

We're extremely concerned about this bill. Bill 8 was released on the first anniversary of the Romanow royal commission report into health care. In his comments on the bill, Health and Long-Term Care Minister George Smitherman noted the connection, with a glowing reference to the Romanow report. He actually said to the Legislature in his speech, referring to Romanow, "His thorough review came to an irrefutable conclusion. The pursuit of corporate profits weakens, not strengthens, health care by taking dollars and resources out of medicare." That was the minister on November 27, 2003. The Minister of Health and Long-Term Care claimed this new bill would "make universal, public medicare the law in Ontario and put an end to the creeping privatization of the system in recent years." These are clearly the themes that helped elect the Ontario Liberal government, but Bill 8 falls far, far short. In fact, it opens the door to the privatization of health care services.

The ban on queue-jumping is the professed centrepiece of the legislation, but to a large extent, this practice is already prohibited by the ban on extra-billing for insured services under the existing Health Care Accessibility Act, a bill entered into by the previous Liberal government in 1986. The bill does not, however, shut down the main threat in the Ontario public debate to universal, single-tier health care; in other words, the recently established for-profit MRI and CT clinics. Election promises notwithstanding, these corporate clinics are still in business.

P3 hospitals also threaten universal, single-tier health care through the use of their medical equipment by private, fee-paying patients in so-called off hours. Again, despite election campaign promises, instead of outlawing P3 hospitals in this legislation, the government is deepening its commitment to P3 hospitals.

The proposed Ontario Health Quality Council will not deal with many vital issues. It cannot report on the extent to which the Ontario health care system conforms with the requirements of public administration, comprehensiveness, universality and portability, key provisions of the Canada Health Act, focusing instead on accessibility. Further, the council is not required to report on two-tiered medicine, extra-billing and user fees despite the fine statements expressed in the preamble to the bill by the minister when he released the bill. The council is also specifically prohibited from making recommendations. In other words, the council cannot deal with most of the key issues that confront public health care and cannot defend public health care.

Our greatest concerns, however, relate to part III, sections 19 to 32, of the act. Specifically, we are concerned about the broad powers of the minister to require accountability agreements or to issue compliance directives.

While the government has made much of the accountability set out in the act, it is notable that the accountability in this part of the act is accountability of health care providers to the government, not accountability of the government to the public. This latter form of accountability is the sort of accountability that CUPE members and, we submit, the public really care about. Accountability to the provincial government may be an issue for the government and its top bureaucrats, but it also threatens reduced accountability to the community.

The provisions in part III have been drafted in extremely broad and general terms. They grant the minister virtually unprecedented power to require individuals

and organizations to comply with ministerial health care initiatives.

We have two related but distinct concerns about these powers. Firstly, as written, the legislation could be used by a government to try to override collective agreements. Health and Long-Term Care Minister Smitherman has recognized these are problems with the bill as written. He promised this committee on February 16 that he would introduce amendments that would make explicit that (1) the bill cannot open collective agreements and (2) that unions are not subject to accountability agreements. We tabled these amendments in Sudbury and your committee voted them down. This sends a really bad signal to CUPE and to front-line workers in all of the trade union movement that you are not being up front with us with respect to this bill. We are glad to see that the minister has recognized the bill must be amended. However, as I indicated, we remain very concerned about our collective agreements.

Prior to the election, the Liberal Party campaigned against P3 hospitals. However, the government is now attempting to implement public-private partnership hospitals in Brampton and Ottawa. The British experience with P3 hospitals shows that these hospitals are so costly that health authorities have been forced to reduce beds in P3 hospitals by 30%. Spread across Ontario, this would mean a loss of 10,000 hospital beds. This would be particularly severe as hospitals have already lost 19,000 beds between 1989 and 2003. In addition, we also note that in Britain there were 14% fewer nurses hired. This is coming from a government that says your intention is to hire an additional 8,000 nurses.

There are 38% fewer support staff and 7% fewer doctors in the UK P3 models. For just these two initial projects, hundreds and hundreds of vital hospital jobs will be privatized and well over one billion public health care dollars will be turned over to joint, for-profit, transnational corporations. It's very hard for us to see how this puts an end to creeping privatization, as the Liberals promised, particularly as we have learned that the government has allowed six other hospitals to investigate P3s. So trust must be earned.

In BC, another Liberal government told hospital workers they had nothing to fear. When elected, they introduced legislation that ripped up collective agreements and introduced performance agreements for health care institutions. The result to date has been massive privatization of health care services and the firing of 6,000 health care workers. For-profit corporations have moved in and the new workers are paid a fraction of what the fired workers were paid. In Quebec, another Liberal government has brought in legislation that severely undermines collective bargaining in the health care sector and opens the door to privatization.

I can assure you we will not let that happen here. Be assured that CUPE members are mobilizing as we speak to ensure that our collective agreements are not opened. Our collective agreements are paramount; tens of thousands of CUPE health care members depend upon these agreements for their families' futures. At the end of this submission we have attached, once again, the amendments we need to see to protect our collective agreements. We urge this committee to review these carefully and to ensure that the government does not miss the mark and fall short.

We do not need simple protection of our current collective agreements, as many collective agreements, including all the major hospital agreements, expire this year. We must ensure that this legislation will not open current nor future collective agreements, nor undermine upcoming negotiations.

Minister Smitherman has promised to release his amendments by March 9. We believe these should be released as soon as possible. Should the amendments not be tabled at this time, we believe the government should take the bill back to the committee following second reading to give the committee members an opportunity to review, in detail, the amendments.

Our second major concern deals with the sweeping powers this bill confers upon the Minister of Health and Long-Term Care to reorganize health care. As written, the minister can direct any "health resource provider" to enter into "accountability agreements" with the minister or with the minister and any person, agency or entity.

The minister is also empowered to issue directives compelling health resource providers and any other prescribed person, agency or entity to take any action specified in the directive or to comply with prescribed compliance measures in section 22. There is little limitation on the scope of such directives. This does not fit with the call for "negotiated accountability agreements with publicly funded health resource providers" that Minister Smitherman talked about with this committee on February 16. Indeed, this is a heavy hammer of control.

Under the bill as written, the minister's discretion is as wide as the government determines it should be. These powers could be used for health care reorganization—for example, the consolidation and privatization of laundry, lab, dietary and other services—hospital restructuring, or more privatization of health care services and facilities such as those proposed for the Royal Ottawa and Osler hospitals.

Taken together, all of part III as written can only be viewed as an attempt to bestow upon the minister and the government virtually unlimited authority to unilaterally order and direct fundamental changes to the health care system and to do so in a top-down manner, without any traditional procedural safeguards or substantive limitations. This could well be used for more privatization of health care services, deepening the serious attack on public health care that this government has launched through the secret P3 deals for the Osler and Royal Ottawa hospitals.

There are troubling similarities between the accountability agreements proposed in Bill 8 and the health care performance agreements recently adopted by the BC Liberal government. Both flag the compensation of chief executive officers of health authorities. In BC, the per-

formance agreements require health care authorities to establish performance-based compensation for CEOs and a reduction in spending on support and administrative services. The Daily News, Kamloops, notes: "Chief executive officers of BC's six health authorities will pocket fat bonuses if they make cuts that surpass criteria set out by the provincial government"—in other words, an incentive built into these agreements to slash and burn the front-line services, and the CEOs end up getting fat bonuses as a result of laying off workers.

Hospitals in Ontario have been forced to run deficits to defend health care in communities. We know this is a concern to the provincial government, but it is very important for hospital boards and hospital managers to be, first and foremost, focused on defending the health care of their local communities. Separating top hospital CEOs from their local communities is not a long-term solution to hospital deficits.

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As we noted above, more accountability to government may mean less accountability to local communities. We believe it is very important for hospital boards and hospital managers to be primarily concerned with the health care of their communities.

The takeover of community care access centres by the provincial government is instructive in this regard. In 1996, the provincial government established 43 community care access centres to govern delivery of home care in Ontario. The CCACs were directed to contract out services through a competitive bidding process. In this process, private for-profit corporations were invited to compete for contracts against the non-profit service providers. For-profit companies won contracts across Ontario.

This did not resolve the problems in the sector—far from it. In 2001, the government responded to increasing home care costs and campaigns by CCACs for better funding by sacking the CCAC boards and replacing them with their own people. They took the community out of the boards. The fight back by CCAC boards immediately died away and the result was significant cutbacks in funding and, most importantly, in home health care services. The effect of this was a reduction of 115,000 patients served between April 2001 and April 2003, and six million hours of services were cut—a 30% drop.

Out of necessity, hospitals have incurred significant deficits. But replacing accountability to the community by accountability to the government is not the way to resolve this issue. Indeed, if BC is an example, it may well threaten community health care.

If there is a problem with health care funding, it has not been driven by service and administrative employees. These bargaining groups are some of the lowest-paid employees working in the health care system, yet we are presently the main target of hospital privatization and restructuring.

Stats Canada figures indicate that staffing by hourly rated employees has not increased significantly since 1995, despite a large growth in the number of nursing home beds. The total increase, less than half of 1%, is significantly less than the growth in the population of the province, and does not account for the aging of the province. Notably, hourly paid hospital staff have decreased by 12,000 employees. As well, the average weekly hours for hourly paid hospital employees, excluding overtime, has declined by 3.4% since 1995, from 32 hours per week down to 31 hours per week.

In this context, wages have largely followed inflation, so it is not surprising that a recent study by the Canadian Institute for Health Information has revealed that Canadian hospital expenditures on support services have declined rapidly as a percentage of hospital expenditures. Indeed, in the most recent period for which information is available, 1995 to 1999, there was an absolute decline in spending on hospital support services.

The only part of the health care system that is controlled by for-profit corporations has seen by far the largest cost increases, far outstripping health care sectors where public not-for-profit delivery plays an important role. For example, in 1997-98 the Ontario drug programs were budgeted at $800 million. By 2003-04 they were budgeted at $2.4 billion—a whopping 200% increase in just six years, four times the rate of increase in funding for all health care sectors.

In conclusion, we'd like to say we're not sure why the government chose to introduce a bill that gives such sweeping powers to the Minister of Health and Long-Term Care. We believe this committee needs to review the full amendments put forward by the government after they are available. The minister indicated that this bill should not be able to open collective agreements. This must be established through amendment, without loophole or ambiguity. If the government truly means what it says, then this should present no problem. Indeed, such amendments will rebound to the government's credit.

We also believe that this committee, and especially the members from the governing party, should reconsider the powers the bill gives the Minister of Health and Long-Term Care to reorganize and restructure health care. The hospital system has already undergone extensive reorganization over the last 10 years. Allowing the minister to unilaterally impose more is a recipe for strife, chaos and more privatization of health care services. As well, we must ensure that accountability to communities is not undermined by the type of accountability to government that this bill proposes. A wedge should not be driven between hospital CEOs and their communities.

Health care workers have lived through previous rounds of hospital restructuring, cutbacks and SARS. They have been a key force moderating the increased cost of health care. They should not be pushed to the brink through giving almost unlimited powers to the Minister of Health and Long-Term Care to launch yet another round of health care restructuring, with the threat of privatization hanging in the air.

With this, we hope the committee and its members can work with us to ensure that Bill 8 is amended so that

collective agreements are not threatened, Bill 8 is adequately amended to maintain real community accountability and limit the minister's power to force accountability agreements and issue compliance directives, and finally, Bill 8 truly eliminates threats to public medicare by shutting down for-profit MRIs, CTs and P3 hospitals and replacing them with public facilities.

I'd like to thank the committee for listening.

The Chair: Thank you, Mr Ryan. You've left us with somewhere between three and four minutes for questions, starting with Mrs Witmer. They'll have to be brief ones.

Mrs Witmer: Thank you very much, Mr Ryan. I think you and your group have done an absolutely fantastic job of summarizing the concerns that you have with the legislation and the concerns that you have for individual union members whose jobs obviously could be in jeopardy.

When the government introduced this bill, the headline was, "McGuinty Government Moves to Outlaw Two-Tiered Health Care in Ontario; Would Stop Creeping Privatization." I guess you've said here, according to your interpretation and analysis, that this bill does nothing of the sort. I guess you see it going exactly in that way.

Mr Michael Hurley: Thank you for the question, Mrs Witmer. On the P3 hospitals alone, we're anticipating bed cuts of 30% and staff cuts of 25%. When we're told by the OHA that all future hospital redevelopment will be done through accessing private capital in P3s, it will mean across the system a reduction of that magnitude. That's going to mean dramatically reduced accessibility to these services, and that's huge. In that sense, this bill represents a smokescreen for the true drivers, which are the drugs, the doctors' fee-for-service billing systems, and this push for privatization, which is going to be a huge escalator for health care spending and is going to reduce accessibility big time.

The Chair: Mr Marchese, one brief question.

Mr Marchese: Quickly. We all probably agree that the principles set out in the preamble—some good; there's no doubt about that, right? Then you go on to say that it does nothing to stop P3s, which is true; it does nothing to close private MRIs, which is true; it does nothing to end competitive bidding in the home care sector, which drives down wages and benefits for health care workers and disrupts continuity of care; it does nothing to implement Romanow's recommendations regarding pharmacare; it does nothing to protect the universality of health care programs in Ontario, as the Liberals are clearly considering changes to the Ontario drug benefit; the health council has no specific powers; it just advises. What the heck does this bill do?

Mr Ryan: We've lived through eight years of Tory Orwellian statements where bills are introduced and they do exactly the opposite of what they were intended to do. I was expecting real change. I was expecting the Liberals to get elected and basically say, "OK, we're going to deal with these problems in the health care system." We were very pleased—let's go back a little bit.

Prior to the election, CUPE was making noises and had serious concerns about P3 hospitals. We got clear, unequivocal statements both from the Premier and others, at the time he was the leader of the opposition, that they have absolutely no intention of allowing P3s in this province. Lo and behold, they're only elected a wet day and they turn around and basically play games with mortgages versus lease-backs and in essence what we're left with is a P3 hospital.

Speaking to the minister and to David Caplan, who is dealing with infrastructure, they're making it clear that this is the model that they're going to pursue and they're going to put this before the public and CUPE can make its case to the public and they'll make their case to the public. So in other words, we're going to have a battle in this province over front-line workers earning $19, $20 an hour or the $9-an-hour model that they've got in British Columbia.

I'm going to say to the Liberals, that's a battle that we're more than happy to take on. We will take this fight on. We'll take it to every hospital, to every community. We'll take it to your constituency offices. You have not heard the last of CUPE on this front. You either come out front and ban P3 hospitals, be clear and unequivocal about it, or we're going to get into one major battle in this province about the future of health care. We will not sit back and allow this government to privatize the health—

The Chair: Mr Ryan, thank you. Your time has expired, unfortunately.

Mr Duguid: I've still got a minute left.

Ms Wynne: Sorry, Mr Chair, I just wanted to clarify. When there's a minute left for each question, my understanding is that that's the time for the party, but the answer doesn't necessarily have to fall within that minute. Is that not the case?

The Chair: That's not the case. The entire delegation—

Ms Wynne: Why not?

The Chair: Because if that was the case, we'd still be here from last night, probably.

Ms Wynne: That's not my experience. OK. All right. Fine. Thanks.

The Chair: With 20 minutes for each delegation, it is tough. The members could assist by asking shorter questions and allowing more time for the answers.

Ms Wynne: It's just a little hard to control the length of time of the answer. You don't want to cut people off, but yes.

The Chair: I think we just saw an example of that. I'm trying my best.

Ms Wynne: You're doing a very good job.

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CASSELS BROCK AND BLACKWELL LLP

The Chair: Our next delegation is Michael Watts, partner with Cassels Brock and Blackwell. You have 20 minutes, sir. You can use that any way you like. At the

end of that time—that's what we were discussing—any time that is left over will be used for questions—from all three parties, we hope. The floor is yours.

Mr Michael Watts: Mr Chair, ladies and gentlemen of the standing committee, my name is Michael Watts. I am a partner responsible for the health law practice at Cassels Brock and Blackwell LLP. I was called to the bar in 1991 and have been practising exclusively in health care for the past eight years.

In the past year, I've provided legal advice to over 100 health care organizations in the province, including teaching, community, rural and northern hospitals, long-term-care facilities, independent health care facilities, private sector clients and individual health care practitioners. Relevant to today's discussion, I have also previously provided legal advice to five of the province's last six provincially appointed supervisors and the Ontario Association of Community Care Access Centres and their 43 members in their final deliberations relating to their legal rights under Bill 130.

I have read a number of presentations made to the committee, including yesterday's made by the OHA. I do not intend to repeat what has already been highlighted in the OHA's report that the bill, even with the minister's proposed amendments, seriously undermines the province's hospital volunteer board structure. Instead, I want to focus on what I perceive to be two of the greatest dangers of part III of the bill as currently drafted, which are (1) the shift of control from voluntary boards to the minister, and (2) the resulting increased likelihood of arbitrary political interference in the governance and management of hospital operations. I'll address each of my concerns separately.

The shift of control from the boards to the minister will occur if the CEOs are subject to sections 21, 22, 26 and 27 of the bill; if the bill does not specifically require the minister to act in good faith and the public interest in negotiating the accountability agreements and issuing the compliance directives; and if the performance monitoring process for the determination of the issuance of the consequences or incentives is not transparent and independent.

With the shift of control, our health care system will become less accountable, not more accountable, because our communities will eventually lose the advocacy voice that volunteer boards and their CEOs to this day have been able to provide for them. While the advocacy role of boards does on occasion create tension between the government of the day and the hospital board, it should, in my opinion, be viewed as a healthy tension that helps make both parties more accountable to the public.

With the shift of control, CEOs will be more accountable to the minister, local MPPs, the deputy minister, the assistant deputy ministers, the regional director and others within the bureaucracy. This shift will occur immediately upon proclamation of the bill regardless of whether the minister ever uses the extraordinary powers. With the shift, the CEOs will be less accountable to the board, the community, the patients and the hospitals' internal stakeholders. Over a matter of time, there is a great risk that the boards will be converted to advisory boards rather than governing boards. As a result, we will lose accountability in our health care system, as the boards will no longer be able to govern or advocate on behalf of their communities.

In my opening remarks, I shared with you my previous experience. I think that the experience most relevant to my concern expressed above that the silencing of the boards will result in the loss of accountability is my experience in representing the Ontario Association of Community Care Access Centres with respect to Bill 130.

Bill 130 was the bill that the Conservatives passed in December 2001, which converted CCACs into government agencies. Pursuant to the legislation, the government now appoints board members and the executive directors by order in council, and can terminate the CEO at any time. I have reviewed excerpts of comments made in the House with respect to Bill 130 by Mr Caplan, Mrs Lyn McLeod and the current Minister of Health which essentially highlighted their concerns that Bill 130 would silence the CCACs' boards and their CEOs with respect to advocating on behalf of their patients and that, accordingly, public accountability would be lost. For brevity's sake I will refer to excerpts of their comments. You have fuller text in your handout.

From Mr Caplan: "This is unbelievable. And we don't want to let the people who are the health care advocates, community care access boards and their executive directors tell the public about this, so we're going to give them a gag order. That's what Bill 130 is, pure and simple. It says the minister will decide. There's no public accountability. It's accountability to the minister. If the minister gives her directions and says, 'You shall,' or 'You shall not,' that is what happens."

From Mrs Lyn McLeod: "Talk about intimidating. Talk about a power for silencing. Is it any wonder that we are not likely to hear the outraged voices of executive directors of community care access centres across the province when they know they can be fired without notice and fired without severance and when they see the evidence before them in this bill that all they have to do to warrant that kind of hammer being brought down is dare to speak on behalf of the clients their agency serves?"

From the current Minister of Health: "For anyone who was at home and listening and subjected to that, here, in less than seven minutes, is the straight goods on a bad bill, one more bill from a command-and-control government that seeks to gag the voice of the local communities....

"Let's be clear. The word 'respecting' may be in the title of the bill, but respect, as it relates to local communities and as it relates to the patients in this province, ends right there."

The previous speaker identified the impact that the loss of the volunteer boards' right to advocate has had on the services provided by the CCACs. I'm fearful that if

this legislation passes in its current form, the same will happen to hospitals and their CEOs.

I'll move on to my second concern, which is political interference. Basically, the context of these comments is the work I've done with five of the last six provincially appointed supervisors. The more control the government has over hospitals and their CEOs, the more the spectre of political, partisan interference is likely to arise in the day-to-day operations of a hospital. We believe that with the introduction of accountability agreements, the hospitals' stakeholders are likely to perceive that the minister and local MPPs have greater accountability and control over the operations of the hospital. As a result, the stakeholders are more likely to seek the help of their local MPP and the minister in influencing decisions relating to the governance and management of the hospital. Contrary to the minister's intention of making health care organizations more accountable to their communities, we believe the more likely outcome is that the organized stakeholders in the communities, rather than the members of the community, will be able to exert greater influence on the hospital's operations. In addition, further accountability to the community is lost because the minister will be able to issue the compliance directives without considering the public interest, which is a requirement under section 9 of the Public Hospitals Act, or without getting an order in council. The minister will be able to act unilaterally with respect to these extraordinary measures. We believe that to be able to use extraordinary measures, the minister should be required to consider the public interest and also seek Management Board approval with an order in council. What measures will be put to ensure that the minister acts in good faith and in the public interest when the minister issues compliance directives?

Further, why does the government believe they need the power to issue directives to the CEO? The hospital can be made to comply with the ministry's requirements via directives to the board, pursuant to the Public Hospitals Act, leaving the CEO free of dual accountability.

There are other concerns I've identified in the handout, which you can read at your leisure. My final comment is that like other presenters before me, I'm hoping that when the proposed amendments are made, this committee will have another opportunity to consider them and to give the communities opportunities to present again to you on those proposed amendments. Thank you.

The Chair: Thank you. I appreciate that the length of your presentation has left us with 12 minutes. That will be four minutes from each party, starting this time around with the New Democrats.

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Mr Marchese: Mr Watts, you pointed out some powers that the government has under the Public Hospitals Act already, and some of those powers include: the ordering of an audit; they can send in a supervisor; they can take over a board; and many other powers probably that I'm not aware of. That's true, isn't it?

Mr Watts: Yes, it is true.

Mr Marchese: In your view, why would a government, given that they already have such a power, want to then introduce another bill that gives them the same power or more power?

Mr Watts: My concern about the distinction between the proposed bill and the Public Hospitals Act with respect to your question is, under the Public Hospitals Act there are certain protections in terms of ensuring that the decisions of the ministry are made with regard to the public interest, and also with regard to having a requirement to obtain the Management Board's approval and an order in council.

For example, we have in the past questioned a minister's decision to appoint a supervisor by bringing forward an application for judicial review based on the fact that the decision wasn't made in good faith, nor was the decision made in the public interest. Under the proposed bill, we would not have been likely to even consider bringing such an application because there is no requirement under the bill as it's presently drafted.

Mr Marchese: Again, it seems odd, at least for me as a New Democrat, because I've been around with Liberals for many years and they have opposed every centralist effort, every autocratic effort made by the previous government—Bill 26 and others; you made reference to Bill 130 as well. They opposed these kinds of things. It puzzles me as to why it is that they have such an interest now to move ahead with this Bill 8, which gives the minister incredible powers. It's a political question, I imagine. I don't know.

Mr Watts: I don't mind commenting. I believe essentially, as do most people in the industry, that there is a need for performance or accountability agreements. One of our clients recently had a stakeholders' review, and patients, employees and community members all agreed that hospitals should attempt to balance their budgets, which is a drastic shift from three, four or five years ago. The issue is, how do you hold an organization accountable? The best way of holding the organization accountable and not creating great harm in the system, a system that's already extremely complex to govern, is to hold the organization accountable. The BC auditor's report contains very good information as to what should go in an accountability agreement, and then it's critical that the board be held accountable internally or hold its employees, through the CEO, to account for performance.

Mr Marchese: But you have concerns about that.

Mr Watts: Great concerns. I'm here not paid by any client; I'm here because of my great interest in health care governance and the risk of great harm that I see pursuant to this legislation, and it primarily relates to the experiences I've had with clients being asked to go to Queen's Park and answering to local MPPs on such arbitrary issues as, "Why are you transferring six nurses from community A to community B? Why have you decided to shut down the ER at one of your four hospital sites?"

Many ministers in the past have said hospitals must be accountable and hospitals must balance their budgets, but

very few ministers and local MPPs stand up to the pressure that results in such decisions in their communities. So when the communities bring pressure upon the minister or the local MPPs, they run to the Minister of Health, they call in the staff, the CEO and the board chair, and they say, "You can't do that." So it's sucking and blowing at the same time, and I think this performance agreement, unless carefully crafted, and the ability of the minister to hold a CEO directly accountable will greatly increase the risk of arbitrary political interference in the operations of a hospital.

The Chair: Thank you, Mr Watts.

Ms Wynne: I just want to be clear, because in that last gambit I got a bit lost. What I think I'm hearing you say is that there does need to be an accountability relationship.

Mr Watts: I'm saying that most people agree there is a need for an accountability relationship. The issue is, how do you implement it? Under the current bill, I think there are some great deficiencies that should be addressed prior to implementing the accountability agreement framework.

Ms Wynne: Right. So you think that the accountability agreement should be between the government and the organization, not an individual?

Mr Watts: Correct. However, the proposed amendment of the minister does still allow the minister to invoke sections 21, 22, 26, 27, so those changes are not substantive. The ability of the minister to issue directions to the hospital CEO must be removed.

Ms Wynne: OK. Just to be clear, we don't have the final wording of the amendments. Those are not written in stone anywhere yet. They're still in process. We don't have the final wording. Sections 21, 22, 27 are all going to be amended. The ability of the minister to reach in and deal with the CEO is the absolute last resort. The relationship is between the minister and the organization, exactly what you've laid out. Could you identify for us what you think a key characteristic of such an accountability agreement would be? You've agreed that it needs to be in place, you've agreed that it needs to be between the minister and the organization, which is exactly what this legislation is laying out. What would that framework look like?

Mr Watts: I'd like to address one of your earlier comments, though. I was here when the minister made his introductory comments, and the minister clearly indicated that he still intended to keep the power to issue compliance directives and require a CEO to enter into an accountability agreement.

Ms Wynne: As a last resort.

Mr Watts: As a last resort.

Ms Wynne: And he already has the ability to put a supervisor in place under other legislation.

Mr Watts: Correct, so if I can please finish.

Ms Wynne: Yes.

Mr Watts: Essentially, the extraordinary measures that he referred to, I agree they should be extraordinary; however, I disagree with the fact that if that decision is unilaterally within his powers it is an extraordinary event. In order to be an extraordinary event, I suggest that the same process that's identified under the Public Hospitals Act for appointing a supervisor or an investigator be followed.

Ms Wynne: What will define it as extraordinary are the things that have to happen leading up to that, and that's exactly what will be laid out in the amendment.

Mr Watts: I'm here to make one point, and that point is that if the minister has the ability to enter into accountability agreements with the CEO or to materially alter a CEO's agreement—

Ms Wynne: Which he doesn't.

Mr Watts: —which is currently in the bill, that this will cause great havoc in the hospital system.

Ms Wynne: I appreciate your point. It's taken. The accountability agreement will not be with the CEO; it will be with the board of the organization.

Mr Watts: The minister has kept the ability to use sections 21, 22, 26 and 27 with respect to the CEO. There is not a substantive difference, in my opinion, if those powers remain. The harm will be immediate.

I represent probably over 50 or 60 hospitals. I've spoken to a number of the CEOs about this section and, of the ones I've spoken to, everyone has agreed that if this legislation comes through, they will immediately be more accountable to the Minister of Health, the deputy minister, the assistant deputy ministers, the regional directors, and that their accountability to the board will have drastically changed and, in my opinion—I worked for a previous government on the divestment of mental health facilities. They have what's called community advisory boards. Community advisory boards are recognized by all as having little governance influence. You will be converting hospital boards into community advisory boards if you allow the minister to directly reach in and hold the CEO accountable to him through sections 21, 22, 26 and 27.

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Mrs Witmer: Thank you very much, Mr Watts, for a very thorough and insightful presentation. I certainly share some of the concerns you have. The one point that you've made I think is very legitimate and that is that this would allow for political interference. That would be a concern that I would have. I think stakeholders at the end of the day will tend to seek more help from their local MPP. I think regrettably this could influence what goes on in local communities.

If I take a look at the whole accountability section, is it possible to rewrite that section? We've heard from a few of the presenters that that entire section should be removed and rewritten. Is it possible to introduce amendments that would address the concerns that you've brought to our attention and that others have brought to our attention, or should the government begin again with the accountability section?

Mr Watts: From my reading of the BC auditor's report, I believe that something as significant as the accountability framework requires a lot more consulta-

tion and time and effort than this government seems to be willing to give to the issue. So do they have to start all over or, as part of this process, do they give the time required to consult with the stakeholders and improve upon it? I think it's just a question of timing. I don't say it necessarily has to be rewritten, but I think it definitely needs a lot of work.

Mrs Witmer: I appreciate that, because I think—this legislation was introduced. It certainly was a surprise to the stakeholders, as you know. The hospitals were working with the government on performance agreements, and then this was introduced. So we seem to be having the consultation after the fact. From what I'm hearing from stakeholders, there's not much that's going to be left untouched once the government starts to redo this bill and rewrite the amendments.

I guess at this point I would tend to recommend that the government withdraw this bill, take into consideration what the stakeholders have brought to their attention, and start again, because I don't think there's a connect between the preamble and the content of the bill. The preamble says one thing, the press release says one thing—creeping privatization, two-tier health—but what we're seeing is certainly something very, very different. I don't know if you have comments that you would like to make.

I guess the other issue is, do you see this as an attempt to get rid of hospital boards?

The Chair: This will be your closing comment.

Mr Watts: My closing comments. Essentially, the information I have is that this government seems to understand the political dangers of tackling boards front on. This bill, to me, represents a Trojan horse that essentially is going to effectively achieve the same goal over a period of time.

As I mentioned initially, my feedback is that I think the change, from my experience, will be immediate in terms of how CEOs will hold themselves accountable to boards versus the government, but that over time the boards will lose their influence. At that time there will be less powerful people on the boards, and if they do want at that time to get rid of the boards, it would be a much easier issue.

The other concern that I have about it is that if you look at the Provincial Auditor's comments about government reporting entities, this is something that might shift them toward government reporting entities. If that's the case, again, the boards will lose influence. So this is something that will have a drastic impact over time that eventually will render the boards to nothing more than advisory boards.

The Chair: Thank you, Mr Watts. We do appreciate your coming today.

CREDIT VALLEY HOSPITAL

The Chair: Our next delegation is from Credit Valley Hospital. Mr Norm Loberg is here today, and Wayne Fyffe. Mr Loberg is chairman of the board of governors, and Mr Fyffe is the president and CEO. Welcome. Make yourselves comfortable.

Mr Norm Loberg: I'll just get a little bit of water here, Mr Chair.

The Chair: I'll explain the rules as you are pouring. You've got 20 minutes. You can use that any way you like. At the end of the presentation, if there is any time left over, we'll try to apportion that as equally as we can among the three parties for questions. I've got 11:55 and you've got the floor for 20 minutes.

Mr Loberg: Thank you very much, Chair, members of the committee. I guess it is still good morning. I'm Norm Loberg and I'm chair of the board of governors of the Credit Valley Hospital. I'm joined by Wayne Fyffe, our CEO. He's here to support me and to answer all the tough questions today.

I'm presenting our comments on Bill 8 on behalf of my colleagues, who, like me, are volunteers who firmly believe that the best form of public administration is by unpaid volunteers, members of a local board.

The Credit Valley Hospital agrees with the intent of Bill 8 to enact new legislation concerning health service accessibility and to provide for accountability in the health service sector.

As acknowledged by the Minister of Health and Long-Term Care, the Honourable George Smitherman, the original draft of the legislation left many boards, including ours, CEOs and physicians aghast. The document was seen as inflammatory and did not realistically impart what we believe was a sincere attempt by government to develop an accountability structure that will promote the best interests of the patients and communities we serve and provide an equitable standard of care to which our health care providers and administrative bodies would aspire. However, I must admit that I am feeling considerably more comfortable making this presentation to you today as a result of Minister Smitherman's proposed amendments to Bill 8, as communicated late last week.

We sincerely thank the committee for the opportunity to share our thoughts and to work collaboratively to develop legislation that will enhance productivity, accessibility, accountability and, above all else, improve access to quality care for the people we collectively serve.

I'd like to speak to four areas today: access to care, physician contracts, standards of care, and governance and administration.

Access to care: I'd like to tell you a story about an actual patient event in Credit Valley Hospital's emergency department, which is unfortunately more often the norm than the exception these days. An elderly woman is brought to the hospital by ambulance. She appears to have suffered a stroke. The ambulance attendants wheel her into the department expecting to transfer her to a stretcher in one of 40 treatment rooms, but every treatment room is full. Instead, they wait hours until she is eventually moved to a temporary stretcher bed, where she remains for the next three days until an in-patient bed is available on a proper nursing unit.

Her family is distraught of course, not because of the lack of patient care but because their mother remains confused and uncomfortable on a narrow, board-like stretcher. As much as this is upsetting to our patients and their families, it is extremely frustrating for our health care providers, who are doing their best to care for patients in cramped, ill-equipped rooms offering no privacy or comfort for patients or families. Why is this happening?

Credit Valley is situated in Mississauga, Canada's sixth largest city—and I have to say that or Mayor Hazel will be all over me. Mississauga is experiencing phenomenal growth. On any given day, we have between 20 and 30 patients like the patient I just told you about, who may wait from one day to three days before they are moved from the emergency department to an in-patient bed.

Bill 8, and more specifically Minister Smitherman's comments of February 16, acknowledge the bill's intent to "ensure that health care is available to all Ontarians, in every community in the province." We ask you, the committee, to entrench a process to establish an equitable and accountable mechanism to ensure that our patients have the same access to a patient bed and services as a patient elsewhere in the province.

We can't provide better access for our emergency patients unless we have enough in-patient beds and funding to staff them. Only then can we meet the performance targets. Performance contracts, if properly constructed, with mutually agreed-upon standards, could assist us in achieving the equity we seek for our community, so we see them as a positive.

Physician contracts: We are pleased that the proposed amendments to the legislation acknowledge the considerable challenges hospitals face in providing access to care for those patients who do not have a family physician. At Credit Valley we have eight hospitalists. There are 22 hospitalist programs across the province, employing well over 100 physicians who are required to champion the needs of acutely ill patients who arrive in hospital without a family physician and require immediate medical care. Without them, and the ability to pay them, patient care at Credit Valley would be seriously compromised.

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As well, it would seriously jeopardize our ability to recruit and retain the brightest and the best physicians to care for our patients. We're pleased that the proposed amendments recognize that this portion of the legislation should be changed to avoid serious repercussions for the people we serve.

Point 3: standards of care. We agree that standards need to be developed to ensure a patient receives the same standard of health care no matter where in the province he or she seeks treatment. However the outcomes must be achievable based on equitable funding and access to care. When this is unattainable due to circumstances relative to geographic and/or funding realities, the accountability agreements must be modified to reflect the realities of the individual hospital's situation until such time as a level playing field has been created. We are pleased that the minister has suggested that the language in the bill be changed so that such matters are negotiable, and that the minister will not unilaterally impose accountability agreements.

Our fourth, and last, point: governance and administration. Accountability is not all about money. It's about all kinds of resources, including the human resources—doctors, nurses, respiratory therapists and support staff—to provide good, quality patient care. I know we can all agree on that.

We hold our CEO and chief of staff accountable to meet mutually agreed targets for quality of patient care, access to care, safety and sound financial management. We are pleased that proposed amendments to the bill reflect this reporting relationship. As the minister says in his letter of February 19 to the Chair of the committee, he intends to "Maintain independence of governance structure (eg, executive board) by requiring accountability agreements between ministry and the health resource provider. The health resource provider could be required to have a performance agreement with its CEO that is consistent with key performance requirements contained in the accountability agreement." That's subsection 21(2).

We believe this is our role according to the Canada Health Act: to commit to a universal, accessible, comprehensive, portable and publicly administered health insurance program.

In our opinion, we as members of the board of governors are mutually accountable to our communities, whom we represent and who financially support our system through their tax and donated dollars, and to our elected representatives at the legislative table. Our elected representatives are responsible to answer for the health care received through the public purse. We are ultimately responsible to our communities as unpaid, volunteer, private citizen representatives on our hospital board of governors. Together, through federal and provincial tax dollars and revenue generated through our own initiatives, we provide universal health care.

Notwithstanding our support for the minister's proposed revision of section 21, we do have concerns with section 27 of the bill. We acknowledge that in the minister's discussion of Bill 8 on February 16, he states that "only in exceptional circumstances" will "the ministry impose penalties directly on the CEO." We ask that section 27 be deleted from the bill, as it undermines the trust between boards and their CEOs, as well as boards and government, and is inconsistent with the spirit of the proposed amendments in section 21. Should this be allowed to stand, our ability to attract and retain CEOs will be jeopardized.

Section 27 is not necessary because the Public Hospitals Act already provides the minister with the power to intervene in exceptional circumstances. If the intent is to find less intrusive ways to fix smaller problems before they become bigger ones, then there are

existing opportunities to provide a more proactive approach to ensure consistent governance across the province and to support hospital CEOs through peer counsel and mentorship.

I refer to the OHA's existing trustee institute, which is an educational certification program for trustees. This program could be made mandatory to ensure that minimum standards of governance are met. The OHA also commissioned a task force on operational reviews, which recommends a mechanism for joint accountability and early intervention through peer support. We have copies of this report for your information. It's dated January 12, 2004, so it's very hot off the press. Both of these proactive initiatives deserve support and could eliminate the need for such heavy-handed intervention as section 27.

In summary, we believe that by strengthening accessibility through equitable per capita funding mechanisms and developing a standard, realistic and mutually agreed upon set of performance indicators, hospital boards will be better able to monitor progress and provide necessary direction for improvement. This of course assumes that accountability is a two-way street. The Minister of Health must be held accountable to inform hospitals of expectations, how they will be measured and their level of funding on a timely basis.

We are pleased to hear that the minister acknowledged his ministry must also be accountable, although it is unclear how this will be reflected in amendments to the bill.

We believe that through mutually agreed upon and publicly acknowledged performance agreements, our communities will be better served by the health care system and more willing to financially support our ongoing capital needs. We, through our performance agreement with the minister, will be accountable to government to ensure our CEO and health care providers uphold the mutually negotiated components of the agreement.

We believe accountability between the minister and the board should be consistent in every respect.

On behalf of the board of governors of Credit Valley Hospital, I'd like to thank the committee for hearing our submission today. I'm a volunteer on the Credit Valley Hospital board of governors, a position I've been proud to hold for the last five years. Like the people who work at Credit Valley, my colleagues on the board and I have only one mission: to provide good, quality health care to the patients and families we serve in our community within the scarce resources we have available to us. I believe the Minister of Health and Long-Term Care and the many people associated with the ministry want the same thing. An amended Bill 8 will help us meet our shared mission together.

The Chair: Thank you, Mr Loberg. We appreciate that. We've got about six minutes left, two minutes to the government side. Ms Wynne.

Ms Wynne: I believe Mr Delaney has a question.

Mr Bob Delaney (Mississauga West): Thank you very much for your deputation, and welcome to Queen's Park. Thank you especially for the co-operative approach you've taken. We acknowledge the helpful and constructive tone of your comments.

I have two very quick questions for you and one that you may want to elaborate on. After the passage of Bill 8 in the form it's in now and as you see it evolving, do you anticipate having a good, constructive working relationship with the Ministry of Health?

Mr Loberg: Certainly. Particularly with the proposed amendments that were released late last week, we feel that with the modifications we've recommended, we could have an excellent working relationship with the ministry.

Mr Delaney: In that vein, is there anything in the bill that would cause the board, for example, to have any concerns about whether it should resign?

Mr Loberg: I think section 27 is still a major concern to us. We feel the performance standards should be agreed upon between the board and the ministry and the minister, and that the performance standards should be carried out by the board through the management of the organization. I think that's the classic kind of structure you would find in any organization. Our concern is to ensure that the board maintains its accountability and, in turn, that that accountability is shared with the management of the organization.

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The Chair: Mrs Witmer.

Mrs Witmer: Thank you very much for your presentation, Mr Loberg and Mr Fyffe.

We've heard a lot of concerns about the impact of the accountability agreements, particularly the fact that the CEO, in many respects, is now going to be accountable to the minister, and the minister has ultimate power—unprecedented power—to do whatever he or she wants in the future. Do you see the shift of control from the board to the minister resulting at the end of the day in your board, which represents your community and is accountable to your community, becoming nothing more than an advisory board with no real power, no ability to hold the CEO accountable?

Mr Loberg: Yes, we do. More importantly, I think the people who sit on our board want to make a difference. They represent the community, they live in the community, they work in the community and they're concerned about making sure we have the very best level of health service we can provide in our community. If they can't make a difference, if they walk into that boardroom and have one hand tied behind their back when they're dealing with those critical issues, they won't stay on the board. So we run the risk of not having the same high-quality people represented on the board.

Mrs Witmer: So if there are not substantive changes, that could be the end result?

Mr Loberg: I think that's entirely possible.

Mrs Witmer: The bill doesn't require that the minister act in the public interest. That's been brought to our attention by several presenters. Does that concern you?

Mr Loberg: I think it would have to concern anybody when a minister does not act in the public interest. There is a provision available now through the health act that allows that action to be taken. We feel that's appropriate and adequate, and protects against actions taken that are not in the public interest. That's how we feel the powers of the minister should be performed.

The Chair: Mr Marchese.

Mr Marchese: I have three questions to both of you, and I'm going to be as fast as I can.

In your brief, on page 4, you say, "We are pleased that the minister has suggested that the language in the bill be changed so that such matters are negotiable and that the minister will not unilaterally impose accountability agreements." That's what you think he's saying or what you think he said.

In the suggested changes, section 22 reads as follows: "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 language doesn't speak to negotiations. It's not something that's negotiated. The minister will hear from, but in the end the minister decides what he will do. I don't see that as negotiation language. Do you?

Mr Loberg: That's the way we have interpreted the proposed amendment.

Mr Marchese: It worries me. I think it worries you if it's not written in such a way that it kind of speaks to negotiated—

Mr Loberg: I referred to the spirit of section 21, which I think sets up an environment where there can be mutual discussions and negotiations. That's where I'm looking for consistency through all the proposed amendments.

Mr Marchese: I just read the language to you, and it doesn't speak to what you're saying. Maybe Ms Wynne thinks it does, but it doesn't to us.

Ms Wynne: That's not the language of the amendment. It's the framework.

Mr Marchese: It's the framework. Wonderful. It'll come. Just wait for it.

In terms of section 27, your worry is that if we keep the language that is there, we might lose some good CEOs. But the problem goes beyond losing CEOs; the problem, as Mr Watts was saying, is that that relationship between the government and the CEO, whoever he or she is, good or bad or excellent, is a matter of serious concern in terms of who the CEO is responsible to. It's not a matter of just losing some good CEOs, because somebody will be there, it's a matter of serious concern about the relationship the CEO will have to the minister versus to the board. Doesn't that concern you as well? I'm sure it does.

The Chair: A very brief answer.

Mr Loberg: Yes.

The Chair: That's what I thought you were going to say. Thank you very much for coming today. It certainly was appreciated.

ONTARIO COLLEGE OF FAMILY PHYSICIANS

The Chair: If we can move on to our next delegation, the Ontario College of Family Physicians: Dr Peter Deimling, the president; Jan Kasperski, the executive director and CEO. Please make yourself comfortable. You have 20 minutes to make your presentation. Make it any way you see fit. Any time that is left over will be split amongst the three parties. If you would introduce yourself for Hansard, that would be wonderful. I've got 12:17. The floor is yours.

Ms Jan Kasperski: Good afternoon to all of you. My name is Jan Kasperski and I'm the executive director and CEO of the Ontario College of Family Physicians. With me here today is Dr Peter Deimling. Dr Deimling is president of the college, but he is a family physician who works full-time in a practice in Orillia and, until very recently, was the chief of staff of his local hospital.

It's a privilege for us to be given an opportunity to address the committee members regarding Bill 8. Before we do so, let me introduce you to the college. We are a chapter of the College of Family Physicians of Canada. The college has close to 17,000 members across Canada and 6,800 here in Ontario. We were founded 50 years ago and were given a federal charter to establish standards of practice for what was then a new and emerging discipline called family medicine. We were also asked to establish residency programs in family medicine in the 16 medical universities across Canada, including the five that were established here in Ontario.

Over the ensuing years, we have stayed very close to our quality and educational roots. Today, the OCFP is involved in the education of medical students and family medicine residents and the continuing professional development of family physicians throughout this province. Our mission statement, "Promoting the quality of family medicine in Ontario through leadership, education and advocacy," says it all.

We are honoured to represent the family physicians of Ontario, because being a family doctor is one of life's greatest callings. Family doctors are privileged to be at the bedside when a baby is born or when a loved one dies. We develop intense, personal relationships with our patients and their family members. Because of our broad scope of practice, our knowledge of clinical medicine and our understanding of the health care system, we are in the best position of any health care discipline to support people in making good decisions about their own health.

In addition, as we help patients to navigate our increasingly complex health care system, we see first hand what works and what doesn't work. We are here today because we believe that Bill 8 needs to be amended so that it preserves those aspects of the system that are

working and provides the legislative framework to address what isn't working.

Rex Murphy—you all know Rex Murphy—once stated that the health care system is the best example of our Canadian values put into action. He went on to emphasize that nowhere in the system are Canadian values more on display than in the relationship that family doctors establish with their own patients.

As the college chartered to maintain the four principles of family medicine, we are committed to the values enshrined in the Canada Health Act. We advocate for our patients to have equal access to care based on need and not on their ability to pay.

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We are committed to accountability in our practices, and it is very important that this committee and government understand the nature of the accountabilities family physicians have with their patients. The patient-physician relationship is central to the practice of family medicine. We establish a covenant with our patients, not a contract. A contract says, "I will do this and nothing more." A covenant says, "I will do everything in my power to provide you with the care that you need." It is this covenant with patients that is the hallmark of all that is good in our health care system. A contract with government, no matter how well-meaning it is, will never override our primary obligations contained in that covenant with our patients. It is that covenant that drives physicians to advocate on behalf of their patients.

It is the loss of this covenant that people fear when they do not have a family doctor or when they hear that their doctor is being replaced by a team. It is this covenant that makes it so difficult for the people on boards of hospitals, community care access centres and other health care organizations to restrict access even when their budget shows a deficit.

The delivery of health care is not a business based on contracts with the government; it is a calling based on covenants. The question the committee needs to ask is: Does this bill help or hinder health care professionals to meet their covenant with their patients? You need to know that we are increasingly frustrated and alarmed by our inability to meet our covenant with our patients.

Our public health care system was on display during SARS and it became apparent that it is so poorly funded and organized that it cannot meet even basic expectations. Will this bill help ensure that water, food, air and soil are safe?

Our primary health care system is in disarray. People simply can't find a family doctor. Family doctors provide 90% of the medical care that people receive, and yet one million people in this province do not have access to the main providers of primary care: a personal family doctor. The picture gets worse when we realize that 25% of family physicians are retiring in the next few years. Relatively few doctors are choosing family medicine and our new graduates are reluctant to set up family practices in these unsettled times. The preamble gives lip service to primary health care, but the bill is silent on how primary health care will be strengthened.

Hospitals have been downsized during the last 10 years, yet the community sector has not been funded or properly organized to cope with the added demand for services. Our hospitals have been promised stable, predicable funding for many years. Their fiscal year ends in a month and we still don't know how much they will receive. Will the bill address those concerns?

This government was elected having promised change. It promised to restore our public services. Family physicians throughout this province who have been working their hearts out under untenable circumstances were very eager to roll up our sleeves and get to work establishing family health teams. We wanted to integrate those teams with well-functioning public health units, home care, community services, hospitals and long-term-care facilities.

Then this bill came out as one of the first acts of this government. We read Bill 8 with a very heavy heart. This bill is aimed at provider accountabilities but is relatively silent on government and public accountabilities. It is hard to read the various sections in this act without feeling that once again providers are left with all the accountabilities and none of the supports they need to meet those accountabilities. It's hard to accept that caring, committed health care professionals are viewed as criminals deserving jail terms for failing to comply with various sections of the bill. It's not what we expected of this government.

The major problem that government faces in Ontario is not queue-jumping, extra-billing or lack of provider accountability; the major problem is that people in this province are so concerned about the lack of access to care, so concerned that care will not be available for them or their loved ones when they need it, that they are willing to consider two-tiered medicine as a potential answer to their concerns. Instead of working with government to address these concerns, we find ourselves in a somewhat adversarial position that is not of our making and is very uncomfortable for us. We were somewhat reassured by the minister's presentation to this committee, but we still remain concerned about various components of this bill.

Let me now turn it over to Dr Deimling to tell you why we are so concerned.

Dr Peter Deimling: The preamble to Bill 8 raises expectations by recognizing primary health care as the cornerstone of Ontario's health care system. It acknowledges the shift from hospital-based care to the community, and the need for both pharmacare and home care. Yet none of the sections in the bill addresses these components of the continuum of care implicit in the preamble. The bill is silent on the government's accountabilities to enhance the primary and community sectors and on how the various sections of the bill apply to these two sectors.

The bill causes rather than relieves confusion for those of us in community-based practices. Will a physician who has signed an alternative funding contract with the

government, such as the contract signed by physicians who have formed a family health network, be held to the same level of accountability to government as a hospital that receives a half-billion dollars in funding each year? We have been reassured by the minister that this is not the case, but the bill sent waves of anxiety throughout our membership.

We support part I, which establishes the Ontario Health Quality Council; however, we feel that the functions of the council need to explicitly include monitoring of access to care. Enrolment with a family physician and a family health team would be one of the access indicators. For other selected services, the council would establish maximum reasonable wait times and compare them, community by community, with actual wait times. In those communities where the wait times are exceeded, the minister would be expected to work with the providers to develop a strategy to gain compliance with the established wait times.

We are not talking about punitive measures. We are talking about a true collaboration between government, the community and the providers to work together to provide adequate access to services. The bill needs to ensure that the council has the teeth it needs to support the government in its efforts to ensure reasonable access to care.

We would like to see the Ontario council well aligned with the National Health Council so that efforts are not duplicated. Family doctors are the backbone of our Canadian health care system, yet family doctors are conspicuously absent among the members appointed to the National Health Council. Ontario has an opportunity to recognize the key roles that family doctors play in our health care system by ensuring that our voices are heard at the Ontario council's table. We are asking to have family doctors appointed to the council and to be actively involved in the work of the council.

We recognize that the Ontario Medical Association and the Ontario Hospital Association have been working with the Ministry of Health and Long-Term Care to develop various amendments that will preserve the intent of parts II, III and IV of the bill while modifying it to ensure the appropriateness of the various sections. We will not repeat advice given to the MOHLTC by the OMA in regard to many of the provisions in part II of the bill, but we would like to emphasize that block booking fees were developed to prevent patient office visits and subsequent OHIP charges for services that can be easily handled by phone, e-mail or fax. There are many family physicians who provide such services as telephone prescription renewals who will likely revert to office visits for all medication renewals, thus initiating a fee billed to OHIP and, in most cases, an unnecessary inconvenience for patients. In other cases, the fees cover delisted and non-insured services.

Block bookings should be continued where they are appropriate. This system is well managed by the College of Physicians and Surgeons and their role in overseeing the block billing system should be included in this bill.

If section 9 were to pass as written, the rights of physicians to accept payment for services covered by third parties would be prohibited. We do not believe that the MOHLTC intends to be the direct employer and paymaster for all physician services provided in the province. However, as the section is currently drafted, that would be the case. We believe that the provision in subsections 15(3) and (3.1) of the Health Insurance Act should remain as written and be included in the bill as amendments to subsection 9(2). Otherwise, major adjustments to the funding of physician services will need to occur that will paralyze the system.

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While we do not support practices that allow people to pay to jump the queue, daily in our practices we see evidence of two-tiered medicine. The minister, in his presentation to you, used the example of a clinic that allowed people willing to pay for an enhanced cataract lens to jump to the front of the cataract removal line. This should not have happened.

But the major problem is not this rare case of queue-jumping. The evidence would show that the more expensive lens is the better lens, but only those who can afford the quality lens get the lens that providers would like to see all patients receive. Unequal access to quality products is the problem the minister should be addressing. The minister is only too aware of the fact that how one is injured greatly affects the level of care that can be provided. It shouldn't matter if someone is injured in a car, at work or in their own home, but it does. How does this bill address these common problems of unequal access to services? Will we create a bureaucracy to deal with whistle-blowers or will we use our precious dollars to address these quality issues?

While we agree with the intent of sections 14 and 15, we are opposed to the level of information sharing with the manager of OHIP permitted under the bill, especially in light of the apparent contradictions in this bill and in the health privacy act.

In addition, we oppose in principle mandatory reporting in any instance where public safety is not a demonstrated concern. The mandatory reporting of serious criminal activities has yet to be made a provision under the law. Having mandatory reporting included in this bill implies that anyone violating the spirit of sections 14 and 15 or anyone who is knowledgeable about such a violation has committed the ultimate crime. We do not believe that to be the case and would request that subsections 14(5) and (6) and 15(2) and (5) be deleted from the bill. Frankly, the idea that our members would be required by law to spy and snitch on one another is repugnant to us. The vast majority of providers are overwhelmingly honest in their dealings with their patients and with government. These sections seem very heavy handed.

In regard to part III, concern has been expressed that family doctors who sign alternative payment plan contracts with the ministry may be required to abide by the conditions in this part of the bill. We recognize that

the minister has stated that he will clarify this section in this regard, and we look forward to seeing this amendment.

In addition, many of our physicians serve in positions that included membership on the board of hospitals, long-term-care facilities and district health councils or as physician advisers to community care access centres. They are expressing concern about the dual reporting relationships of the chief executive officer to the board and to the minister. Ontario has a long and proud history of voluntary hospital and community boards. Previous governments have weakened the strength of various health care boards through this dual reporting mechanism. This bill does the same for hospitals. We would request that the bill be redrafted to ensure consistency and to restore appropriate board accountabilities for the management of their operations to our health care boards by supporting the direct reporting relationship of CEOs to all boards.

In summary, the overarching reasons for preparing this bill were to confirm Ontario's commitment to the Canada Health Act and to enhance that commitment by ensuring that accountability for the governance and management of the Ontario health care system is enshrined in law. As major providers of health care in this province, the family doctors of Ontario are committed to adhering to the principles of the Canada Health Act and look forward to enhanced accountability in the system amongst government, the public and providers.

The preamble identifies the need for collaboration between consumers, health service providers and governments, and a common vision of shared responsibility. Provider accountabilities are addressed in this bill. The supports consumers need to use the system wisely and government accountabilities are absent. Without accountable and responsible behaviours in these three realms, the intent and spirit of the bill will not be realized. Without government and public accountabilities, Bill 8 will serve to further dishearten the caring health care professionals in our system. If this bill passes as it is currently crafted, it will reinforce the message that health care professionals are once again left holding the bag for an increasingly dysfunctional system. To legislate increased levels of provider accountability with no guarantees that the resources we need to carry out our responsibilities will be available, gravely concerns us. There is much rework needed to make this bill worthy of this government, and even more work is needed to restore confidence amongst the public and providers that our system is in good hands. Thank you.

The Vice-Chair (Mr Jim Brownell): Thank you for your presentation. You have used your 20 minutes. I would like to thank you for the presentation this morning. We have the information, and it's much appreciated.

CATHOLIC HEALTH ASSOCIATION OF ONTARIO

The Vice-Chair: Next we have the Catholic Health Association of Ontario. If you would like to come up to the table and make yourselves comfortable, you will have 20 minutes to make your presentation. Should there be time remaining after your presentation, we will divide the time between the three parties. I would like you to give your names for Hansard, please.

Mr Ron Marr: Good afternoon. It's probably getting close to lunchtime for the committee so I'll try to stay on schedule here. My name is Ron Marr and I am the president of the Catholic Health Association of Ontario. Joining me today, to my left, is the chair of the CHAO, Mr Jeff Lozon. Jeff is also the president and CEO of St Michael's Hospital. To my right is Mr Tom Reilly. Tom is the general secretary of the Ontario Conference of Catholic Bishops.

Before I comment specifically on Bill 8, and by way of background to some of our concerns, let me take a few minutes to tell you a little bit about the Catholic Health Association of Ontario and our membership and Catholic health care in this province. The CHAO is a voluntary association of all Catholic hospitals, long-term-care facilities and community health services in the province of Ontario. There are 29 such institutions and services in this province ranging in size from large teaching hospitals, long-term-care centres and psychiatric hospitals in our major health science centres to smaller facilities in mid-sized and rural communities. Many of these institutions are multi-site facilities.

Also included in our membership are the seven religious communities of sisters and lay groups that sponsor these facilities, as well as the Ontario Conference of Catholic Bishops, which is composed of all the Catholic bishops in the province.

Catholic health services strive to provide the best-quality care with respect and compassion to all in need regardless of religion, socio-economic status or culture. We collaborate in open partnership with other members of Ontario's health care system and we are dedicated to voluntary community governance to ensure accountability to the government and to the residents of the local communities in which we serve. Voluntary governance is also a key to the maintenance of the Catholic health ministry in this province.

Our member health organizations have more than 150 years of history of providing exemplary care in all parts of this province. We have an outstanding record of good stewardship and have taken leadership roles in many areas of need. We were among the first to work with Ontario's more vulnerable groups, such as those with HIV and AIDS and the elderly. We have set high standards in providing palliative, pastoral and spiritual care as well as in clinical and organizational ethics. Most recently, we have accepted responsibility for several inner-city health and mental health services. We collaborate with others for the community's welfare and for the health of all.

Catholic facilities reflect a proven, community-based voluntary approach to governance. Our boards of directors are representative of the cultural, linguistic, socio-economic and religious composition of the communities in which our organizations are located.

The Catholic Health Association of Ontario wholeheartedly supports the overall theme and intention of Bill 8: the preservation of a universal public health care system in Ontario. The association and its member hospitals, long-term-care facilities and community services are committed to the five principles of the Canada Health Act. Also, and most important, the fundamental values of accountability and improvements to the system are important elements of the philosophy of Catholic health care.

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With this background, let me speak specifically about Bill 8. Our written brief will provide you with the background and details of our various, and very serious, concerns about this bill. Thus, I will not go into them in detail at this time; rather, I will focus on our recommendations for amendments to the bill. We believe very strongly that major amendments to the bill are required and that these amendments will improve the bill and better aid in achieving particularly the goal of accountability.

Let me start with part III, accountability, as this is the section that causes our association and our membership the most concern.

The Catholic Health Association supports the underlying principles of sections 19 and 20 of part III of Bill 8, which appear to set the foundations and definitions for accountability within Ontario's health care system. However, much of the language of Bill 8 is unclear and confusing or left to be defined by regulation, which removes it from public scrutiny prior to becoming law. We believe that many of these items, especially those with regard to governance, are too important to be described by regulation. We feel they should be clearly discussed in the public arena, and preferably deleted from the bill or amended to better reflect the respectful partnerships existing today between the government and all health care sectors.

Even though we believe that Ontario hospitals in particular are leaders in accountability—for example, the hospital report cards—we could support the creation of agreements between the government as funder and policy-maker and the health care organization as provider. However, it is fundamental that such agreements, if implemented, must be collaborative in nature between the providers and the government and must be characterized by trust, mutual respect and collaboration. With this foundation, such agreements could include mutually agreed-upon components such as performance goals and objectives regarding roles and responsibilities and service quality, as contained in clause 19(a), and a plan and timetable for meeting those goals and objectives, as outlined in clause 19(b).

Given this support for the principle of agreements between the government and providers, we have grave difficulty with the coercive nature of part III of Bill 8 as currently drafted. This is the section that outlines the methods for achieving this most important goal of accountability. Rather than facilitating accountability, we believe that Bill 8, as drafted, gives the Minister of Health and Long-Term Care direct and strict controls over health care providers and powers that will substantially interfere with the governance of health organizations. These provisions make the existence of all voluntary hospital boards irrelevant and will effectively eliminate Catholic health care in this province.

Part III of Bill 8 also represents a significant and fundamental shift in direction for the health care system in Ontario, from a system of non-profit charitable organizations with accountable voluntary boards that are elected from the local community to a system of government agencies. This is a strange course, in our opinion, for the government to take, given the history of the past 30 years or more, where the Ontario government has divested itself of direct control and operation of hospitals and other health services while retaining a leadership role in funding and policy. A recent example of this divestment of operations and governance is that of the provincial psychiatric hospitals to community boards. Many of these facilities are now under the sponsorship and governance of Catholic groups.

We acknowledge that Minister Smitherman, in his presentation to this committee last week, signalled that important changes will be made to the act and that he is looking forward to hearing the ideas and recommendations of the public and of this committee. I would like, then, at this time to submit to you our recommendations on how the accountability section of Bill 8 can be amended to achieve these intended goals.

With respect to accountability:

(1) We recommend that the provisions that grant the minister the right to require hospitals and hospital executives to enter into accountability agreements, to issue compliance directives to hospitals and hospital executives, and to unilaterally alter hospital executives' terms of employment be deleted from Bill 8.

(2) Rather, we recommend that accountability mechanisms be developed that establish the expectations that the minister, the hospitals and other providers have of each other; that hold voluntary community boards accountable to the government and to the public; that hold executives accountable to the voluntary community boards to carry out the operations of the hospitals; that require all agreements to be negotiated, mediated or arbitrated if there is a dispute; and that a statement be included in Bill 8 that the minister must act with just cause and in the public interest in all his requirements of health care providers.

I want to stress that, in our opinion, the accountability relationships must be between the minister and the board and between the board and the CEO of the hospital or other health sector. This latter relationship is already sufficiently addressed in the Public Hospitals Act.

(3) We recommend that the minister put in place incentives for good management and achievement of goals, rather than punishments which would remove already scarce resources from the system.

(4) We recommend that the government make clear to the public any intentions regarding potential changes to

the role of voluntary community boards. As well, if the government intends to proceed in this direction, the government should hold extensive hearings on this aspect of the bill across the province in order to hear from the public as well as the health care sector.

(5) We recommend that the language regarding personal liability in part III of Bill 8 be amended to reflect that of section 10 of the Public Hospitals Act, where a person is protected from consequences for acts or omissions committed while carrying out his or her employment duties in good faith.

(6) We recommend that personal information not be disclosed as proposed in Bill 8 and its protection be maintained as in current legislation and consistent with Bill 31.

(7) Finally, given the speech by the minister to this committee, we recommend that the minister table his proposed amendments to this act with this committee during the public hearings.

There are two other parts of Bill 8 that concern us, and I'll just quickly refer to them.

In reference to the Ontario Health Quality Council, we recommend that the hospital and long-term-care sectors, along with their boards, be represented on this council.

We recommend that the council be able to make recommendations to the minister and providers on its findings in order to make improvements to the health care system.

Finally, in reference to the Ontario health council, we recommend that the language in part I of Bill 8 be clarified with respect to specific terms such as health resource provider, and that fewer areas overall are left to be defined by regulation.

In terms of accessibility, we only have one very short recommendation. As a prelude to that, CHAO commends the government on its commitment to prevent two-tier medicine, extra-billing and user fees. However, part II of Bill 8 appears to jeopardize arrangements between hospitals and some of the physicians that hospitals currently pay directly, such as pathologists, hospitalists and on-call physicians. Thus, we recommend that these parts of Bill 8 be deleted from the act.

Mr Chair, we thank you for the opportunity to appear before you this morning. We ask the members of the committee on justice and social policy to give serious consideration to our recommendations and comments, and we'd be pleased to answer any questions that you might have.

The Vice-Chair: Thank you very much for your presentation. We have about six minutes left. We will start with the official opposition.

Mrs Witmer: Thank you very much for your presentation. I know that you've demonstrated your strong commitment to Catholic health care in providing outstanding quality and compassionate care to the people in this province. But I guess there is an indication here that this bill at face value, this supposed commitment to medicare, might also, at the same time, be an attempt to remove voluntary boards from the role that they enjoy today. You've pointed out that if that were to happen, if indeed the CEOs became responsible to the minister and the minister could unilaterally make whatever decisions he felt were necessary, this would be the death blow to the Catholic health care system, if we had no more boards. Is this what you're saying?

1250

Mr Jeff Lozon: That's the position of the association, that the bill as currently constituted really does fundamentally alter the essential nature of Catholic health care in the province of Ontario, or has the potential to do so.

Mrs Witmer: So then what amendments would be required to ensure the continuation of Catholic health care in this province in the way it's presently structured and allow you to continue to deliver those services?

Mr Marr: The fundamental principle we're trying to articulate is the importance of maintaining the voluntary nature of hospital governance. In that regard, that applies to all hospitals in the province, that if you remove the boards, which in effect this bill has the potential of doing, you've virtually done away with voluntary governance. The essence of Catholic health care is based on maintaining the mission within the public health system. The people responsible for ensuring that the mission of Catholic health care is maintained are the local board elected by the members of the corporation, the sponsor of each Catholic hospital, and then the CEO is held accountable to the local board. If that chain of mission is broken, if effectively the board is powerless in areas of mission and values and the CEO is reporting directly to the minister, there is no Catholic health care, there is no guarantee that the mission of the hospital or facility will be maintained.

Mr Marchese: So many questions. It is remarkable that we have heard from so many deptutants, most of whom have a great deal of criticism about the bill and so very little positive to say about it. The previous delegation spoke well about many things, and I wanted your comments. "The bill is aimed at provider accountabilities but is relatively silent on government and public accountabilities. It's hard to read the various sections in this act without feeling that once again providers are left with all the accountabilities and none of the supports needed to meet those accountabilities." I think there's a great deal of truth in that. What do you say?

Mr Lozon: I've been in the health care system for more than 25 years. When I read Bill 8, I was dismayed because I thought I had actually been contributing, but Bill 8 was a statement that I was unaccountable, that we were basically not to be trusted and that we had to be in a command-and-control environment, when in point of fact most people—I think the previous deputation, and I would include myself in this—think we're actually trying to contribute to the health care system.

Mr Marchese: They add, "It's hard to accept that caring, committed health care professionals are viewed as criminals deserving jail terms for failing to comply with various sections of the bill." Certainly it's hard not to get that impression, isn't it?

Mr Lozon: There was a very confrontational tone to the bill. I think the system has been put into a defensive perspective, in the sense that it came rather unannounced and without any prediscussion.

Mr Marchese: And the Public Hospitals Act is quite clear in terms of the powers the minister has to deal with certain problems. We heard from a previous deputant, a lawyer, Mr Watts, that in the language of that bill there is a public interest component, including an oversight component, ie, an order in council, which means there's greater oversight. This particular bill doesn't have any of those oversights or public interest language. It simply gives the minister the power to come and correct you whenever there's a problem. That's certainly a big cause for concern.

Mr Lozon: Yes.

Ms Wynne: There's a bit of imagination going on and some flights of fancy, so I just need to be clear about what we are saying. Currently the government has the ability to remove boards, take over boards, put in supervisors, so I guess I'm a little unclear as to why the member opposite would be characterizing this bill as being a new authority. What we're trying to do here is introduce some accountability measures into a system that needs them. The minister has admitted that we probably didn't get the tone of the bill right at the beginning, and there are a number of amendments that I hope you'll take a look at before you leave. Those tone issues and the business about incarceration and fines and those kinds of things are going to be changed.

I'd like to hear your feedback on the public interest piece we're proposing. What we're proposing is that the public interest, which doesn't appear in the bill right now, go into the preamble as an overarching principle of the bill. I wonder if that sounds like a good idea to you.

Mr Marr: It's a fine idea. I think the tone is not the issue we're concerned about.

Ms Wynne: You raised the tone.

Mr Marr: The tone is one thing. I think specifically, if the government wants to take over and run hospitals—

Ms Wynne: Which we don't.

Mr Marr: —then do it.

Ms Wynne: We could now, but that's not what we want to do. The point is that we want to establish accountability between the boards and the minister. That's what this bill is about. It's between the boards and the ministry, in fact not getting rid of the boards but validating their role.

Mr Lozon: Perhaps I could make a comment. The act, as it's drafted, does not specifically reference any ministerial or government accountability.

Ms Wynne: That's exactly where the amendments come in.

Mr Lozon: It only references accountability agreements that are actually required to be entered into by individuals. I think you can understand why the system—not just the Catholic Health Association of Ontario—is responding in the way it is. The bill, as it was circulated, and the minister's comments, although providing some general direction for amendment, fall short of providing specifics that the system can actually identify and understand.

Ms Wynne: Right.

Mr Lozon: You can understand why the concerns are being expressed.

Ms Wynne: Yes, absolutely.

The Vice-Chair: I'd like to thank the Catholic Health Association of Ontario for coming today to make a presentation.

STASHA NOVAK

The Vice-Chair: Next we have Ms Stasha Novak. Would you like to come up to the chair and make yourelf comfortable? You have 20 minutes for your presentation. With any time remaining, we'll have a chance for the three parties to ask questions.

Mr Marchese: Mr Chair, is this the last presenter?

The Vice-Chair: The last before our recess.

Ms Stasha Novak: Good afternoon, Mr Chair and members of the committee. Thank you for allowing me to speak to you. I'm just an ordinary citizen, so I'm not going to speak on small details in Bill 8. I would like to speak to you about my experience in the health system, and I'm also speaking on behalf of members of survivors of medical and dental abuse, of which I've been a member for the last 10 years.

I'm in a lot of pain right now. I do not have dental coverage, and I have excruciating pain. Sixteen years ago a dentist assaulted me and did faulty dentistry while I was in his office. To this day, I have received no compensation for expenses etc.

I tried to write something in some order; I could not. Whatever reference I'm making to the health minister was addressed to the previous ministry, because you're all new. Unfortunately, it's like ballet: There is applause or boos for the dancer who just left the stage.

I trust that your definition of health includes oral and dental health. I trust that you support accountability and absolutely not two-tier health care for those who can pay and those who cannot.

Some of my major concerns: Apart from the fact that some people can pay extra fees and some cannot, you must be aware that some people get sick because they work or live in a toxic environment. The government that did not protect them for all possible reasons from an unhealthy environment is now the same government that would penalize them again: Pay for your own health if you can afford it; otherwise, suffer and die, particularly from an environmental illness, because it's relatively new and until you establish that you have something wrong environmentally, you are perceived as crazy. I'm quoting from a health minister, but not the present one.

1300

In a civil society, one would find a way to provide compassionate health care and alleviate pain and suffering and to honour human dignity from birth to the end of life. I'm speaking with the authority of personal experi-

ence as a child under the occupation in Europe in the aftermath of war. Health care should never be for sale or used for unethical purposes, and that includes human experimentation on a healthy individual without consent, which is a violation of the Nuremberg Code. The responsibility of doctors, dentists and all health care professionals is to the patient: Do no harm.

I find it shocking that a very ill person is mistreated in a medical or dental setting, and the same ill person is expected to sit down and write a complaint, go through three years of the complaint process through the college of physicians or college of dental surgeons and the health discipline board. Why is there such a division between health care users and providers and managers of the medical-legal-dental industry? I'm sorry if I'm so naive, but aren't we all human?

I'm sorry you have to hear this story. I'm just telling you my experience. Perhaps you'll say, why do you bother? Why come before this committee? I thank you for listening. If you want to change something, I appreciate that you're listening.

One definition of insanity is to do the same thing over and over and expect different results. Each one of you could be in my situation, but I am glad that you are not.

In February 2003, after the Toronto Star and CBC TV did a program on medical horrors, the college of physicians announced to their members that Ontario doctors had to contact their patients about any errors or wrongdoing they did to those patients. Three of my treating doctors lost their licences, and to this day, no one has contacted me. Two of the doctors lost their licences after I filed a complaint of sexual assault. At that time, they were believed, so they assaulted two other patients. I have to ask, is the person who looks the other way just a passive observer or an accomplice in crime? I have no other choice of words. I think that's what any reasonable person would say.

The CBC program Disclosure was a shocking eye-opener to a wider audience. People who chose legal action against their doctors were harassed and publicly stated they were afraid of doctors' lawyers. Some cases were in the courts unsolved for up to eight years. When CBC interviewed a medical defence lawyer, she said there was no intentional delay. But I think the government of Ontario, for a while, abdicated its responsibilities and allowed such barbaric abuse of its own citizens. To me, violence by pen and paper or by the gun is the same. Violence is violence in any shape or form.

Similarly, my case against a dentist was before the courts for about eight years. I had several lawyers. About eight years later, I had a grafting of soft tissue. That means the periodontist cut a piece of flesh from the roof of my mouth and sewed it below. It's very painful. For one month I could not eat anything but pureed food and I was taking Tylenol 3. About that time, the lawyer for dental insurance came out of nowhere. He filed a statement of defence after the case had been in an Ontario court for eight years and lied to the judge that I had a psychological problem and that I had pulled my teeth out instead of treating them, and did not provide evidence or medical or dental reports. The judge dismissed my case, and I have to pay the dentist's lawyer's fees.

I wrote a letter to the lawyer and to the judge. The lawyer replied that I did not appeal. Perhaps he should not have lied. Where were my lawyers for eight years, and why did dental liability wait for eight years to file a statement of defence, and why didn't one of the lawyers notice? Apparently, there is a procedure when one doesn't file a statement of defence within 20 years. You can go to court and ask, "What is the problem?" Perhaps they didn't have a good defence.

My concerned doctors and dentists wrote expensive medical and legal reports to my lawyers. I suffer in pain and I have to ask that you address this irresponsible liability insurance and their lawyers. My life is not on sale. The dental work is not covered by OHIP. If I have no money, I have to suffer in pain. If I have a prescription for Tylenol 3 and no money, I suffer.

The dentist who put the crown on my teeth was not qualified to do the dental work on me, and I consider that battery and assault, and criminal assault. It should be dealt with as such, not some cover-up. The college reprimanded the dentist in question and asked him to take some more courses in dentistry after examining his dental work on my teeth. The college decided that all dental work will have to be removed and replaced by someone else, but someone else would require over $30,000, which I didn't have.

When the dentist messes up your teeth then you develop medical problems. Some family physicians are unwilling or unable to recognize medical consequences of dental disasters. You come back to the dental profession, provided you have lots of money, and the dental profession can correct the mistake of the first dentist. Often, the dental profession cannot do much for you. Some dentists would not treat you and some would further abuse you.

In the last 16 years, I had over 500 dental appointments and I was treated by some 32 dentists at Mount Sinai clinic alone. Some of my dentists were exceptional human beings—by no means am I painting everyone with the same brush—like Dr Cutler, Dr Perlus and Dr Barzilay. I don't know if they are honoured to be mentioned here, but they are wonderful human beings. But it takes only one dentist to mess up your teeth, and because of all the dental work I suffer chronic pain, facial neuralgia, horizontal loss of bone. I had abscesses. I had numerous X-rays, panorex. I have TMJ, inability to speak and earn my living.

Prior to that, I worked in a bank for 20 years, and when I was sick the bank threw me on the street with no means for survival. I am so humiliated that I have to speak before you today. This should never happen to another human being.

I could not write to you, but I brought you an article by the dentist Dr Boudin, "Importance of Co-operation Between Physician and Dentist." It was published in the Journal of the American Medical Women's Association

in 1947. It discusses the relationship between the family doctor and a dentist. Many times dentists will discover things in the mouth ahead of a physician, and dentistry and the rest of the body are very much connected.

Please excuse me for my sloppy presentation. I am in pain as I'm speaking to you.

The Vice-Chair: We have nine minutes, so we'll start with Mr Marchese.

Mr Marchese: No questions, except to thank you for coming. If one of the members has any expertise to deal with the particular problem, hopefully they might help in the individual case.

Ms Wynne: I just want to thank you for coming as well. I'm sorry you've had to go through what you've had to go through.

I don't think I can comment on the specific issue, but on the general question of government holding medical institutions and the health care system accountable, because that's what this bill is about, do you have any specific suggestions on that issue?

Ms Novak: The leader sets the tone. The Chairman set the tone of this meeting. The symphony orchestra concert master sets the tone. So you set the tone. You can't ask every medical office to have their own agenda etc—something that is acceptable in society. We have auto insurance, but you know, in every human activity errors do happen, even human errors. But nothing have I ever read anywhere that anybody would address how to deal with that. So why are patients being penalized and excluded from the process, that all other people have? That's not fair.

Ms Wynne: So you think government has a leadership role to play in terms of setting a tone and putting those frameworks in place.

Ms Novak: Absolutely. I can protect myself from the bullies; I don't walk in a back alley. But when I go to a doctor's office, an MD or a DDS, that's what I would like to find there, not some unqualified person.

Ms Wynne: Thank you, Ms Novak.

The Vice-Chair: Thank you for your presentation.

We stand recessed until 2 o'clock.

The committee recessed from 1312 to 1401.

ONTARIO CHIROPRACTIC ASSOCIATION

The Vice-Chair: I would like to call our afternoon session to order. First on the agenda for deputations we have the Ontario Chiropractic Association, if you'd like to step up to the table, make yourselves comfortable. Just a few ground rules: We have 20 minutes for a presentation. Should you not use the full 20 minutes for the presentation part, if we have some time remaining, it'll be split between the three parties for questions.

Dr Bob Haig: Thank you, Mr Chair. My name is Dr Bob Haig. I'm the director of government and professional affairs for the Ontario Chiropractic Association. With me is Dr Dean Wright, who is the president of the Ontario Chiropractic Association. We will most certainly take less than 20 minutes, and look forward to your questions.

Dr Dean Wright: The Ontario Chiropractic Association is pleased to provide this submission in support of Bill 8, the Commitment to the Future of Medicare Act. The OCA believes that this legislation will enable the government to take a significant step toward achieving its vision for the future of health care in this province. Bill 8 will not only protect the principles of medicare but also ensure that Ontario remains a leader in the delivery of health care. The OCA firmly agrees that the preservation of medicare is essential for the health of Ontarians now and in the future.

In his remarks to this committee, Minister Smitherman said that medicare is in need of protection. He also said that the health care system is anchored in the foundation of hospital and physician services, but to be relevant it must evolve to encompass the full continuum of care. So while medicare is in need of protection, it's also in need of reform.

The OCA represents over 80% of the 3,000 practising chiropractors in Ontario. We are regulated by the CCO under the Chiropractic Act and the Regulated Health Professions Act. Chiropractors are the third largest primary contact health profession in Ontario, following physicians and dentists. This means that citizens of Ontario can visit a chiropractor directly without the need for referral from another health care provider.

Because of their expertise and education, chiropractors are one of the six health professions with a duty and obligation to perform diagnosis and the attendant use of the title "doctor."

Chiropractors diagnose and treat patients with neuromusculoskeletal disorders and conditions. On the whole, chiropractic practice is comprised of patients with back pain, neck pain and headaches. These are the prevalent conditions which result in a majority of the cost to society in both health care and in direct costs such as lost days at work and productivity. Some patients visit chiropractors for treatment of acute injuries related to work, sports, or slips and falls. On the other hand, some patients seek help in managing their pain from chronic conditions such as arthritis.

Dr Haig: I left Minister Smitherman's speech at the Economic Club. One of the things I can paraphrase him saying is that the future of medicare in Ontario will be largely influenced by the reform of the primary care sector. He spoke at some length of the government's plans with respect to primary care reform in the family health teams.

Primary care reform is complex, and we're encouraged by the government's commitment to move forward on it. We believe strongly in the principle of ensuring that the right service is provided to the patient by the right practitioner at the right time at the right cost. We look forward to continuing to work with the government and with others to make this happen.

In Ontario, where chiropractic is a part of the publicly funded system, the use of chiropractors by the public has risen steadily over the years. Currently, about 12% of

Ontarians visit a chiropractor annually, and over the last five years probably 40% of the population has been to a chiropractor.

This increasing utilization of services is happening for a number of reasons. First and foremost, it's because chiropractic is a safe and effective form of health care. There is in fact a considerable body of evidence that supports both the health benefits and the economic benefits of chiropractic care, particularly for those conditions that Dr Wright mentioned.

One of the results of this increased level of scientific evidence is that the Workplace Safety and Insurance Board has put in place a new program of care for acute back injuries. In fact, that program of care, which is based on the evidence, effectively mirrors the way that chiropractors treat their patients all the time: with education, with return to activities, with spinal manipulation and mobilization and with exercise. So the way that chiropractors treat these common, prevalent and costly conditions is in fact largely supported by the evidence.

The second reason for this increasing utilization is that physicians and other health care practitioners now commonly refer patients to chiropractors. This is in fact the natural evolution of community-based coordinated care that is reflected in the concept of the family health teams. This is happening on an ad hoc basis as it is. This is in fact effective health care. Using the chiropractor's expertise where it's most valuable means that the physicians can focus their expertise on those patients who cannot be managed by somebody else. With the shortage of physicians and the increasing number of Ontario residents who do not have a physician, freeing up a physician's time to focus on medical priorities is in fact a good strategy.

Medicare can only be preserved and reformed with careful planning. That planning must include better coordination and better use of health care professionals. That's the concept of the family health team. That planning is hampered by the fact that our system has developed with individual professions and individual institutions in regulatory and funding silos. To truly preserve and reform medicare, we need to look beyond those silos to find a way to utilize all of the available resources. We shouldn't focus so much on who to fund as on what to fund; not on which professions or which institutions to fund, but on the funding of services that are known to be and shown to be effective and evidence-based, that are shown to have a good cost-benefit ratio, and services that are not just add-ons but which take pressure off and integrate well with the rest of the system.

Having said that, I want to turn to a few of the specific provisions in Bill 8.

The Ontario Chiropractic Association supports the increased accountability measures that are laid out in the bill. There are already accountability measures within the system. The college of chiropractors has standards of practice and has a peer review program which maintains high standards for the chiropractic profession. But the significance of the health budget to the Ontario budget means that there's no such thing as too much accountability. We understand that there is debate and discussion over the penalty clauses, and I see that Minister Smitherman has made recommendations that the accountability agreements not apply to individual practitioners. But you need to know that we were prepared to support that, and in principle, increasing accountability through accountability agreements is something that we fully support and that we think is sound.

With respect to accessibility, the act has a number of specific provisions for eliminating barriers to access, including the financial barriers of extra-billing, direct billing and block fees. In Ontario, chiropractic is partially funded, so that on each visit there is a patient co-payment. This is not considered extra-billing by this legislation because the insured service is defined as only that part of the service that is funded by OHIP. But chiropractic is an anomaly in the Ontario health care system in that it is only partially funded this way. We've pointed out that the utilization of chiropractic services is increasing and that for clinical and economic reasons this is appropriate. But because of the budgetary limitations that exist—and we all know budgetary limitations exist—OHIP coverage for chiropractic service has declined over the years on a per-patient basis. In 1970, OHIP covered 82% of a visit; it now covers about 30%. So on a typical visit to a chiropractor for the treatment of back pain or neck pain or headaches, OHIP would pay $9.65 and the patient would pay somewhere in the range of $20. That means that patients actually face a very significant and sometimes a completely insurmountable financial barrier to access, and this is happening at a time when the evidence points to the effectiveness of that treatment to the patient but also to the payer as well, at a time when we're trying to encourage rather than discourage coordinated care.

1410

When patients can't go to a chiropractor for financial reasons, it generally means that they seek an option that incurs no personal cost but which costs the province of Ontario much more. They might see a physician; they might visit an emergency room; they might take some medication that's paid for by the Ontario drug benefit plan; they might do nothing and simply have to stay off work or remain disabled for a longer period of time.

Generally speaking, that's why we say and we believe that protection isn't enough. Medicare needs to be substantially reformed, and to do that, it needs a very high-level view of it to look at how to best utilize all of the resources that we have.

Section 10 of the act provides for the government to enter into agreements with respect to dental, medical and optometry services, but not chiropractic services. Subsection 10(2) specifically identifies the professional associations that would be a party to those agreements, namely the Ontario Medical Association, the Ontario Dental Association and the Ontario Association of Optometrists, but again, not the Ontario Chiropractic Association.

We think that Ontario has a commitment to comprehensiveness that goes beyond what the Canada Health Act says, and that's reflected in the fact that some services other than physician services are funded by OHIP. It's not just chiropractors; there are others as well. We think it would be appropriate for this legislation to reflect that commitment and be amended so that it includes those other services in section 10.

That concludes what we had to say, and there is all kinds of time. So we're happy to take questions.

The Vice-Chair: Yes. We have nine minutes, to be exact. We have the government side.

Ms Wynne: I just have a quick comment, and I think Mr Delaney would like to ask a question.

Thank you for coming and thank you for articulating your support of what we're trying to do here. You of all practitioners would understand the difficulties in shifting from a culture of treatment of illness to prevention and education and wellness. So I certainly applaud that.

I just want to clarify the issue around section 10, and I have spoken to some of your members before about this. The way section 10 is written, it lifts the language directly from the Health Care Accessibility Act. In subsection 10(3), what is possible there is for the minister to enter into agreement with pretty much anybody who meets the qualifications, and it doesn't have to be an association itemized in section 2. So my understanding is that you would be covered in that section. What we didn't want to do was to be exclusive. So that's how we're proposing it be left at this point.

Dr Haig: I do understand that that section gives the minister the ability to enter into any kinds of agreements with anyone there and that chiropractic services and the other non-physician services that are funded by OHIP could be covered by that.

What I'm suggesting is that it doesn't actually reflect as well as it could Ontario's commitment to integrating the services. We know that's where you're going, we know that's where you want to go, and this is an opportunity to further demonstrate that.

Ms Wynne: We'll take your comment. Thank you. I think Mr Delaney had a question.

Mr Delaney: It is in fact one quick question. Thank you for a very interesting brief.

One of the priorities of Bill 8 is to enable health care providers to collect and use a consistent body of data that shows how effectively health care resources are being used. In your brief, you support, to use your words, "evidence-based" service delivery and service that demonstrates "a good cost-benefit ratio." As a question to you, do you think this emphasis on measuring effectiveness is going to cause Ontarians to look at chiropractic services differently? How might this affect your members and their views?

The Vice-Chair: And as quick an answer.

Dr Haig: I can't do that quick an answer.

We're very confident that when you look at the cost-benefit ratio, when you look at the cost of providing services to treat those conditions, if you have a collaboration and a coordination of care that includes chiropractic services, there are very substantial cost savings. Estimates are certainly in the hundreds of millions of dollars for Ontario.

I forgot to turn my phone off; I apologize.

The Vice-Chair: I'm going to have to stop it there. Ms Witmer?

Mrs Witmer: Thank you very much for your presentation. I'm glad, Mr Haig, that you had the $65 or $650 to be able to get a seat at the Economic Club luncheon that was promoted by the Deputy Minister of Health so people could hear the minister speak. It's really an interesting scenario. I think some of our health stakeholders figure they would be entitled to hear the minister speak free of charge and not be encouraged to pay.

Having said that, do you see this bill as an attempt by the government to centralize power in the hands of the ministry and the minister? Or if not, how do you see this bill?

Dr Haig: Quite frankly, I see the bill for what it's intended to be.

Mrs Witmer: Which is what?

Dr Haig: Which is a commitment to medicare. The debate that has gone on in Canada and in Ontario for quite a while is bringing people to this point of saying, "We need to recommit to this. We have to do this." Certainly, from your experience, you understand that and you understand how difficult change is as well. The measures in the bill—the accountability, the accessibility measures—are right in principle. I know there's debate and discussion about whether they go too far or do not go too far. There are some provisions that affect other professions much more than they affect our profession, but in principle it is right that Ontario makes a commitment to publicly funded, coordinated health care.

Mrs Witmer: I don't disagree. I just don't think this bill goes there. A lot of hospitals have told us it doesn't go there, as has the medical community.

The Vice-Chair: OK, moving on to Mr Kormos.

Mr Peter Kormos (Niagara Centre): I'm not going to use up a whole lot of time. Yes, that's right. I saw it: 650 bucks a table, 10 seats to a table. Is that what you were talking about?

Interjections.

Mr Kormos: I'm amazed that any member of this committee with experience would somehow suggest that's the first time this has ever happened. But what also amazes me is how people get sucked into these things. They're inevitably promoted as getting access to the minister, right? That's the subtitle. Honest, I'm telling you, I'm just amazed. I meet mayors, all kinds of officials in elected positions, some with considerable experience, who somehow think these are bona fide contacts. The ministers are at these events—and I don't want George coming here tomorrow saying, "Oh, Pete, you're wrong. I was paying full attention to every person whose hand I shook." But if you take a look, the ministers go to these events and they've got their little entourage. If you'll

notice, ministers acquire this ability to look over your shoulder as they are talking to you feigning interest, right?

Interjection.

Mr Kormos: You know what it is. They'll pass you on to their handlers at the earliest opportunity. They have no idea who you were within an hour of leaving the event. All I'm saying is that it is the money most ill spent—

The Vice-Chair: You have a minute for your question.

Mr Kormos: Thank you kindly. What have we got here? It actually was being promoted as—oh, this was the highly partisan politicization of the civil service. That's right. That's what this one was, because this was a deputy minister touting this as a chance to buy your way into the minister's graces. But I'm telling you it's a fraud, a scam. You're better off buying something late at night from one of those infomercials and hoping that it actually works than you are thinking that you're going to make an impression on a minister by going to these high-priced dinners. Gentlemen, don't get sucked in. Heck, you can hang around outside the cabinet meeting on a Wednesday morning and I'll introduce you to the minister—end of story.

Thank you very much for coming here. I'm a fan of chiropractic.

1420

Dr Haig: So there's no question and answer in that?

Mr Kormos: There's no question and answer.

Dr Haig: Just checking.

The Vice-Chair: Thank you very much for your deputation. We appreciate your coming.

Mr Klees: On a point of order, Mr Chair: I wonder if we could ask the parliamentary assistant to let us know if chiropractors will be listed as one of those associations, when the amendments come forward.

Ms Wynne: I think I indicated that subsection 10(3) of the legislation actually allows for chiropractors to enter into agreements with the minister. At this point, there isn't a plan to change that. I said to the deputant that we would take their comments back, but at this point the legislation actually allows for those agreements, and I think I made that clear to the deputant.

Mr Klees: It's a great opportunity to actually entrench it in legislation. That's what this is all about.

Ms Wynne: We'll take the deputant's comment back.

BRANT COMMUNITY HEALTHCARE SYSTEM

The Vice-Chair: Next we have the Brant Community Healthcare System. Welcome. Make yourselves comfortable at the table. Like the previous deputation, you have 20 minutes. Any time remaining at the end will be split between the parties to ask questions.

Mr Ray Finnie: Thank you very much. Ladies and gentlemen of the standing committee on justice and social policy, my name is Ray Finnie. I am here today representing both the Brantford General Hospital and the Willett Hospital, which together form the Brant Community Healthcare System. With me is the president and CEO of the system, Rick Woodcock.

I have been a member of the hospital board of governors of the Brantford General Hospital for the past five years. For the past three years, I have chaired the finance and property committee, where I have found systems, processes and relationships to be of great interest compared to the business world, which I normally work in. My occupation is in the for-profit world, where things function quite differently. To put things in perspective for you, I am a chartered accountant and the president and CEO of Wescast Industries, based in Brantford, Ontario. Wescast is a global automotive parts company with revenues of almost $500 million and 2,600 employees.

Back to the hospital boardroom: I am proud to say that volunteer boards and each member on these volunteer boards is very committed to the public we are privileged to serve and does the utmost to provide an appropriate level of programs and services to our local community in an efficient and cost-effective manner. There is a very difficult balancing act that we must undertake as we attempt to meet community demands while at the same time working with the Ministry of Health and Long-Term Care to balance budgets.

I am not here to criticize the Ministry of Health and Long-Term Care, because I recognize it also has a very difficult challenge. But it is difficult for members of the board to be accountable and responsible when operating budgets are seldom approved until some six to eight months into the fiscal year, and periodically have never been approved at all. The theory of balancing one's budget with a 2% or 3% increase over two successive years when inflation or the cost of operations is running at some 5% to 8% increase, without reducing programs or service levels, is quite unacceptable.

When approximately 75% of the operating budget is allocated to salaries and wages, and the vast majority of costs related to salaries and wages are determined by central negotiations or arbitration outside the control of the local boards, the impact on our budget is also very much out of our own control. It is my opinion that we wish to stand accountable to both the Ministry of Health and Long-Term Care and to our local communities, but together we need to find a better way.

We were told by the Minister of Health at the OHA convention this past November that volunteer boards are, and I paraphrase, a valued and vital part of the health care system in Ontario. As an Ontarian, I am very proud of our hospital industry, which is reported as having the fewest acute care beds of any province in Canada, the lowest per capita hospital expenditures in Canada, the lowest inpatient utilization in Canada, the shortest length of stay in Canada, and day surgery rates, compared to inpatient rates, higher than the average of other provinces. We clearly recognize that available resources are not without limits. As taxpayers and consumers of health

care services at the local level, we expect hospitals to be responsible and accountable, and thousands of us across Ontario are here to help achieve this goal. But Bill 8 is not the way to do it.

I wish to speak to seven aspects of the proposed legislation, which in my opinion are unacceptable as currently drafted. Please recognize that several other sections also deserve greater attention; however, we do not have the time in this presentation to address them all.

Allow me to begin by saying that we have reviewed the preamble to Bill 8 along with the draft bill itself and find a significant disconnect between these two sections. We strongly endorse the philosophy expressed in the preamble but are concerned that the recommended legislation does not fulfill the expressed intentions of the preamble.

Part I: the Ontario Health Quality Council.

I believe the proposed council is a positive extension of what is currently provided by hospital boards and district health care councils. Is it duplication? Does it provide more of what the Ministry of Health and Long-Term Care already has? Those are the important questions.

My recommendation is that an independent council reporting to the Legislature will be much more likely to hold the government accountable than a council that reports to the minister.

I further recommend that the council permit membership that may include all representative stakeholder groups. Logically, there should be a predetermined allocation of membership from non-stakeholder and stakeholder groups. Members of volunteer hospital boards and senior hospital administrators who have valuable experience and insight about the health care industry should not be prohibited from participation on this council.

Part II: health services accessibility.

We support the intention of the bill to bar two-tier medicine. There is a specific aspect of this issue that we have been concerned about for several years: the payment of global budget dollars to physicians for other than stipends for medical administrative duties, which have long been recognized as an appropriate expense. In recent years, solely due to the shortage of physicians—as an underserviced area, for example, Brant county requires some 26 additional family physicians—hospitals have been forced to pay physicians amounts that greatly exceed those that such physicians can bill OHIP.

Recognizably, the billing-funding problem may be caused by (a) a fee structure that does not adequately represent physician services provided within the hospital setting and/or (b) no system to adequately provide for all medical and diagnostic physician services to be funded from the OHIP pool of funds.

The following programs are subsidized by hospitals, as noted above, and would inevitably terminate with the impact of Bill 8 as currently drafted: hospitalists, which we currently employ at our Brantford General Hospital site; psychiatrists, as we are a schedule 1 facility; pediatrics; complex continuing care and palliative care at our Willett site; urgent care at the Willett site; and, potentially, emergency services at the BGH site.

We understand it is not intended that Bill 8 will impact this relationship with physicians. However, it is recommended that an amendment be made which will not prohibit such payments, at least until an alternative funding mechanism is created by the Ministry of Health and Long-Term Care.

Part III: accountability.

Bill 8 seeks to tighten the reins that the minister has over hospitals and will give the minister powers that may substantially interfere with the volunteer governance and management of hospitals. Such action may bring an end to volunteer hospital boards in Ontario, a goal contrary to that expressed by the minister at the OHA convention in November 2003 and in the preamble to Bill 8.

The bill will put in place mechanisms to have the hospital CEO report to both the minister and the board, and by granting the minister the right to unilaterally alter the CEO's contract with the board, the minister is interfering with a fundamental principle of corporate governance.

Clearly, all literature supports that accountability for the corporation resides with the board. In turn, the board delegates responsibility to the CEO to run the facility and operation in accordance with its expectations. The board can only remain accountable and responsible when the CEO reports directly and solely to the board for all aspects of the hospital's operations.

Our chair, Jackie Delong, is quoted as saying: "I feel strongly that this legislation devalues the work of volunteer boards such as ours in that we are accountable for our programs and services through our one employee, the CEO, and it removes that relationship. We have clear systems in place to ensure that both his performance as a CEO and our performance as a board are regularly evaluated against high standards. If he/she is not accountable to us but to the Ministry of Health, how can we be held accountable? Furthermore, where is the ministry accountability in this legislation? This legislation appears to send the message that we are not providing quality health care services to our community and that our volunteer commitment is not valued by this government. There appears to be a disconnect between the messages from the government to work in partnership with communities and the language of Bill 8. I sincerely hope the amendments to this bill encompass our concerns."

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This bill allows the minister to invoke certain provisions of Bill 8 without the "in the public interest" test currently required by the Public Hospitals Act to deal with extreme situations, or approval of government to the extent that the CEO may be required to sign a performance agreement at the discretion of the minister in the form of an end run around the board. Further, the minister may materially change a person's—ie, the CEO's—terms of employment with the board.

Long-standing principles with respect to governance and management models would be terminated in Ontario

hospitals. For example, no board should take responsibility for a CEO who is not fully responsible to one authority. Similarly, a CEO should not agree to work for more that one master. Simply stated, the CEO could not adequately perform his or her responsibilities in such an environment.

The minister should not be given authority to deal directly with the CEO, which leads to the question, why does the minister need to deal directly with the CEO at all? The minister's goals can be accomplished by issuing directives to the boards.

I am sure you are aware of the 2003-04 British Columbia Auditor General's report, which indicates: "Traditionally, boards decide on CEO appointments, terminations and remuneration.... We found it was unclear whether the CEOs are accountable to the boards, the minister, or both. This situation creates a number of potential 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 management of the board on behalf of the ministry, rather than reporting to the board."

It is therefore recommended that the bill be amended to provide for the CEO to report directly to, and be held accountable by, the hospital board.

It is noted that sections 8 and 9 of the Public Hospitals Act currently provide several avenues for the minister to act with some force when he or she believes the ministry should be directly involved in hospital activities. Such forces, in the form of appointing an investigator or supervisor, currently cannot be unilaterally exercised by the minister. The minister must first convince the Lieutenant Governor in Council to take action. The authority granted through this bill would undoubtedly provide for a less onerous mechanism for the minister to become involved, a purpose that appears ironic at a time when the minister is looking for increased accountability.

On the issue of accountability, this bill clearly delineates a process that makes the CEO and the board more accountable against the very significant backdrop of the minister being required to be less accountable. Why do I say "less accountable"? There are several examples, but most evident are the following two:

(1) With respect to part III, the bill permits arbitrary government intervention in hospital operations at the minister's level, as opposed to the government, by removing the requirement for the minister to obtain an order in council with proof that it is in the public interest, or any other level of government support. The bill provides for the minister to merely issue compliance directives. Unilaterally, these compliance directives could effectively be just as intrusive as the appointment of a supervisor, because they could make the role of the board irrelevant.

(2) With respect to part I, the minister does not have to be accountable to the council for funding or levels of service, provided, however, the council is responsible to the minister as opposed to the government. There is clearly no mechanism for the council to make recommendations to the minister with respect to the ministry's role in the provision of services or the quality of services. Needless to say, the provision of services and the quality of services are often related to adequate funding, an issue which cannot be addressed by the council.

Therefore, it appears that this bill seeks to increase CEO and board accountability while decreasing the accountability of the paymaster, ie, the Ministry of Health and Long-Term Care.

I recommend that the minister continue to abide by the provisions of the Public Hospitals Act as it relates to dealing with exceptional circumstances.

Part III: accountability and accountability agreements.

We support the concept of accountability agreements, which will improve the annual planning process and hold both parties accountable for the level and types of services to be provided to the community. Ensuring that performance goals and objectives are met on a regular basis is an appropriate aspect of our board's responsibility to the community we serve. To establish, review and monitor such goals and objectives in partnership with the ministry would be a worthwhile process that will make both parties jointly accountable.

As mentioned earlier, the hospital industry has suffered too long with budgets that are approved long after it is able to react to the impact of the approved budget within the fiscal period. The current process will inevitably continue the current situation, where reportedly 90% of the 71 community hospitals in Ontario are experiencing annual operating deficits. At our property and finance committee, we have often stated that this is no way to run a railroad, and especially not a hospital. The process, or lack thereof, is destined to lead to working capital deficits in the future.

Inasmuch as we support the concept of accountability agreements, we believe that such agreements must be negotiated in order to establish commitment and accountability from both parties; due process must provide for circumstances when agreements cannot be negotiated, when key underlying assumptions change or when disputes exist around compliance; such agreements must be signed by the hospital board and the minister; and all directives with respect to amended directives or compliance issues must be from the minister to the hospital board. Once again, the CEO remains accountable to the hospital board to ensure that agreed performance goals, objectives and outcomes are satisfactorily met.

I recommend that the concept of accountability agreements be endorsed and that the foregoing suggestions be included in the development of related policies and procedures.

Part III: accountabilities and penalties.

It is apparent that government is of the opinion that accountability only comes with the threat of penalties. It is increasingly evident through the draft of Bill 13 that the government supports significant penalties to individual members and boards. Such penalties are replicated in Bill 8. We agree with the minister's own statement that

the penalties in Bill 8 are too harsh. The penalty provisions of the bill are inconsistent with the principle embodied in the Public Hospitals Act, which endorses the concept that volunteer board members shall not be held liable or subject to actions if he, she or they are acting in good faith.

It seems to me that if volunteer boards are an integral part of the system for Ontario, the government should be supporting in actions things that would attract additional good-quality board members through education, orientation and just plain moral support, not through draconian or punitive measures such as these.

We note that the minister has issued written amendments to reduce the amount of the penalties; however, the principles delineated above are driven by the idea of penalties, not the amount of such penalties. I recommend that the principle of penalties be removed from the legislation.

Other: hospital foundation and fundraising.

The government should be concerned about the potential impact of such a bill on volunteer board members, associated foundations and the community at large. Brantford and Brant county, through a fundraising project to support the directives of the Health Services Restructuring Commission, raised nearly $12 million in a 12-month period through the generous support of personal, corporate, association and club donations. This generous support continues, with some $7.6 million additional dollars raised since 1999.

Currently, municipal councils in Brant believe that hospitals are and should be fully funded by the ministry for both the cost of operations and capital renovations and construction. It is apparent that in the event that local hospitals are seen as facilities of the ministry only, as opposed to locally governed facilities, the ability of foundations to generate income through fundraising efforts will be reduced. I recommend that great caution be exercised with respect to the predictable impact of this bill on local fundraising, due to the potential negative effect on our ability to attract funds at the local level.

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In summary, we as a board are alarmed and disturbed by the legislation proposed by this government.

All issues raised in this submission give us great cause for concern; however, the most significant, in order of importance are: the proposed interference in the volunteer governance and management relationship; the prohibition of payments to physicians for the provision of services which exceed the amounts recoverable from the Ontario health insurance plan—without a solution to shore up programs in underserviced communities; and the need for accountability agreements to be negotiated.

Members of the committee, Bill 8 is not the appropriate method to use to support volunteer boards who have worked through extremely difficult circumstances, often with no two-way dialogue and void of adequate funding both operating and capital, for many years. The bill has been described by many as "draconian" and "punitive," amongst other stronger terms.

At this very difficult time in the history of Ontario hospitals, when provincial resources are insufficient to meet our growing demands in all sectors, we strongly suggest that the minister recognize the immeasurable level of commitment and support amongst staff and volunteers to fortify and sustain the system.

A significantly "tempered" bill or preferably a further period of dialogue and consultation would better enable all parties to address the challenge related to scarce resources and the need to maximize the efficiency and effectiveness of the system that we treasure so dearly.

In summary, I thank you for taking the time to seek input from a cross-section of people and organizations interested in commenting on this bill. I commend you for making such sessions available in major centres across Ontario, and I look forward to following the process and reading the legislation that evolves from this process. Thank you.

The Vice-Chair: Thank you for your presentation. That was a 20-minute presentation. Therefore, we've run out of time for questions, but we do thank you for attending here today and we wish you a good afternoon.

Mr Finnie: Thank you.

GE CANADA

The Vice-Chair: Next we have GE Canada. If you come to the table, perhaps you were here to hear my words before: 20 minutes for the presentation; any time remaining is split between the parties. Welcome.

Mr David Brennan: Thank you. My name is David Brennan. I'm the vice president and general counsel for GE Canada. On my left is Dr Millman, the occupational health physician and director of corporate medicine at GE. On my right is Dr Sax from DuPont with the same position. I'd like to thank you all for the opportunity of being able to speak to you on this matter. I think everybody now has a copy of our presentation.

We're here not to speak about the general merits of Bill 8, but rather to just speak to you about part II and the health services accessibility, and how it appears that will impact on companies' provision of occupational health services.

Before we get into the specifics, I would like to just give you a little background so you can have a context of where we're coming from. For a number of years now, there has been a growing body of evidence and research that shows a positive correlation between corporate occupational health services and improved productivity. In other words, the healthier your employees are, the more productive they are. At the risk of sounding insensitive, I guess the best way to look at it is by drawing a comparison to the equipment in a company. Companies find it prudent to invest in annual maintenance services for maintaining equipment. You've got healthy equipment; in the same sense if the employees are healthy, they're going to be productive. So, over the last few years, companies have been investing an awful lot of money—I know Mr Kormos, you may see that as a bit insensitive—

Mr Kormos: You passed the insensitivity test.

Mr Brennan: Did I live down to your expectations?

Mr Kormos: You leapt over it—superman dimensions—but I get the point.

Mr Brennan: That's good.

The Vice-Chair: Continue, you have the floor.

Mr Brennan: Companies have put an awful lot of investment into health care services for the reason that we think it's a good investment.

The concept of accessibility as contemplated by Bill 8 has not been and is not being considered as one of the factors in trying to decide whether to make these kinds of investments in health services. It's not, from our perspective, a relevant consideration. Accordingly, any impact on accessibility is purely coincidental.

Second, as background, to speak to what occupational health services amount to at GE, anyway, we've provided here a list, a number of bullets, showing the different kinds of services that are provided. I don't plan to go into those in any detail, but if you're looking at them and you have questions, we'd be happy to speak to those. The majority are not, as we understand, insurable services, but they do involve some insured services.

One that I would bring your attention to is in the middle, fitness-for-duty assessments. That's a critical area where the occupational health physicians get involved in looking at employees from the perspective of bringing them back to work if they're off on STD, LTD or WSIB claims. Their input, their technical knowledge, is absolutely vital.

As other background, as context, the physicians who are retained by companies are generally retained on an annual basis, on a fixed fee arrangement.

Are there any questions on any of those services?

The Vice-Chair: Perhaps we could have the questions at the end.

Mr Brennan: OK. These services are provided on a universal basis to all employees at the company regardless of the level, be they an administrative assistant, be they the president of the company.

The benefit to GE, as we alluded to a moment ago, is productivity. Healthy workers are more productive workers. GE believes, to date, that it has received a positive return on this investment and would like to—and plans to—continue to make that investment.

Having this service around allows us to ensure compliance with health-related legislation. We have the expertise on staff to ensure that we are complying.

Incidental benefits from these kinds of services are that we believe they complement the public health system without any additional cost to the province.

The third element of background is that GE, like many companies, has a very strong and active integrity policy. Within that integrity policy is a code of conduct and one of the key planks within that code is the requirement to comply with all applicable laws and regulations. Accordingly, if something is not permitted under the law, we cannot partake.

Looking at our specific areas of concern, we've highlighted in here the specific sections out of part II that create concerns for us.

Subsection 9(2) addresses insured services and basically says that a physician cannot provide any insured service without billing that. The only compensation they can receive is from OHIP. Subsection 16(1) addresses non-insured services. It's a bit indirect but it basically says that no person or entity can charge a block or annual fee. Then you have to look at the definition of "block or annual fee." As you can see there, it's a fee regardless of how many services are rendered to a patient that are not insured services. Our concern is, with the physicians who are compensated basically on an annual fee basis, when you look at these two sections as they're written, on the face of them, that runs completely counter to the process that's currently in place.

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As I was saying, when you take 9(2) and 16(1) together, you basically cover virtually all the services that are being covered today by the occupational health service program at GE, I believe at DuPont, and many other companies.

When you look at 15(1), there's an argument that can be made that under that section, there is a prohibitive preference being given to employees by using these services. Then on top of that, as you're aware, the penalty section is very severe.

Our conclusions from looking at this is that the rationale for GE providing these occupational services is focused solely on the achievement of corporate benefits, ie, productivity, not on their impact on accessibility to health services in Ontario. Any impact on accessibility is, we believe, minimal and purely coincidental.

The continued provision of GE's current occupational health services—if this bill is passed the way it is currently written, it will stop us from providing those services, because they'll be contrary to the law. If it is, that will have a number of implications, all of which are negative from our perspective. It will impact productivity, because we believe we are having a positive influence on the health of our employees. It will have a negative impact on employee morale, because we will be removing a benefit that is there today. It will have a negative impact on recruitment, because this is something that is of benefit, these kinds of services to employees.

The other interesting benefit that will come out of it is that GE, which is a global company—this would result in Ontario being the only jurisdiction in the world where GE would not be able to provide its current occupational health services.

In summary, our recommendation is that either the bill itself be amended or that there be regulations added that carve out this concept of occupational health services in the context of them being incidental to the primary purpose of an organization.

The Vice-Chair: Thank you very much. We have about nine minutes remaining, three minutes for each party. We'll have the official opposition.

Mr Klees: Thank you. I appreciate your presentation. If I were in your shoes, I would be recommending that this bill be scrapped, because without changing it fundamentally, you folks—I think there are two physicians sitting at the table—will end up in jail if you do what you're doing.

I think the minister has agreed perhaps to remove the jail sentence, but in the letter that we have from him, the penalties will still range from $10,000 to $25,000 for you folks doing your job. So that's a little bit challenging. Do you take heart in that, the fact that penalties are reduced, the minister's suggesting, perhaps down to $25,000?

Dr John Millman: I've got a big-time concern about that, sir.

Mr Klees: And so you should have. When I look at the list of services that you provide, many of these are actually preventive care initiatives, aren't they?

Dr Millman: It's basically a preventive service that we provide.

Mr Klees: Can you, in your wildest imagination, come up with some reason why the Minister of Health would have come forward with a bill like this that sends the kind of signal that it does to your company?

Dr Millman: I have difficulty accepting why this is being put forth. I think that preventive services are an important element of health care in Ontario today. The Romanow commission made a tremendous thrust as far as preventive health care services, many of the things that we're doing at the work site. We feel that we're doing a good job at that. We feel that we are basically complementing the health services of the public health care system, at no cost to the health care system.

Mr Klees: And at a time when the minister—everyone, really—is concerned about sustainability of health care, to send a signal to a major employer that what you're doing at no cost to the government somehow becomes illegal: How rational is that?

Dr Millman: As you have presented it, it's not rational at all. It's a problem, too. We do a lot of work in prevention and I think we have a healthier workforce as a result of that. The costs to the system are minimal, if anything.

Mr Klees: So we continue to call for really the scrapping of this legislation. When you read through the preamble of the bill, the intention is very good, but once you get beyond the preamble into the context of the actual legislation, there really is no connection to reality whatsoever.

As much as the minister is saying that he'd like to amend it, our sense is that if in fact there were enough amendments that could be tabled in this room to actually do what they say, it would be so far removed from the initial scope of the bill that the House would have to find it out of order.

Mr Kormos: I suppose I'm most interested in hearing the parliamentary assistant explain to you that this isn't what the bill's intended to do, that "This was not our intention," to maybe suggest that it's a matter of "Trust us; no one would ever be prosecuted for doing these things." "Trust us," coming from the government? Please. That reminds me of the world's three greatest lies: "Your cheque is in the mail," "Your money cheerfully refunded," and "I'm from the government; I'm here to help you."

I'll cede my time to Ms Wynne, because I take heed of your carefully prepared presentation.

Ms Wynne: You are a gentleman.

Mr Kormos: I certainly am, and I want to hear Ms Wynne defend her government.

I've just sat in from time to time on these committee hearings, because Shelley Martel's got carriage of this bill. I've not had occasion to see a single participant in these hearings who supports and applauds the bill.

These people are insisting that the whole world's wrong but them. We've had some very carefully researched presentations—fault after defect after fault after defect—and the government members are insisting that somehow all these people are wrong. The Sack Goldblatt Mitchell submission—remember that? I was here day one, and I was chastised by, I think, legislative counsel. He says, "Oh, Mr Kormos, you've got to read the bill in its entirety." Well, I knew that. I read it in its entirety, for Pete's sake, and it still stinks to high heaven.

Ms Wynne, please.

Ms Wynne: Thank you, Mr Kormos. I am actually not going to say the things that Mr Kormos said.

Mr Kormos: Not now.

Ms Wynne: I wasn't going to.

Thank you for coming down and speaking specifically to the part of the bill that you're concerned about. I understand that you would have concerns. What I want to check out with you is whether you understand that—well, you do; I know you do understand this—many of the services that you provide as a good corporate citizen are not insured services. They actually fall outside the bill. So the sections that you were concerned about won't pertain.

Mr Klees: Trust them.

Ms Wynne: No, actually it's not "Trust me."

The other thing I want to say is that I don't know if you've spoken to the officials in the ministry, but if there are questions that remain after this, I hope you'll have a chance to do that. Do you want to speak to that first?

Dr Millman: The one concern I would have is, for instance, flu shots. We developed a flu program at the work site that we feel is a very valuable adjunct to employee health. We bring it to the employees. We get a good result from that. We get a lot of people to participate. That's something that you could get at your own family doctor's office as an insured service.

Ms Wynne: Yes, so there are some—as I look through the list, most of these things are not insured. If there are some that are insured, that may be one of the things that we need to talk about with the officials, OK? But for the most part, the issues that you're raising, the services that you're providing are not insured, so they don't fall within the bill.

Mr Brennan: Can I ask you on that point on block fees, the way that's defined?

Ms Wynne: Yes, I want to speak to block fees. My understanding from your presentation is that the physicians are not charging the patients a block fee at this point. You are providing a service to your employees, right? So as block fees are defined, these are not block fees.

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Mr Brennan: My concern is that while that may be your intent, when you look at the words, we, GE, pay a block fee to a physician, and he is providing services that are not on a per-service basis.

Ms Wynne: In other words, if GE can be defined as the patient, that's your concern.

Mr Brennan: No. I don't think the legislation, the words, says that. It's broader. The way it's drafted right now, the words are broader than that. It just talks about a block fee being paid for services. These are specifically non-insured services.

Ms Wynne: My understanding of the way the bill is drafted is that a block fee would be payment by a patient to the practitioner.

Dr Sol Sax: But it doesn't say that.

Ms Wynne: OK. So that's the clarification you're looking for. All right. Thank you. We'll take that comment back.

Subsection 9(2) basically will be silent on the situation you're dealing with. Section 9 is going to be amended. I mean, there are going to be things that will fall outside this bill, and your situation is one of them.

Dr Sax: But what is the intent on things like flu clinics in the workplace that Dr Millman was just talking about?

Ms Wynne: When it comes to an insured service, that has to be clarified. I don't know, Mr Chair, if we want to get staff to actually answer the question. Would that be helpful?

The Vice-Chair: We have about a minute and a half.

Ms Wynne: Would you like to hear a comment from the staff on that issue at this point? Is there somebody who can do that?

Mr Brennan: Can they talk fast?

Ms Wynne: They can talk fast.

Interjection.

Ms Wynne: You know what? We're asking a technical question here. I'm not asking staff to make a political commitment, nor should anyone in the room.

Mr Klees: That's your job.

Ms Wynne: Exactly.

The Vice-Chair: OK. Ms Wynne has asked a question.

Ms Wynne: Can we just have a clarification on that? The flu shot issue, for example.

Mr Thomas O'Shaughnessy: Thomas O'Shaughnessy, senior policy adviser on the bill. What was the specific question?

Ms Wynne: The issue was around flu shots, so the example of an insured service.

Mr O'Shaughnessy: If a physician employed by an institution such as GE or another corporate entity provided an insured service such as a flu shot, there would be an expectation that the physician would bill the plan for that service.

Mr Klees: Is that the answer you wanted?

Dr Millman: No, that is not. It certainly isn't.

Interjections.

Ms Wynne: Excuse me. This is obviously an area where we are going to have to have further conversation. It is not something that has been talked about with the ministry officials. The fact is that we're coming out on this bill after first reading; there's a lot of time to make changes. So I encourage you to continue that conversation, and we'll take your presentation back.

Dr Millman: May I just comment briefly?

The Vice-Chair: Very briefly: 15 seconds.

Dr Millman: In the broadest sense of this whole bill, wellness covers things like flu shots. You can go to your doctor and get advice about diabetes prevention and all that. A lot of the wellness activities we do fall under that same realm of services, and we would have to bill the plan for that. We do not feel that's appropriate.

The Vice-Chair: Thank you. I would like to thank GE Canada for the presentation. We appreciate your coming to the deputations. Have a good afternoon.

Mr Klees: Chair, we should just thank the civil servant for his very specific response, which wasn't what the presenters wanted to hear, but at least it was the truth.

Ms Wynne: Which is what we trade in.

SECTION OF INDEPENDENT PHYSICIANS OF THE ONTARIO MEDICAL ASSOCIATION

The Vice-Chair: Next we have the Section of Independent Physicians of the Ontario Medical Association. If you would come to the table, there's water there. You have 20 minutes for your presentation. I went through the rules. Also, could you identify yourselves for Hansard, please.

Dr Julio Szmuilowicz: I am Dr Julio Szmuilowicz. I am the chairman of the Section of Independent Physicians of the Ontario Medical Association, and to my right is sitting Dr Eugene Mandryk, who is a past chair of the section.

Thank you, members of the committee, for the opportunity to present to your committee. It is a privilege to be permitted to speak with you about our concerns in regard to Bill 8.

We represent about 400 doctors who choose to belong to the section because they believe in independent practice. About 120 of us are opted out of OHIP. That is, we bill the plan for insured services at the prescribed rates no different than those for our opted-in colleagues. The difference is that the payments for these services go directly to our patients, who then pay us. In other words, we work for and are paid by our patients, who get reimbursed by the government of Ontario at the same

rates as other physicians who receive payment for services rendered deposited into their bank accounts.

I want to make sure that you all understand what this means. We get paid neither more nor earlier than our colleagues. We submit claims on behalf of our patients and bill them. They then receive a cheque and pay us. Since we wait for patients to get their cheques, we often receive payments later than our colleagues. We collect from our patients directly only after they are sent the cheques covering the services provided the month earlier.

On occasion, we wait many months to collect since patients move without letting OHIP know about their new addresses, which means cheques get sent to their last known residences. Only patients are permitted by law to notify OHIP directly and request a change of address, which can only be done reliably in person or by attending a government kiosk. Mail is sometimes unreliable and OHIP's change of address forms are sometimes—not always—not acted upon.

Rarely, patients who see us fail to remit their payment even though they are in possession of their cheques. As a result either of an erroneous address in the OHIP computer or a wilful withholding or non-payment of our bills, our accounts receivable are higher than those of our colleagues who are paid directly by OHIP. We write off considerably more unpaid balances than our opted-in colleagues, sometimes as much as a few hundred dollars every year.

So, members of the committee, you may wonder what leads us to remain opted out when it is clear that there are no advantages and clearly several disadvantages in doing so. Why is it that I, the chairman of the section representing those hard-working independent doctors, am here to draw your attention to the fact that Bill 8 would outlaw opting out? Why, if there are more disadvantages than advantages, are we complaining and wish for you to recommend that this part of the bill be revised?

The answer is simple. We are opted out and suffer from late payments, higher receivables and more frequent write-offs because we believe in working for the patients directly. We believe that by being independent, we offer our patients a doctor-patient relationship that is unencumbered by the presence of a third party who pays us without notifying patients how much we earn, when or how we bill and for what activities. We consider our patients our employers who pay us for services they know they received and are aware of the actual charges claimed on their behalf. We take pride in being independent of and yet accountable to both government and our patients. We feel employed directly by our patients.

Adding accountability to the five well-known pillars that underpin the edifice of medicare, as the bill suggests, is a responsible avenue. We support the concept of accountability and transparency since this is also our money that is being spent. Mr and Mrs Ontarian are entitled to know how much we spend, how effectively we are serving their needs and what, if anything, we must do if there are problems with waiting lists, physicians' remuneration and hospitals' efficiency.

However, we independent physicians have been practising accountability before the Romanow report was contemplated or written. We are accountable to our patients because they pay us after getting reimbursed by OHIP. They receive the cheques with which they pay us and read the stub describing each service, the date on which it took place and the amount paid for their medical care. Only our patients know how much their care costs the people of Ontario. I dare say that most patients attending an opted-in physician have no clue as to how much their doctor received on their behalf for the services they provided. We cannot bill for a service we didn't provide; our patients would quickly hold us accountable for any such actions. We cannot bill for a service different than the one we provided because the cheque stubs detail the service in question. We cannot bill for a date of service that is wrong because patients know when they attended our offices. OHIP deposits not even one cent into our accounts; it issues cheques only to patients or, as they are now called, subscribers. Opted-out physicians' claims are classified in the OHIP computers as "pay subscriber" claims. And, ladies and gentlemen, we like it that way. It is a source of self-respect to us that we are independent. We work for and are paid only by our patients. We are prepared to accept the disadvantages attending our freedoms, even with the disadvantages of higher receivables and occasional write-offs.

I am here today because the Ministry of Health has not provided us with a clear explanation as to why they need to ban opting out. One ministry official asserted that it is policy—every physician should be in the plan; no one should be allowed out. This, notwithstanding the fact that the Canada Health Act, on which this bill is based, explicitly allows physicians to be opted out should they so choose, as long as they do not ask for, bill or receive for an insured service an amount greater than that prescribed by law.

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The Canada Health Act explicitly permits us to choose to bill on behalf of patients so that they collect from their provincial insurance plan. Every province, bar none, allows doctors to opt out. In some provinces, such as Quebec, opting out means something different. Quebec physicians who opt out are allowed to charge their patients whatever they and the patients agree upon, even if this is more than the sums paid by the Régie, but their patients receive no reimbursement from the province.

Should the bill be enacted as it now reads, ladies and gentlemen, Ontario will be the only province in Canada that does not offer physicians, and patients by implication, a choice. With respect, we cannot understand the reasons for this conscription. It is true that there are very few of us who are opted out. According to the ministry, there are about 76 physicians. According to our calculations, there are probably about 120, or a few more. This represents less than one half of 1% of all physicians in the province of Ontario licensed by the College of Physicians and Surgeons of Ontario. Many are psychiatrists, like myself. Some are family doctors, and a few are

gynecologists, ophthalmologists, ENT specialists or plastic surgeons.

Is the cost of sending cheques to patients a factor? I have been told that the cheques are generated by a computer so that the only extra cost is postage. However, members of the committee, for 49 cents a month you have several hundred patients who are accounted to in an immediate and direct manner. This is the very aim of Bill C-8, as I understand it.

I am told that the medical review committee seldom reviews opted-out physicians, or at least does so less often than with opted-in doctors. Doubtless, they are aware there cannot be any cheating, as patients receive payment and then pay their physicians after reviewing the stub attached to the cheque. Isn't this the very accountability sought by the government?

It is possible the ministry believes that there are problems in accessibility to the few specialties that have the highest number of opted-out physicians. How is this the case? We cannot, and do not, bill any more for insured services than the amount permitted. Even if we did, the OHIP computer pays only the amount that is programmed and allowed. We generally wait for patients to receive the cheque before collecting. We do not demand any upfront fees that could be construed as a barrier to accessibility.

I consulted the CPSO, the college, and could not find a complaint against an opted-out physician because a physician demanded payment from a patient before they were reimbursed. Not one case, ladies and gentlemen, not one.

It is possible that the proposed ban originates from the perception that opted-out physicians are more likely to charge block fees for services OHIP does not cover. You probably know that this is not the case. Perception is in this case not the reality. Many opted-in family doctors charge block fees. I might add that this bill recognizes that physicians can, and do, properly offer services that are not insured by OHIP, and does not proscribe fees for such services.

Can you imagine banning the provision of circumcision, or cosmetic surgery, or hair removal, which was delisted by the NDP government a few years ago? They are services not considered medically necessary and/or services that the province has decided should not be covered. However, patients still seek such services, and physicians, those who are opted in as well as those who are opted out, can and do offer them. They fall within the purview of "voluntary" and are paid on a negotiated, contractual basis between physicians and patients. While such services are not paid for by OHIP, the CPSO regulates the provision of such services by all physicians, both those who are opted in and those who are opted out. Banning opting out will not reduce the number of cosmetic surgical procedures, circumcisions or any other delisted treatments, because even opted-in physicians can, and do, offer them.

In conclusion, I would like to draw your attention to the section of the proposed bill that bans opting out in the province of Ontario. We opted-out physicians choose to do so despite a number of financial disadvantages, but value working directly with and for our patients. We practise accountability more directly than our opted-in colleagues and pose no barrier to accessibility. Our practices are transparent and every one of our patients knows how much their medical care costs. For the price of one postage stamp, our patients know exactly what, when and for what we bill the plan. Our record at the CPSO is unblemished; there are no complaints directly attributable to our practising independently. We are no more likely to charge for services that are non-insured than any other physicians, regardless of any perception to the contrary. We are happy and pleased to be working that way. From a legal point of view, the Canada Health Act mandates our freedom to choose to be opted in or out of our provincial health plans.

I respectfully remind you today of the oft-repeated but, in politics, seldom practised maxim: If it ain't broke, don't fix it. Thank you for your consideration.

The Vice-Chair: We have nine minutes remaining, so I'll split that: three minutes.

Mr Kormos: Thank you, Doctor. I'm quite frankly more interested in listening to Ms Wynne spar with you. The group of independent physicians—400 of them and only 120 are opted out. What qualifies one to belong to the group of independent physicians?

Dr Szmuilowicz: Belonging to our section is voluntary, Mr Kormos. The reason for the discrepancy in the number is that many of them who feel they work independently work in hospitals, so they are not opted out. The majority of the people who are opted out work outside a hospital in an office and have traditionally been opted out since they started their practice.

Mr Kormos: Forgive me, I've never met an opted-out physician before.

Dr Szmuilowicz: You've met us.

Mr Kormos: Now I know two of you. Why? Why would you do that when you put your patients through the inconvenience of having to get the cheque and remit it to you? You get some shrinkage in revenues, I suppose, because those cheques disappear or the patient moves out of town. So you've got accounts receivable that opted-in physicians probably don't have. So why would you become an opted-out physician? I don't want to be unfair, but why?

Dr Szmuilowicz: As I said in our presentation, because we feel that we work more directly with our patients. They are our employers, not the government.

Mr Kormos: OK, in terms of an answer I suppose that's fair enough.

Dr Eugene Mandryk: It's a choice.

Mr Kormos: Yes. As you say, the maxim is, "If it ain't broke, don't fix it." Another maxim is, "There's an easy way to do it and a hard way to do it." But then again, who am I to talk about doing it the hard way? Ms Wynne, please, answer these gentlemen's questions.

Ms Wynne: Actually, Mr Duguid has got a question.

Mr Duguid: I'm going to take another crack at Mr Kormos's question, because I've been trying to figure

this out myself from the beginning. Is it strictly a philosophical view that the current system is not appropriate, that you want to opt out of the current system? Could you explain that?

Dr Szmuilowicz: With respect, I've been opted out since I started practicing in 1978; it's not a new decision. I've always practised as an opted-out.

Mr Duguid: I recognize that.

Dr Szmuilowicz: You're asking the same question and I'll give you the same answer: because I like it that way. I feel that I work for my patients more directly because my patients pay me.

Mr Duguid: I'll accept that answer. I'm just wondering, is your patient in any way benefited from this system? I don't see the benefit to the patient at all and I don't see the benefit to you, frankly, other than the fact that you like it that way.

Dr Szmuilowicz: There is no benefit to me, because there are higher receivables and it's more difficult to practise that way. Is there a benefit for my patient? I would say yes, because my feeling about the way in which I work with them is different. I work for them; I don't feel that I work for OHIP.

Mr Duguid: OK. Mr Delaney, did you want to follow up?

Mr Delaney: Yes. You say 120 physicians have opted out; the Ministry of Health says 60. Let's take your number. One half of 1%, then, have opted out. Why aren't there more?

Dr Szmuilowicz: Before 1986 there were 12% of all physicians who were opted out. Over the years people have felt tired, tired of having to maintain more records, tired of having to chase money, tired of whatever way. They still feel independent, but they've decided to opt in.

Mr Delaney: Among the members you keep in touch with, what percentage of their gross billing is bad debt?

Dr Szmuilowicz: I wouldn't be able to tell you. I can only tell you in my case it amounts to about $1,000 a year, perhaps a little bit over.

Ms Wynne: Do any of the opted-out physicians charge their patients up front? Does that ever happen? There's nothing to prohibit that, right?

Dr Szmuilowicz: At the time of Bill 94, the Health Care Accessibility Act, there was a provision passed that we could not actually ask for the money before the patients received the cheque. I think most people abide by that. I can't tell you that nobody does that, but I can tell you I don't know anybody who does that.

Ms Wynne: That's one of our concerns. Having grown up in the household of an opted-out doctor at one point, I understand the philosophy, but that's the kind of thing we're trying to avoid, the up-front charge. That actually does affect accessibility.

Dr Szmuilowicz: With respect, I don't know of anybody—I've never seen a patient who comes to me saying, "I don't want to see you because you're opted out." Nor have I seen patients of other opted-out physicians who come to see me because I work in a different way. If that were the case, I would have liked the ministry to actually have come to us and said, "This is a problem. Can we resolve it in a different way?"

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Mrs Witmer: Thank you very much for your presentation. I respect the fact that you feel so strongly about the method of billing that you're presently using, but I'm not sure that you're going to win the battle that you're currently waging, if I listen to Ms Wynne. I think the government has made a decision and I think part of it is based on more centralized control, making sure that doctors work differently—less independently, I guess, than before. What will the impact be on your group? You've got a group of 400; you say you've got 120 who are opted out. If the government is unwilling to make an allowance for you, what will happen to the members of your group? Will they continue to practise? What's the age group of your membership?

Dr Szmuilowicz: Thank you, Mrs Witmer. It's a very important question. I would say that the average age is about 60 or a little bit older, because we have been in practice for much longer than the younger graduates. There may be an unintended result from this bill and that is that maybe a few of them will retire. If they retire, instead of getting more accessibility, you are actually going to get less accessibility because there will be fewer doctors. But it's only a guess. I'm not here to scaremonger. I have no idea what will happen. But that is one of the possibilities.

Mrs Witmer: That's why I asked about the age. I guess that's what we've heard from other physicians as well, that this bill, instead of increasing accessibility to physicians, actually, because of the draconian measures that are suggested, it could have the reverse impact and could cause doctors to not stay in the province. Young doctors won't want to be so hamstrung by the government. So there's a real fear that the whole issue of accessibility could be severely impacted.

Dr Szmuilowicz: Yes.

The Vice-Chair: Thank you very much for your presentation.

Mr Kormos: Chair, if I may, on a point to legislative research: This is the most interesting presentation we've just heard. In view of the fact that we can't question these people any more, I'm hoping that legislative research would perhaps obtain some answers for us: (1) the number of opted-out doctors; (2) the point at which they opted out, with a view to discovering whether opted-out doctors is an historical phenomenon such that they are going to—not disappear, but they're going to naturally—

Mrs Witmer: Attrition.

Mr Kormos: —attrition will take care of it; and (3) what problems have been encountered with opted-out doctors that this legislation purports to fix, specifically what Ms Wynne spoke to, the prospect of compelling a patient to pay before that patient receives the OHIP coverage.

I understand the Liberals' discomfort with these people because these are people of principle. Sure, I agree with them, but they are—

The Vice-Chair: We thank them for their presentation this afternoon.

ONTARIO DENTAL HYGIENISTS' ASSOCIATION

The Vice-Chair: We do have a cancellation. The Toronto and York Region Labour Council has cancelled. Bridgepoint Health I don't think has arrived yet. But the Ontario Dental Hygienists' Association is here, so we will have the deputation from the Ontario Dental Hygienists' Association.

Ms Michele Carrick: Good afternoon. My name is Michele Carrick and I'm here today representing the Ontario Dental Hygienists' Association, known as the ODHA. I am a practising dental hygienist in Owen Sound and I currently serve as vice-president of the association. I am also the incoming president.

This is my first time speaking to a committee in this format. Most dental hygienists are accustomed to speaking with a client when they're in a horizontal position, so please bear with me.

The Ontario Dental Hygienists' Association represents approximately 6,000 dental hygienists across Ontario, accounting for about 85% of the total number of dental hygienists registered to practise in the province today, making us one of the largest health professional associations in the province.

Dental hygienists do more than just remove plaque and floss teeth. We contribute in large part to our patients' overall health through the prevention of oral disease and the promotion of oral health care. Dental hygienists provide a process of care that involves assessing the oral condition, planning the treatment, implementing the plan and evaluating the results.

On behalf of our entire membership, we are pleased to be here today to provide our comments regarding Bill 8, the Commitment to the Future of Medicare Act, 2003. As a whole, the ODHA supports in principle the intent behind Bill 8. In fact there are sections of the bill that we wholeheartedly support. There are other sections, however, that we have serious concerns over and urge you to amend.

We understand that the Minister of Health and Long-Term Care has indicated that he will be submitting to you a number of amendments that may or may not address many of our concerns that I will present to you today. We are encouraged by that announcement and welcome the opportunity to review those amendments when they became available. Until then, our association still feels it's important to take the opportunity to present our opinion and recommendations with respect to the bill.

The Minister of Health and Long-Term Care summarized the intent of this bill in a news release after it was tabled in the Legislature. Bill 8 was tabled to ensure that every member of our society "has an equal right to quality health care based on need, not income." We could not agree more and we fully support that intent.

Whether it is a CT scan, laboratory work or dental hygiene services, the ODHA believes that every citizen in the province should have access to timely, quality and efficient health care. We believe in a health care system that is accountable and transparent. We also believe in the creation of a quality council to monitor and provide assessments to the people of Ontario.

The ODHA welcomes the provisions made in Bill 8 with respect to the establishment of the Ontario Health Quality Council. By working collaboratively with the National Health Council, the people of Ontario will know exactly where health care funding is being spent and what improvements need to be made to the system in terms of access. The council would also track long-term health goals set by the government and ensure that such goals are being met.

Whether directly, by having one of our members on the council itself, or indirectly, by offering any assistance our association can provide, the ODHA will do what we can to ensure that the council is a success and that it provides the most useful information necessary to improve Ontario's health care system.

On the other hand, the Ontario Dental Hygienists' Association has some serious concerns with Bill 8. They are concerns that I am sure you have already heard before, whether outlined by previous groups presenting to you or through a number of media releases from various organizations across the province regarding Bill 8.

The first concern we have is with respect to privacy and the protection of personal health information. A few weeks ago, the ODHA had the opportunity to participate in committee hearings regarding Bill 31, the Personal Health Information Protection Act, 2003. We indicated at that time that Bill 8 would set up another stream for access to and disclosure of health information, as stated in section 13 of the bill. In fact, as currently written, section 15 of Bill 8 would prevail over Bill 31 and would allow personal information to be disclosed without consent in certain situations.

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The ODHA suggests that the issue of protecting personal health information should be a very high priority for the government. For this reason, every attempt should be made to define how personal health information can be collected, used and disclosed under one piece of legislation. Simply put, to avoid confusion and to reduce costs of implementation and enforcement, the ODHA believes that there must be a single regime for the protection of personal health information in Ontario, and that regime should be the Health Information Protection Act, 2003. Accordingly, Bill 8 should be made consistent with and subject to the provisions of Bill 31.

As I mentioned earlier, the ODHA supports and strives for an accountable health care system. Through part III, Bill 8 attempts to tackle the issue of accountability; however, it goes way overboard. Herein lies the major concern of this association and elicits our strongest opposition.

Part III of Bill 8 allows the minister to direct an individual, organization or entity to enter into an accountability agreement or to make compliance directives. When such an accountability agreement is entered into or a compliance directive is issued to an individual in his or her executive capacity or to an organization, the bill allows the minister to terminate or vary said agreement unilaterally and at any time.

The bill goes on to say that an accountability agreement or directive entered into with one person applies automatically to that person's successor, even if the successor has no knowledge of this agreement or directive or was involved in its negotiation.

Further, in sections 27 and 28, the bill allows that any changes in a person's employment terms that result from an order by the minister are deemed to have been mutually agreed upon between the person and his or her 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 laws, collective agreements or in his or her personal contract or agreement of employment.

Needless to say, part III of Bill 8 gives the minister extraordinary powers to direct an organization to fire, demote or otherwise sanction any person within the organization without any right of recourse. Bill 8 gives the minister the sole right to determine the contents of accountability agreements and to enforce compliance. In one fell swoop, part III of Bill 8 sweeps aside the Employment Standards Act and labour law in general, as well as any collective agreements and individual employment agreements.

From the provisions outlined in part III of Bill 8, the laudable desire to create an accountable and transparent health care system in the province has been nullified. The ODHA believes that if this bill is passed without further revisions, it will create an unworkable and even hostile relationship between the government and health service providers.

We appreciate the opportunity to speak to you today. We are grateful that the government is willing to listen and work together with stakeholders and service providers, seeking input and advice before submitting the bill for second reading.

That concludes our comments for today. We would be happy to take any questions that you may have.

The Vice-Chair: We do have 12 minutes remaining, so four minutes, the government side.

Ms Wynne: Thank you for coming today, and thanks for your comments. You're right; some of your comments we have heard before. I'm hoping you'll have a chance to take a copy of the framework of the amendments that are going to be introduced, because a number of the issues you've identified are going to be addressed. Section 13 is going to be amended to remove the sweeping power of the minister to directly collect, use and disclose personal information. But on that information issue, Bill 31 will prevail except in specific circumstances around collecting information for queue-jumping. So Bill 31 is the framework and Bill 8 will only prevail in certain very specific circumstances.

On the issue of the accountability agreements, I wanted to make sure you know that in the amendments that are coming forward, it's going to be very clear that there's going to be an exclusion of trade unions and collective agreements. This bill is not designed to reach into collective agreements. That's not the point. So that's going to be articulated. The accountability agreement is going to be between the board or the provider and the minister and not the front-line employee.

Having said that, I'm just wondering—it sounds like you generally agree with the direction that we're going here, so can you talk just a little bit about the things that you think should be in an accountability agreement, appropriately and mutually designed? What are the things that you think we should be tracking? I guess that goes to the issue of the health quality council as well. What are the things you think we should be looking at?

Ms Carrick: As you know, most dental hygienists are in private practice. So most of our accountability is governed under our college, because we have our own standards of practice and codes of ethics. We do have dental hygienists who work in public health, so they would be more accountable under Bill 31. Basically, we want the government to understand our position so we can inform our members so that they understand where they have to go and whom they have to be accountable to.

Ms Wynne: We're not talking about monitoring you, but in terms of the health system—because you're part of the health system—you think accountability is a good idea. You think accountability agreements are a good idea. Do you think that there are general areas that the government should be tracking, for example, to increase accountability?

Ms Carrick: I'll get back to you on that one.

Ms Wynne: Don't worry about it. It's OK. That's why we're putting the health quality council in place. It's to set some directions and then to report on them to the public so that people have an idea how the public health system is doing and where we're going.

Mr Klees: Thank you very much for your presentation. We share your concern. You hear Ms Wynne tell you that you're not to worry about a thing, that the framework that the minister has given regarding amendments that he's prepared to make will really look after your concerns.

Life is not that good here in Ontario. I just want you to be aware you have every reason to continue to be very, very cautious and concerned, actually. The truth of the matter is that the document Ms Wynne will give you does not in any way give you comfort. It does not in any way take away the threat of section 27, where—in fact you refer to it in your presentation: the wording where it gives the minister the authority to make changes to agreements with employees. It is yet to be determined just exactly who is going to be lumped into that group.

Ms Wynne: On a point of order, Mr Chair: When something that is being said is absolutely not true, it just seems to me that—

Mr Klees: Mr Chair—

Ms Wynne: I withdraw the "not true" piece.

Mr Klees: She's encroaching on my time.

Ms Wynne: I just want to read into the record the language of the amendment—

The Vice-Chair: This is Mr Klees's time. Thank you.

Mr Klees: I do trust, Chair, you'll give me credit for that time.

The Vice-Chair: Yes, I will.

Mr Klees: I will, to be truthful, read into the record here what the bill says. You refer to it as well.

"Where change in terms of employment:"—I'm quoting from the bill—"the change shall be deemed to have been mutually agreed upon between the person and his or her employer."

If we played word association here and you heard these words being referred to about some other part of the world, what part of the world would come into your mind when you hear this kind of terminology where a minister, a person in a position of authority, comes forward and says, "By the way, we're going to change your contract, and by the way, we're going to pretend that you've actually agreed to it, and by the way, we're also going to take away any right for you to have any recourse"? What part of the world comes to your mind?

Ms Carrick: A very dictatorship type of—

Mr Klees: That's what this bill is really all about. It's taking control of the entire health care system, taking it away from community groups, from boards of hospitals, from associations, and putting it into one person's hand, that being the Minister of Health. You have reason to be concerned. We have reason to be concerned. Ms Wynne goes into her flamboyant way of suggesting the minister will look after everything. One more promise to the people of Ontario, after many that are broken, a trail of broken promises. I suggest this is just one more. We have reason to be concerned.

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Mr Kormos: What's the status of dental hygienists with this government in terms of their search for a capacity to perform procedures independent of dentists?

Ms Carrick: We are still working with the government and we are hoping that some time in the future dental hygiene will be able to work independently.

Mr Kormos: Have you had any specific meetings since the election in October with the new minister or ministry?

Ms Carrick: I believe we've had one meeting with the minister or the minister's staff.

Mr Kormos: But not with the minister?

Ms Carrick: I'm not 100% sure whether it was with the minister or just with the minister's staff.

Mr Kormos: Fair enough, because you may not have been there yourself.

Ms Carrick: No.

Mr Kormos: Is the ministry responsive to the goals and objectives of dental hygienists?

Ms Carrick: They have said they are supportive, but they haven't brought anything forward into the legislation yet.

Mr Kormos: Supportive is good, though. What's your impression as to what the government is prepared to bring forward in terms of recognizing the role that dental hygienists can play as professionals?

Ms Carrick: My personal opinion is that we're hoping the government will come forward and remove the order from the Dental Hygiene Act so that dental hygienists can work independently if they so choose, ie, going into long-term-care facilities, working in remote areas and with the underserviced financially poor; working with all those segments of the population to give health care.

Mr Kormos: Have you been told of any time frames that the government expects to work within?

Ms Carrick: No, we have not.

Mr Kormos: What do you want from this government in terms of time frames?

Ms Carrick: We would like sooner rather than later. We will continue to work as long as we have to with the government and hope they will make this change in the Dental Hygiene Act, like they have said they would possibly do if they were elected.

Mr Kormos: Do you think that if dental services were covered under OHIP like other medical services that the government would move more quickly or that even previous governments would have moved more quickly?

Ms Carrick: I'm not sure if they would have or not, because as it stands right now dentistry codes are not under it.

Mr Kormos: Exactly.

Ms Carrick: I'm not sure if they have or not.

Mr Kormos: The reason I'm suggesting that is because if it were an OHIP service, the government would have an interest in ensuring more economical provision of that service, right?

Ms Carrick: Correct.

Mr Kormos: It may well motivate them to respond to the request of dental hygienists in a way that they're not motivated right now.

Ms Carrick: That is correct.

Mr Kormos: What about the private insurance sector? Surely they have an interest.

Ms Carrick: They do.

Mr Kormos: Where do they stand with respect to the dental hygienists' position. Our insurer is Great-West Life, which is probably one of the big workplace insurers that covers dental work. Shouldn't Great-West Life be interested in getting less expensive dental care by utilizing dental hygienists?

Ms Carrick: We have submitted to the insurance companies, and our association has been working quite a few years with the insurance companies trying to work out an agreement. We're still in the middle of working with that.

Mr Kormos: Where have the insurance companies been with respect to lobbying governments to respect dental hygienists and promote them to the stature they deserve?

Ms Carrick: I'm not sure. I cannot answer that question but I can certainly inquire and get back to you.

Mr Kormos: I'd appreciate that, because I'm not aware of those insurance companies, like Great-West Life, even though they cry all the way to the bank with our premiums—as you know, the insurance industry is just replete with scams and highway robbery syndrome. I'm not aware of them ever rising to the occasion and coming to the plate for dental hygienists and it would seem to be in their interest to do so. Thanks for coming today. I appreciate it.

The Vice-Chair: Thank you very much. We appreciate your coming down. Have a good afternoon.

BRIDGEPOINT HEALTH

The Vice-Chair: Next we have Bridgepoint Health, if you'd like to come up to the table. You have 20 minutes to use in whichever way you'd like. Any time remaining after your presentation will be split between the three parties.

Mr Robert Carman: I know I'm not on the mic, but just to let you know there is a document that we are circulating. I will not speak to everything that's in the document. I will hit some of the highlights and you will see some sections that I will not cover at all.

Chair, I'm here today as the vice-chair of the board of Bridgepoint Health, which is the only integrated network of hospital, community and research facilities in Canada dedicated entirely to medical care and rehabilitation. I'm also here as a member of the public.

We appreciate that Minister Smitherman did indicate in his remarks to the committee that he's prepared to table amendments, and in fact we've seen some of the amendments that have been tabled—they've been circulated by the Ontario Hospital Association—and we very much look forward to continuing this dialogue once we've reviewed those amendments—not just the ones that are presently here, but all the rest of them that we anticipate are going to be coming forward.

Notwithstanding our support of the government's attention to the principles of universal public health care, Bridgepoint Health has significant concerns with, and therefore cannot support, the current draft of Bill 8.

We have four overarching concerns and I just want to give you a quick highlight of those.

First is the shift away from health care as partnership with providers. I would like to say the partnership approach evidenced in the voluntary governance of hospitals has led to significant capacity for community participation in, and support for, hospitals.

Hospital boards provide significant stewardship and leadership for what has been characterized as one of the most complex businesses in the world. Not only do they do that competently, but because they do, whole communities support their hospitals in ways that would not otherwise happen. Local government provides the impetus for the community's support of hospitals in fundraising and other volunteer roles.

Hospital boards and hospital foundations contribute billions of dollars to research, capital and other initiatives that improve the health of Ontarians. The bill does not appear to recognize that.

The provisions of Bill 8 create a system focused on demands by the funder—government—of the providers, without opportunity for dialogue or collaboration. We question whether any system designed for the public good could operate effectively and in a sustainable way when the balance of power is shifted so significantly in one direction.

It has created a feeling of lack of value for voluntary governance and raises serious questions about its continued role and function, especially in relation to the accountability segments of the bill.

Having said all this, I listened to the minister at lunch today and, as Ms Wynne said, he spoke in very glowing terms about collaboration. What I find difficult to understand is why on the one hand he would be so committed to those principles and on the other hand the bill would not reflect those principles in its initial drafting.

My second point is the lack of synchronization with existing accountability initiatives and mechanisms. Over the last several years, health providers, often in partnership with the Ministry of Health of Long-Term Care, have established a number of mechanisms that augment accountability and transparency in the provision of health services. The paper gives three examples—I'm not going to go into them, but I'm sure most of you know them well—the Canadian Council on Health Services Accreditation; the hospital report card, which is a real milestone in co-operation among players in developing a transparent performance report; and performance contracts for multi-year funding with the joint policy and planning committee.

Our third point was privacy, and in the interest of time, I am going to leave that one; you already dealt with it in the prior submission. I'm also going to leave the fourth point, punitive approach and penalties, because it really refers specifically to the accountability provision, which I want to discuss in greater detail later.

1550

In terms of the Ontario Health Quality Council, in spite of its intuitive appeal, we have a number of reservations around which we would urge further consideration. The first is membership. I know that other hospitals have already covered this, and I'm not going to go into it in detail but just remind you that there is that concern.

In terms of mandate and authority, Bill 8 limits the council's authority to monitoring the system and reporting, with the ability to make recommendations to the minister only in the context of future areas of reporting. That seems strange to us. It seems as if the council only has half a job. Why can't it make recommendations to the minister in terms of what it has learned?

Third, on clarity of metrics, while the Ontario Health Quality Council is welcome, it will only be effective if it has clear accountability for ensuring that it meets the government's objective, which is ensuring that Ontario upholds its commitment to the principles of the Canada Health Act. This can only be accomplished in the context of clearly articulated targets and benchmarks that the government is willing to commit itself to, in areas such as funding, wait times, access to services, number of health professions and services per population segment and population health.

Our fourth point on the council is the relationship to other bodies. The council risks overlap of responsibility and the risk of duplication of efforts with other initiatives and bodies already in place. I've already mentioned some of these.

I'd like to move on to the accountability section, which is the area we have the most significant concerns with. I want to say at the outset that Bridgepoint Health understands the intent of the accountability section of the bill, and we're fully supportive of the principles of accountability.

I should tell you that in my 30-year career with the Ontario government, I was responsible, after the committee on government productivity, for implementing accountability in the public service. So it would be entirely inconsistent with what I did with the Ontario public service if I said anything other than that I was totally committed to accountability. I worked my entire career on it and ended it, as secretary of the cabinet, with performance agreements with all the deputies. So I'm fully committed to accountability; I think it's absolutely fundamental. However, as currently drafted, we believe the bill is seriously flawed and inconsistent with the principles of good governance.

First of all, in terms of the mismatch of accountability and organizational control, Bill 8 places significant emphasis on the accountability of health resource providers in areas that are often outside their control. The definitions of the scope of the accountability agreement in section 19 are very broad and can include one or more of performance goals and objectives respecting roles and responsibilities; service quality; related health human resources; shared and collective responsibilities for health system outcomes; consumer and population health status; value for money; consistency; and other prescribed matters. A number of these elements are partly or significantly outside the control of an individual health care provider, notably consumer and population health status and accessibility. Bill 8 provides no requirement for corresponding commitments by the government to provide the resources to address these various elements of accountability.

Second, the principle of negotiated agreements: Given that accountability agreements are a cornerstone of the accountability provision of this bill, they warrant special attention. Bill 8 extensively references the notion of contracts. However, contrary to the very nature of contracts and contract law, Bill 8 envisions contracts that are unilateral prescriptions from the government to the health provider. No agreement can be valid unless it's entered into freely, and this is not contemplated here. Few leaders—volunteer trustees or senior executives—would be attracted to a leadership relationship that is so unilateral.

Third, duplication of the Public Hospitals Act: As noted in the previous section, we're concerned that a number of the proposed mechanisms may duplicate or contradict other accountability mechanisms that are already in place, most notably the Public Hospitals Act. We believe this act already provides for appropriate accountability mechanisms and sufficient authority for the minister to act in the case of non-compliance. However, it also requires the minister to always act "in the public interest," and the omission of this in Bill 8 is not acceptable.

Fourth, accountability and good governance: The notion of dual accountability of the CEO, and potentially of other senior executives, runs contrary to any reasonable standard of good governance and essentially makes voluntary governance redundant. More significantly, the burden of these one-sided contracts and the punitive nature of the provisions will substantially reduce leadership's capacity to focus on the day-to-day operational demands of running a health care system. We think that providing absolutely first-class health care is our first responsibility, and we see that these onerous requirements could interfere with that. We seem to be headed toward our own Sarbanes-Oxley, and I don't need to tell you what that has done to companies in the United States.

Finally, in the area of compensation and job security, the language of Bill 8 presumes to supersede any employment contract an executive might enter into with a health care organization. The provision neutralizes the ability of any health care organization to meaningfully negotiate an employment contract and significantly reduces the attractiveness for leaders in entering health care relationships at all.

Fifth, compliance directives and penalties: Bill 8 should also be amended to require that any compliance directive issued by the minister must also be in the public interest, as is required when a supervisor is appointed or when directions are issued under the Public Hospitals Act. We believe that the penalty provisions of the bill are inconsistent with the principles embodied in the Public Hospitals Act that volunteer board members should not be held liable or be subject to actions if they are acting in good faith. The bill should be amended accordingly.

We would urge the government to allow the development of health care funding and performance agreements and the requisite monitoring tools to continue in a collaborative manner under the auspices of the joint policy and planning committee. It's already underway; we believe it ought to be continued under the JPPC. We would also suggest that to the extent there is need to further formalize this accountability, this occur through regulations and not through Bill 8.

In conclusion, the intent of Bill 8 is admirable; however, we believe its methods are flawed. It seems to us

that choices we make today will also decide the future of voluntary governance and health care in Ontario. Bridgepoint Health is committed to achieving the highest standards of excellence in serving individuals living with complex illness and disability. We are proud of the progress we've made in raising the bar on our performance and the evidence that we can now produce on improved outcomes, improved staff satisfaction, improved patient and family satisfaction and a strong balance sheet. We embrace the government's commitment to building a health care system that is accountable, transparent and able to meet the needs of Ontario residents. However, we believe it must be built as a partnership of providers and government. We look forward to being an active partner with the government in achieving the important goal of quality health care for Ontario residents. Thank you for providing Bridgepoint Health with the opportunity to share its perspective with you. We look forward to seeing this bill substantially amended and enhanced as a result of these hearings.

The Vice-Chair: Thank you. We have six minutes, so a very quick question from each party. We'll start with the official opposition.

Mrs Witmer: I had to think when I first saw the word "Bridgepoint." I thought, "Who are these people?" Then I saw the faces and I realized. Welcome, and thank you very much for your comprehensive presentation.

Like many other presenters today, I think you've indicated that although the government is probably well-intentioned and has a commitment to medicare, unfortunately the accountability provisions are extremely troublesome. We've heard from people that they demonstrate a shift of power away from boards to the minister. As a result, there is a fear that over time boards would only become advisory and the accountability you would hope for and the input you'd have from the public would totally disappear. There was even a suggestion today, and you might want to comment, that once you get rid of boards as they currently exist and the governance structure we have, we could see more political influence by MPPs in communities. I don't know if you've thought about whether that's a possibility.

1600

Mr Carman: Ms Witmer, the question you raise regarding the political involvement is one that we have not discussed. Our concern goes much more to the enormous contribution that volunteers make, not just on the board but volunteers who work in the hospital, and people who give not just of their time but of their money in support of what they consider to be good causes. Our anxiety is that if the governance structure becomes weakened as a result of accountability relationships that go beyond dealing with the corporation, we feel that could have far-reaching impacts in terms of the willingness of the community to view the hospital as its own. Mariah, Do you want to add to that?

The Vice-Chair: You have about 15 seconds.

Ms Mariah Walsh: While we haven't talked about it extensively, it would seem to me that the outcome that you suggest would be inevitable. Clearly, if there are not voluntary boards who are accountable for the delivery of service, then the government becomes directly accountable for the delivery of service and, I guess by virtue of that, the MPPs who form the government.

Mr Kormos: Thank you, folks. I share with you your passion for accountability, but I put to you this: In the case of a public, community-based hospital, and knowing how boards get selected currently and have been for a considerable part of hospitals' histories, isn't a truly accountable board one which is elected, for instance at the same time as municipal councillors and board of education trustees are elected? Isn't that real accountability, beyond even the level of accountability you speak to now?

Mr Carman: Mr Kormos, one can't disagree with that concept, as you put it. If you're going to make the thing completely and utterly public, why not? Certainly I would never hesitate to put my name up for election for that kind of board.

Mr Kormos: Go ahead. I'm interested.

Ms Walsh: I guess the only additional response or comment with respect to that would be that it really just depends on who the government sees as the ultimate holder of accountability to the public. I mean, is the board of a hospital directly accountable to the public through an elections process, the public that will then judge their performance? Or is it the will of government to have the board of a hospital accountable to the public through the minister and through the Legislature and through that broader electoral process? It's really a choice of who it is the government would ultimately like to see hospital boards held accountable to.

Mr Kormos: Thank you kindly.

Ms Wynne: Thank you for your presentation. You have looked at the framework of the amendments. They are not written in stone. But you understand that in terms of framing the accountability agreements, the amendments are designed to make that a more collaborative process. I hope that when the language is out, you'll be able to look at them and comment further. I hope you will, because you obviously have a lot of experience in this area. Mr Duguid has a question.

Mr Duguid: It's actually more of a comment. I enjoyed your presentation. In particular, I've had an opportunity to review the speech the minister made this afternoon, and there are a lot of commonalities between your presentation and what the minister said. You outline key priorities as being reduced waiting lists, improving access to family physicians and making Ontario healthy. Some of the strategies involved in that are creating a culture of improved accountability and gearing toward improved outcomes. But that's not going to happen easily. It's going to require some very targeted accountability pieces within our process. That's really what the goal of this is in terms of the accountability.

I've served on a hospital board for nine years, up until last year. I can tell you that most of the people I've served with welcome greater accountability and they

certainly welcome the changes to the system, because it's a very frustrating system to work within right now, not geared to outcomes as much as it should be.

So I guess my comment to you is that I wouldn't fear so much some of the rhetoric you are hearing about this being draconian. The measures in here are used only in those extreme circumstances when we run into a rogue board or an organization that does not comply with our goals, which are accountable and agreed to by the people of Ontario as well as boards such as yourself.

The Vice-Chair: Time has run out. I would like to thank Bridgepoint Health for presenting today. We certainly appreciate your coming down, and have a good rest of the afternoon.

CANADIAN CYSTIC FIBROSIS FOUNDATION

The Vice-Chair: Next we have the Canadian Cystic Fibrosis Foundation, who have been patiently waiting at the back. I believe you've been around to hear the rules: 20 minutes, and any time remaining at the end to be used for questions from the three parties. If you would state your names for Hansard, we'd appreciate it.

Dr Josée Chiarot: I'm Dr Josée Chiarot. I'm the director of the medical, scientific and community programs at the Canadian Cystic Fibrosis Foundation. With me today is Jacqueline Romano. She's an adult with cystic fibrosis. I will be speaking for a few minutes and then Jacqueline will be speaking about her life, how she deals with cystic fibrosis and the importance of access to quality CF care and pharmacare. A copy of my speaking notes is included in the package that has just been distributed.

We would like to thank the standing committee on justice and social policy for the opportunity to speak to you today. First, I would like to take some time to talk about cystic fibrosis, or CF, and to provide some background information about the Canadian Cystic Fibrosis Foundation, our work and commitment to high-quality CF care. Then I will make comments on the Commitment to the Future of Medicare Act.

Cystic fibrosis is the most common fatal genetic disease of young Ontario residents. CF affects principally the lungs and the digestive system. In the lungs, where the effects of the disease are most devastating, CF causes increasingly severe respiratory problems. In the digestive tract, CF often results in extreme difficulty in digesting and absorbing adequate nutrients from food. As improved therapies have helped to address some of the malnutrition issues in CF, virtually all CF deaths are due to lung disease. According to the foundation's Canadian patient data registry report from 2001, there are 1,167 individuals with cystic fibrosis attending CF clinics in Ontario and 3,390 individuals with CF attending CF clinics across Canada.

The foundation is a national, non-profit, voluntary health charity that was established in 1960. We have volunteers across Canada in 52 chapters, and 19 of these chapters are in Ontario.

Our mission is to help individuals with CF, and we do this by funding research toward the goal of a cure or effective control for cystic fibrosis, supporting high-quality care, promoting public awareness of the disease and raising and allocating funds for these purposes.

In 2003-04, the foundation has committed over $5 million in support of CF research and over $1.8 million in support of CF clinical and transplant programs, for a total medical and scientific program budget of $6.8 million, of which $2.8 million is spent in Ontario.

Since the foundation was established over 44 years ago, the median survival age of young Canadians with CF has increased from four years of age to almost 36 years today. As a result, the biggest change we have witnessed over the course of our history is the very dramatic growth in the size of the Canadian population of adults with CF. It is anticipated that in the next few years the number of adults with CF across Canada, including Ontario, will surpass the number of affected children for the very first time.

We feel it's the responsibility of governments to ensure that basic, underlying support to individuals with CF in the form of medical and hospital services are provided by the government. In 1960, there were virtually no specialized clinical services for individuals with cystic fibrosis and about half of all children born with the disease died before reaching school age. Since that time, the foundation has successfully pursued the creation of cystic fibrosis clinics. Today there are 37 clinics across Canada, 11 of which are in Ontario. In these clinics, multidisciplinary teams of health care professionals with specialized knowledge of CF provide the finest care available anywhere in the world.

The foundation is committed to the protection and ongoing enhancement of team-based collaborative clinical services for CF and to extending the range of options available to the CF community. The foundation's clinic incentive grants are designed to enhance the standard of clinical care available to Canadians with CF by providing supplementary support for clinical personnel and for ongoing medical and professional education, with the overall goal of optimizing health for everyone with cystic fibrosis.

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Another important development has been the movement to establish outreach clinical services for children and adults with CF. Some affected individuals live a considerable distance from the nearest specialized CF clinic and one of the foundation's objectives is to provide financial support for outreach services, enabling physicians and other health care professionals from established centres to travel to outlying areas to provide care for those individuals with CF.

As part of our clinic incentive grant program, the foundation conducts a clinic site visit program. This program involves a peer review process that provides an opportunity to observe the policies and services being

offered at each clinic and also enables an exchange of information among clinics, ensuring that CF care in Canada remains of the highest calibre.

All CF clinics participate in the collaborative undertaking of the foundation's Canadian patient data registry. The purpose of this registry is to identify and track statistical trends within the CF population, thereby providing an accurate profile of CF in Canada, to generate questions which can be addressed through research and to contribute to improved clinical care and eventually to the discovery of a cure or control for CF.

With data from the registry, it is possible to calculate the median age of survival, which is currently 35.9 years—the highest ever. It's also possible to compute hospitalization rates, and the data have been used to demonstrate decreased hospitalization rates over the past few years. It has also been demonstrated, using the registry, that most cases of CF are now diagnosed in the first year of life, which is crucial in ensuring that treatment programs are begun as early as possible. The response to improvements in nutritional care can also be monitored. The registry has helped the Canadian CF medical and research community remain at the forefront of CF care in the world.

In addition to high-quality care, affordable drug costs are a key element of increased life expectancy and quality of life for patients with CF. While the provincial special drugs program has endeavoured to create an environment of affordable access to necessary, life-sustaining drugs and nutritional supplements, the cost of medications remains a major concern for individuals and families. Annual medication costs for young persons with CF vary; however, they can be as high as $30,000 a year. The foundation believes that all children and adults with CF should have equitable and full access to life-sustaining drugs. Decisions regarding the use of medications for individuals should be based upon the best medical judgment of the physician or specialist, in consultation with the patient, not on the ability of the patient to pay for those medications.

The financial burden of CF is most acute in the adult CF population, where a number of adults with CF are not accessing the drugs they need due to out-of-pocket costs. Many of these young adults work in lower-paying, entry level positions, without extended health benefits. For many, access to publicly funded drugs and nutritional supplements means the difference between being productive members of the community or becoming dependent on social services. Because of the disabling effects of CF, many adults with CF work part-time, without supplementary medical benefits, or are simply unemployed.

Unfortunately, many CF drugs are very expensive. As our understanding of this multi-system, multi-organ disease increases, so does the cost of treating it. The bottom line is that we also have an increasing number of young adults who, with adequate health care, can make useful contributions to our society. Almost 50% of individuals with CF in Ontario are over the age of 18. This impressive statistic keeps increasing and this is a testament to the excellent level of care received by CF patients and significant improvements in available drug therapies.

The foundation was pleased that the government of Ontario confirmed its commitment to the fundamental principles of medicare as laid out in the Canada Health Act: public administration, comprehensiveness, universality, portability and accessibility. We were encouraged by the government's action in announcing the Commitment to the Future of Medicare Act.

The foundation believes all young Ontarians with CF should have access to high-quality CF care and medications, regardless of where they live in Ontario and regardless of how much money they earn. With an increasing population of Ontario adults with CF, future access to high-quality CF care and life-sustaining drugs is vital to sustain these individuals.

In reading the proposed act, however, we are concerned that it only addresses pharmacare and home care in the preamble and nowhere else in the act. As these are critical to young Ontarians with CF, we believe they should be addressed within the act.

The foundation and the CF community have shown leadership and commitment to high-quality CF care in Ontario through our research programs, peer review clinic site visits, the registry and dedicated volunteers and health care practitioners. The government of Ontario has also been a leader in supporting the treatment and care of persons with CF.

However, we have learned of persons with CF not taking prescribed medications, or limiting the amount they take, because of cost, and of situations in which a certain drug, although it would be beneficial to the patient with CF, is not prescribed, because patients simply do not have the means to pay for it and it's not otherwise available to those patients.

This past year, we have learned of situations in Ontario where persons with CF waiting for a lung transplant were denied available lungs as there were no ICU beds available. For many individuals with CF in Ontario and in Canada whose lungs are severely damaged because of chronic infection, a lung transplant represents the only means of survival. Candidates for transplant who wait in various stages of precarious health should not be denied the opportunity for possibly renewed health and longer lifespan because there is no physical capacity for the surgery, despite an available organ, a willing recipient and a willing transplant team. We hope this problem has been resolved with the opening of an expanded ICU facility at the University Health Network.

A commitment by Ontario to provide continuing and extended coverage for CF medications and access to high-quality CF care will bring tremendous advantages to the province, as well as to those affected. The benefits are enormous. You will be keeping individuals as functioning, active members of society: going to work; going to school; participating in social activities; and otherwise contributing to the fabric of the community and the country.

Lack of access, or a reduction in access, to essential and indeed life-sustaining treatments and medications will certainly lead to devastating consequences for young persons with CF. It could also result in higher costs to the health care system with increased hospitalization rates for persons with CF.

It is, of course, much less expensive to maintain an individual at home, and indeed in the workforce, with medication and other supports than to have the individual occupy a very expensive hospital bed. Daily costs for a hospital bed and related treatment for someone with CF far exceed the monthly medication bill for most individuals. It is obvious that maintaining an individual as a functioning member of society will pay dividends to society.

Young Canadians with CF and their families should not be plagued with extensive disease-related out-of-pocket expenses. Fighting CF is hard enough. Diagnosis of a life-threatening genetic disease should not translate into a lifetime of personal financial hardship as a result of one's illness. As the Minister of Health and Long-Term Care has stated, Ontarians should have access to "health care services based on need, not ability to pay." We encourage the committee and the Ontario government to make a commitment to the future of young persons with CF by making a commitment to continued, accessible and enhanced high-quality CF care and pharmacare in Ontario.

I would like now to ask Jacquie Romano to say a few words.

Ms Jacqueline Romano: Thank you, Josée.

Good afternoon, committee members, ladies and gentlemen. Thank you for allowing me to speak to you this afternoon. I'm grateful for this opportunity, because I am one of over 1,000 Ontarians with CF and I am speaking on their behalf as well as my own.

As I appear here today, I may not appear sick or struggling with a deadly disease. However, the average age of a person with CF is now just over 35, and if I were to be average, I have just over two years to go. I am one of the lucky ones. Many of the people with CF that I know today are on oxygen 24 hours a day, are doing up to six hours a day of physiotherapy simply to maintain their lung function, have feeding tubes in their stomachs simply so they may have adequate nutrition to live, or are waiting for a lung transplant, which is their only, final hope. Most of the other people with CF I have met over my life are dead. I am one of the lucky ones.

CF is a genetically inherited chronic disease affecting mainly the lungs and digestive system. In the digestive system, pancreatic enzymes do not reach the area they need to in order to process nutrients, so I need to take enzymes with everything I eat in order to digest the nutrients. In my lungs there is chronic infection, which causes scarring, sometimes bleeding, and a chronic cough. Bit by bit my lungs will be destroyed despite aggressive antibiotic therapy, and I eventually will succumb.

However, I am one of the lucky ones. Most of my life-sustaining drugs are now paid for by the government, due to their catastrophic costs, and my frequent hospital visits have become less frequent due to access to home care. As a result, it gives me great hope that, in his remarks to this committee, the Minister of Health and Long-Term Care, Minister Smitherman, explains that the government believes, "that the health system is the whole of its complementary parts. It was anchored on the foundation of hospitals and physician services, but to be relevant it must evolve to encompass a full continuum of care including primary health care, home care, and pharmacare." Primary health care, home care and pharmacare, those three things, impact my life greatly and are indeed the elements that have given me such good health.

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Primary health care: I was diagnosed a few months after birth right here in Toronto by a CF specialist named Dr Crozier at the Hospital for Sick Children. Because my birth mother was young and lived outside the GTA, she would not be able to provide the hours of special care that I required, nor the regular trips to the CF centre in Toronto. I was put up for adoption, and adopted by a family that was committed to hours of physiotherapy and a strict regime of enzymes and other drugs. When they adopted me, my family did not expect me to live long enough to attend school. Three times a day they ensured that I did an inhalation mask and had chest clapping to loosen the mucus in my lungs and help prevent infection. Every three months, my mom and dad brought me from Guelph to Toronto to attend the CF day clinic, where I was monitored by a team of specialists.

Because I was diagnosed at such an early age, had such dedicated parents and because I was followed by the CF team of specialists, I did well and remained fairly healthy. When I was 12, I was admitted to hospital for the first time for a lung infection. This included a two-week stay at Sick Kids to receive antibiotic therapy to limit the damage done to my lungs. During that hospital stay, three other people with CF died on the floor, and I was sure I was going to be next.

My parents visited on the weekends, but the time in between their visits was almost interminable. These two-week stays became more frequent as I got older, and I now refer to them as a tune-up. In the last 10 years particularly, it has become increasingly difficult to obtain a tune-up because of the lack of availability of hospital beds. Because my infection is chronic and not necessarily acute, I often have had to wait a few weeks before a bed would become available. While this wait has never been life-threatening, infection causes lung damage, and the longer you wait the more damage is done.

It is critical that the government continue to support primary health care in this province so that people with CF can be diagnosed at an early age, receive the specialist care that prolongs lives, and have access to hospital beds when they are required.

It was during a time of too few hospital beds that I became acquainted with the second branch of health care,

that is, home care. I was waiting to get a bed in the hospital but needed antibiotics urgently as I was coughing up blood, had a fever and a raging infection. Rather than go into the hospital for the stay, my CF nurse coordinated with the home care provider to have my IV meds done at home. Since I was already heavily involved with self-care and had been to the hospital numerous times for a tune-up, I was fairly familiar with the regime that I would undergo at home. The nurse arrived at home, put in an IV line, hung the drugs and outlined the schedule I would need to follow. There was a 24-hour pager number to call if I needed help or ran into problems, and the nurse would visit me daily to ensure things were going smoothly.

There are a number of benefits to having home care available to those who can use it: It saves much-needed beds in the hospital for non-acute patients who are either able to look after themselves or who have adequate home support to follow the regimes. It was far less stressful on me as a patient, since I was at home with my familiar surroundings and routines yet still getting the critical therapy. Finally, sometimes I am able to continue working part-time while on IV therapy, going to work between doses and remaining a productive, taxpaying member of society.

There are, however, a number of snags in the home care system. I must take my first antibiotic dose under the supervision of a nurse in the hospital in case of any adverse reactions. A better process is needed for initiating the IV therapy as an outpatient service, but funding is too tight. There is also a need for more IV pumps in the community. When I first started doing home care, I was advised I couldn't have a pump, since there were only two pumps available in the area and both were being used. At several thousand dollars each, no more could be purchased for the program to use. This meant that each time I hooked up to my IV for a two-hour dosage, I had to monitor it constantly to ensure the line was not crimped or the bag was not empty. This is particularly difficult to do into the night, trying to remain awake long enough to monitor the IV line.

It is inconveniences such as these that make all the difference to a person who is sick and in need of rest and can help that person decide against using home care in the future. By ensuring adequate funding and improving support to the home care system, many dollars can be saved while still providing the top-notch health care that Ontarians deserve.

Finally, pharmacare is the third branch of health care that is of utmost importance to people with cystic fibrosis. As Josée has explained, the cost of drugs for a person with CF is staggering, and we would not be living as long as we are without those drugs.

The Vice-Chair: There is one minute left in your presentation.

Ms Romano: So when the Minister of Health and Long-Term Care states that the health system must evolve to encompass a full continuum of care, including primary care, home care and pharmacare, he has my attention and the attention of everyone in Ontario with CF.

How will the government make good on their commitment to make Ontarians the healthiest Canadians? I challenge you to consider what I have said today and to incorporate at least some of these concepts in the bill.

The Vice-Chair: Thank you very much for your presentation. We have two more presentations this afternoon and we do have two of three—is that the Ontario Health Coalition or—it's Lakeridge. So perhaps we could take a question from each party. I think you made a wonderful presentation here today and I'll start with Mr Kormos. Do you have a question?

Mr Kormos: No, thank you, Chair.

The Vice-Chair: Ms Wynne?

Ms Wynne: I don't have a question. I really appreciate your presentation. Thank you very much for coming. The only thing I want to point out—and it's not in any way meant to diminish what you've said—is in the preamble, the recognition for pharmacare and for home care have been placed there because this is a commitment to the future of medicare. So what we wanted to be sure was that all the components that we recognize are critical were in the document, because there will be future legislation. This bill isn't meant to do everything that we're committed to—it's a first step—but we wanted to make sure that we didn't leave those pieces out, because they have to be there for the future.

Dr Chiarot: Thank you.

Mrs Witmer: Thank you very much for coming. I very much appreciate your presentation. I think it's really important that all of us as MPPs have the opportunity to hear first hand the work that's done by the association and also the impact that cystic fibrosis has on individual lives such as yours. Certainly, you're very fortunate to have had wonderful parents who have supported you.

Ms Romano: Absolutely.

Mrs Witmer: I just wish you all the best.

The Vice-Chair: As Chair this afternoon, I'd like to thank you for your presentation. We certainly appreciate you coming down and presenting this powerful presentation to us. To the committee, we will recess for about five minutes and wait for—

Mr Duguid: Are the other deputants not ready to go?

The Vice-Chair: No. The next group is not here and Lakeridge Health have two of their three presenters here. So we'll take five minutes.

The committee recessed from 1629 to 1636.

ONTARIO HEALTH COALITION

The Vice-Chair: Next we have the Ontario Health Coalition. I would like to welcome you. The basic rules: 20 minutes for the presentation. If you don't use the full 20 minutes then we'll have a question period where we'll divide the time between the three parties. If you're ready, we would be happy to hear your deputation.

Ms Natalie Mehra: The Ontario Health Coalition represents over 400 member organizations and thousands

of individuals across the province. Our mandate is to protect and extend a quality, universal one-tier public medicare system.

It's hard for us to comment on this bill, partly because the title of the act is something of course that we fully support. However, there are key things missing from the bill and we have some problems with the direction of some significant portions of the bill. What I'll do is focus on the recommendations that are outlined in our brief and then allow time for questions.

If we were to write an act about protecting the future of the public health system, we would ensure that included in such an act—not just in the preamble but also in the body of the bill itself—are concrete initiatives to restore the accessibility, comprehensiveness and universality of the system. We believe that we need to see some concrete initiatives to actually apply the principles of the Canada Health Act, although we applaud the inclusion of the principles in the preamble of the bill.

We also believe that privatization poses a significant threat to the future of the health system and that the act should be amended to ban P3 hospitals, return the diagnostic clinics back into non-profit hospitals and stop the tide of privatization that is sweeping across Ontario's health system.

We believe that the health council must be amended to be a democratically appointed body, either through appointments from each of the parties or another democratic system and that it should report on the performance of the health care system with respect to the principles of the Canada Health Act. Its purpose should be both to report on how the health system meets the principles of the Canada Health Act and also make recommendations regarding this.

We believe that the accountability section of the act is actually looking in the wrong direction, that accountability includes the accountability of the health minister to the people of Ontario, not just health care institutions to the health minister.

We believe that if the minister has in mind another attempt to restructure the health system, he should make that clear to the people of Ontario, that the people of Ontario should have the opportunity to debate and discuss this openly and have meaningful input about any restructuring taking place in the health system.

We believe that the bill must be amended to provide accountability of health institutions through democratic control, meaningful public input and consultation, transparency and disclosure, and full whistle-blowing protection for those people who make complaints about the practices of corporations and managers in the system.

The bill must be amended to stop queue-jumping for so-called medically unnecessary services and must include recognition that the delisting of services and the growth in charges for access to so-called medically unnecessary services is becoming a threat to the application of the principles of the Canada Health Act in Ontario.

We also believe that the bill must be amended to stop block fees, ban boutique medicine and extra-billing and to support primary care reform.

On the application of the principles of universality, accessibility and comprehensiveness, we believe that it's imperative that the delisting of medically necessary services be stopped and reversed. For instance, audiology services and physiotherapy services that have been delisted are inarguably medically necessary services and should be covered under the public system.

We believe that the lack of access to primary health care, the lack of access to physicians in the system, means that the Ontario health system actually does not fulfil the principles of the Canada Health Act, and that problem needs to be addressed as quickly as possible; that the supply of health care services should be designed to meet population need rather than short-term financial goals; that the homemaking services that have been cut for 115,000 frail elderly people over the last year should be restored; that access to rehabilitation therapy, speech pathology, physiotherapy and other services like that that are almost inaccessible across the province need to be restored; and that the government needs to take firm steps to move on controlling the cost of pharmaceuticals and assistive devices and access to other treatments.

We believe that the surest way to ensure that we won't have a sustainable medicare system in this province is to hand over the control of that system to private for-profit corporations. We need only to look at the cost in the United States to see that a for-profit health care system costs more. In 1971, when the last province signed on to public medicare in Canada, the United States and Canada spent about the equivalent amount—7% of our gross domestic product—on health care. As of last year, the United States spent 14% of its even bigger GDP; we spent 10%. The record of public health systems in controlling costs is evident around the world. We believe that the trend toward introducing P3 hospitals, private for-profit clinics, private long-term-care facilities, private home care corporations and privatization throughout the operation of the health care system poses a significant threat to the future of the health system not only because it will drive up costs but because it also imposes on the health system the culture of for-profit industries: exorbitant executive salaries, low worker wages, advertising, unnecessary duplication, higher administrative costs, reductions in the scope of services offered under the public system, and both the motive and means for corporations to introduce and grow two-tier health care. Therefore we believe that the P3 hospitals, the MRI clinics, the private for-profit clinics must be stopped.

I've talked about the health council.

Most important to us in this bill are the provisions around block fees, or charging patients fees up front for access to family physicians, and the accountability sections of the bill.

I want to share with you a few stories from across the province. These are complaints that have been received by the College of Physicians and Surgeons of Ontario

about the use of block fees: a psychiatrist charging patients to review their daily logs; patients being told that their physicians would drop them from their practice if they did not pay the block fee; patients told that their telephone messages would go unanswered if a block fee was not paid.

In addition, a recent Globe and Mail article describes two family physicians who are charging their patients a $2,500 annual fee for a detailed medical workup, a customized health plan and 24/7 access. These two physicians are aiming at practices with 150 patients each rather than the usual 2,000 patients per physician. Technically, it's believed that these physicians' practices are not in violation of the College of Physicians and Surgeons' block fee policy, but, called boutique medicine, this practice poses a significant threat to the health system, both in violating the spirit and intent of the Canada Health Act and also in reducing the supply of physicians.

We're hearing now that block fees are being charged of about $100 across the province and in some places $200, and recently we heard of $250 block fees being charged in Burlington.

We support this bill in bringing block fees under the regulation of the government by putting it into legislation. However, we believe that the bill should go further in banning block fees entirely. We believe that they are unnecessary charges, that they violate the spirit and intent of universal public medicare, that if physicians can charge piece by piece for those services it's completely unnecessary to charge for them up front, and it's open to abuse.

Further, we believe that the accountability section of the bill should be repealed and replaced with an accountability section that actually draws the lines of accountability from health providers to government to the people of the province; that we must start to institute democratically elected boards, open memberships in health institutions, diverse representation on those boards; that health care workers deserve and must have whistleblower protection—gag orders are rampant across Ontario; that transparency should be imposed regarding delisting and defunding; that there should be democratic governance of the OHIP list; that meaningful restrictions on commercial secrecy and full public reporting on finances within health care institutions and sectors should be in the bill; that public consultation, meaningful input and public debate about changes in the health system ought to be part of public accountability; that full public disclosure of fees and other out-of-pocket costs should be in the bill.

Notably, we tried to find out what physicians can charge for block fees. We phoned everywhere that we could. Eventually, we found out that we could get the list from the Ontario Medical Association if we paid a fee of over $100.

We believe that the accountability section of the bill should include a duty of the minister to provide stable, timely, multi-year funding; that representation of diverse populations, equality seeking groups and geographic diversity should be mandated for all boards of health care institutions; and that meaningful input of health care workers and users should be implemented at all levels. Thank you.

The Vice-Chair: Thank you very much for your presentation. We have about nine minutes left, so three minutes for each party. The government side, Ms Wynne?

Ms Wynne: Thank you for coming and thank you for your sophisticated and knowledgeable presentation. A couple of things: You talk about investigation—the language in the bill is "reporting on"—and there's been a suggestion a number of times that there should be some reporting capacity on privatization. Can you just expand on what you think the council should be tracking?

Ms Mehra: There are a few things. One is that we think it should be explicit in the bill that the council should be reporting on how Ontario's health system measures against the principles of the Canada Health Act—Is it accessible? Is it comprehensive? Is it universal?—and making recommendations regarding those principles and the application of those principles. In addition, we believe that if we could only have access to the information, we would find that the privatization of services across the province is costing us more per unit. It would be helpful if the council would investigate that.

Ms Wynne: OK. So you see the council as a useful body in terms of shining a light on, if not all the things you're asking for, at least on the direction that we're going. In principle, you support the idea of having that council is place. Am I reading you correctly?

Ms Mehra: In principle we support it. However, we believe that it shouldn't detract from the minister's responsibility for ensuring that the Canada Health Act principles are followed. We're also concerned that, as it's presently constituted, it could actually be used by a future government that opposes medicare to propagate reports that are biased against the application of medicare principles.

Ms Wynne: That's interesting, because one of the reasons the council has been articulated or described the way it has been is that the minister does have the ultimate responsibility, and that rests with the government. So what we're looking for is a council that can report on these things but does not take on the power of the minister. That's in line with what you're suggesting.

The Vice-Chair: One minute.

Ms Wynne: OK. There are a lot of questions. Thank you very much. Bob has a question.

Mr Delaney: I have one short question. When you advocate the restoration of access to delisted services, do you mean all currently delisted services?

Ms Mehra: No, we mean medically necessary delisted services. Specifically in the brief we talked about the audiology services and the physiotherapy services that have been delisted. It's actually not possible for us to get a full listing of what's been delisted, because it's not

published anywhere, so we couldn't advocate for that. We don't know what the full list is.

Interjection.

1650

The Vice-Chair: No, time has run out. Ms Witmer?

Mrs Witmer: Thank you very much. You mention in here that you would like improved access to primary health care through primary care reform that includes non-profit teams of salaried health care providers. Could you just explain who would be included, and how would you see those operating? How would that be different from community health care centres?

Ms Mehra: I think it probably depends on the range of the team included in the primary care reform group as to how similar or different it would look compared to community health centres, but community health centres are a good example of that type of model.

Mrs Witmer: OK. Originally, when primary health care was introduced, the intention was that you would expand and you'd have physicians, you'd have nurses, you'd have social workers, pharmacists—the list would go on and on. That's what you are talking about?

Ms Mehra: Ideally, that's what we're talking about, but moves in that direction would be supported by us.

Mrs Witmer: And you support community health centres as well, which is a little bit different concept?

Ms Mehra: That's right.

The Vice-Chair: Mr Kormos.

Mr Kormos: Thank you kindly. With all this talk about accountability, you're the first person coming before this committee whom I have witnessed calling for true accountability, and that is the democratic election of hospital boards of governance. That is what you proposed. I mean, what a novel idea. We've had private members' bills in the Legislature advocating for that. What's the problem? Nobody's hip to the fact that hospital boards are inevitably little cliques? They are, aren't they?

Ms Mehra: I think that they are better and worse in some parts of the province, but the worse ones are self-appointing boards.

Mr Kormos: Incestuous little cliques, right? Rife with backroom dealings. Is that your sense?

Ms Mehra: Our sense is that some of the most powerful hospitals in the province have self-appointing boards so they appoint the membership that appoints the board or they run slate elections that are very undemocratic.

Mr Kormos: Of course, one of the arguments I anticipated was, "You can't have democratically-elected boards because you have to choose people with the right sort of credentials and backgrounds. You've got to make sure people have expertise in that area." That's one of the arguments, isn't it?

Ms Mehra: Yes.

Mr Kormos: Strange how that isn't applied to city councils or to provincial Legislatures or to federal Parliaments, though, isn't it?

Ms Mehra: Exactly.

Mr Kormos: God forbid they should ever require literacy tests of elected members of Legislatures.

The Vice-Chair: Thank you very much for your presentation.

LAKERIDGE HEALTH

The Vice-Chair: Next we have Lakeridge Health. Once again, 20 minutes for the presentation. In the time you do not use up in your presentation we'll have questions. Please identify yourself for Hansard.

Ms Anne Wright: Good afternoon, ladies and gentlemen. My name is Anne Wright. I am the chair of the Lakeridge Health board of trustees. I have with me our Lakeridge CEO, Mr Brian Lemon, and our chief of staff, Dr Donald Atkinson. They should be able to help me in answering any questions you may have.

Today I would like to raise the concerns of my board related to local governance, accountability and accessibility, as well as specific issues related to our rural hospital sites.

While I recognize that the minister has tried to provide some comfort and clarity on some of these issues, unfortunately we have not yet seen the specific language proposed. As a consequence, some of the concerns I am raising today may well be addressed during the redrafting process. However, I still believe it is important to raise our concerns to ensure that they are, in fact, fully dealt with when these changes are considered.

Let me start today by letting you know just who we are. Lakeridge Health was formed in 1998 pursuant to HSRC direction and is one of the largest community hospital networks in Ontario, with four hospital sites, located in Bowmanville, Oshawa, Port Perry and Whitby. Lakeridge Health is distinct among other Ontario hospitals because we serve urban and rural, large and small communities. With over 3,000 employees, the Lakeridge Health system provides a comprehensive range of patient-focused services to over 500,000 residents of Durham Region. On any given day, over 1,500 people come through the doors of Lakeridge Health looking for the quality care they need and expect.

Lakeridge Health agrees with many of the broad goals behind Bill 8, such as: the creation of the Ontario Health Quality Council to monitor and report on important health care indicators for Ontarians; ensuring that the health care system remains accessible for all Ontarians by embracing the five key principles or pillars of the Canada Health Act; and by adding accountability as a sixth pillar, entrenching accountability as a central principle in Ontario's health care system by establishing accountability agreements that set out clearly established, negotiated and agreed to performance measures. We agree with all of that.

Lakeridge is accountable to the Ministry of Health and Long-Term Care under the Public Hospitals Act and abides by the strict directives outlined by government, including the public disclosure of all financial information.

The Lakeridge Health board of trustees is also accountable to its patients and the community it serves in a variety of different ways. Whether it be better use of taxpayer dollars, balancing the budget, acting on community concerns or simply keeping the community informed, we take our responsibilities seriously.

Like other hospitals across Ontario, this dual accountability helps to ensure a balance between the concerns of the minister and the community. This, however, can occasionally create a dichotomy between community expectations and ministry funding capability.

We are particularly concerned, however, with the provisions contained in Bill 8 that will undermine community-based voluntary hospital governance. Specifically, Bill 8 allows for the imposition of accountability agreements without negotiation or agreement. The government would effectively undermine the current check and balance that ensures the community has a voice in the health services they receive and how these are managed. We would like to see more clarity regarding the minister's February 19 commitments relating to notification prior to the minister or the ministry unilaterally directing changes to health services provided by the hospital in the community.

Notwithstanding the minister's clarifications issued on February 19, Bill 8 would still allow the minister to direct and/or penalize a hospital CEO, effectively altering or removing from the board its powers to determine CEO terms of employment under the Public Hospitals Act. Responsibility for negotiating and enforcing accountability agreements should remain with the board and the government. Responsibility for ensuring that a hospital CEO lives up to that agreement should rest completely with the board, not the ministry.

The CEO and chief of staff are the only direct board employees and are therefore accountable to the board. Whether by threat of penalty or by direction, Bill 8 provisions related to the CEO still appear to clearly usurp the role of the board, while placing him or her in the unenviable position of having potentially two masters with differing priorities. The Lakeridge Health board commits to you that we will continue to fully hold both the CEO and chief of staff accountable for performance.

It is important to remember that accountability in the hospital sector is not a one-way street. For hospitals to become fully accountable, government—our major funding partner—must also shoulder its accountability responsibilities, particularly as it relates to stable funding.

Over the years, working together, government, hospitals and the OHA have forged close working relationships in order to fulfill our obligations to the health care system. Hospital report cards and work on multi-year funding and accountability solutions are just a few examples of the benefits of collaboration. They illustrate clearly that by working together in partnership on behalf of Ontarians, we are all truly better together.

The tone of Bill 8, as it is currently drafted, does not support the spirit of collaboration that is necessary to advance health care, nor does Bill 8 provide for appropriate reciprocal responsibility on the part of government, hospitals and other health care providers.

We are supportive of the government's directive to move from providing expensive hospital-bed-based services to outpatient services where these have been shown to be appropriate and maintain or improve patient access and quality of care. However, Bill 8 fails to define key terms such as "accessibility," "medically necessary services," "quality" and "comprehensiveness," nor does it provide for guaranteed waiting times to ensure that the system is accountable to patients. Without clear definitions in Bill 8, we will continue to struggle to provide the perceived needs and expectations of the community and the much increased needs of the acute care sector. For example, what are the core and non-core clinical services hospitals are mandated to provide?

The Lakeridge UV clinic—which is ultraviolet—is a case in point. We have provided this service because these patients see it as an important part of their treatment. However, there is little evidence of its efficacy, and these services are also available elsewhere in the community. In the case of the UV clinics, it is clear we should discontinue the service. However, there are many more issues where it is less clear. With tightened funding and increased accountability, boards now have to look at possible changes to some services without the clarity necessary to determine whether they are considered core clinical services and can meet the test of the Canada Health Act.

1700

To enhance the ministry-hospital accountability relationship, multi-year funding commitments are a critical necessity in making real improvements in long-term accountability. I have just received a copy of the minister's comments from today, and he does talk about predictable funding. I hope it is targeted at this issue. If so, we would definitely welcome that as an initiative.

From a review of Bill 8, it would appear that many of the government's accountability concerns are currently being addressed by the multi-year funding and performance agreement task force of the joint policy and planning committee. Bill 8 currently makes no provision for multi-year accountability and funding agreements.

Ontario hospital boards understand the need to ensure prudent fiscal management and accountability; however, there are ministry funding issues that also need to be addressed to allow us to appropriately discharge our accountability responsibilities and balance our budgets. While we wait for multi-year funding, we continue to operate in a sea of funding uncertainty. No organization can plan and operate efficiently without knowing what its budget will be.

Additionally, all too often hospitals are not given their operating budgets until well into the fiscal year. At Lakeridge Health, for example, despite the fact that we are obligated to plan for the coming fiscal year, we have not yet been given our revenue budget. In previous years, budget notification has varied dramatically and has always been received long after the planning period and

often well into the fiscal year. So as you can see, for a year beginning on April 1, for the last five years we have received notification of our revenue budget on April 14, September 26, September 28, June 28 and August 1. This means that more dramatic cuts must be made if a board wants to balance its current-year budget, and given the terms of collective agreements, it can take six months or more for a hospital to make necessary adjustments.

While these issues are problematic for all hospitals, they are especially so for rural sites where, due to their small size, budgetary surprises can be devastating or make it impossible for those hospitals to adjust to revised budgets.

The board of trustees of Lakeridge Health is committed to and accountable for ensuring appropriate access to quality health services to both our urban and rural communities. As a hospital system with a strong rural element, it is important to note as strongly as possible that Bill 8 is troubling. For example, while we believe in accountability, the provision of care in rural and/or remote sites can be both more difficult, perhaps because of a lack of physicians, and more costly, because we may be resourcing essential services even when patient volumes are low.

The unique circumstances faced by rural hospitals limit our options for reducing costs or finding economies of scale while need demands that we continue to provide many of these necessary services. This is why Lakeridge continues to advocate for appropriate financial and medical resources on behalf of our rural citizens. It is also why the board recently approved the creation of a rural health training institute, to be located at our Port Perry site.

However, by removing the requirement for the minister to act in the public interest, as defined by the Public Hospitals Act, the minister is less accountable to the public in ensuring accessibility to health services in the community where the hospital is located. Coupled with the prospect of forced accountability agreements, this opens the door for a potential weakening of accessibility and is of particular concern for rural facilities.

Lakeridge Health is also extremely concerned that one of the consequences of Bill 8 is the potential for decreased accessibility in a number of other ways. The lack of clarity around section 9 is of major concern to our rural sites in particular. Specifically, we are concerned as to whether this section might prohibit current practices such as incentive recruitment bonuses, locum coverage or guaranteed income agreements necessary to recruit and retain certain medical specialists.

We are also concerned that we have not yet seen the proposed changes to section 9. While the minister has undertaken to allow for payments to hospitalists, lab physicians and other specialists who currently receive direct payments from the hospital for work such as providing on-call services, we feel it is nonetheless important to reinforce the need for this change in section 9. In addition to reducing access, disallowing these payments will eliminate the many proven benefits derived, while inadvertently raising costs and reducing efficiencies.

The Lakeridge Health board of trustees unanimously believes that Bill 8 in its current form will not achieve the goals of ensuring accessibility and accountability, because it undermines the role of community voluntary governance of public hospitals. The bill, as currently drafted, may in fact limit accessibility, particularly for Ontario citizens residing in smaller communities. We believe that working together to improve accountability and access is the preferred approach. Together, not only have we made impressive strides over the years, but Ontario and its hospitals are also leading the way on accountability.

As proof of our commitment to improving accountability and accessibility, all Lakeridge Health board of trustees have affixed their signatures to this presentation, with the exception of three who were absent and we were unable to get theirs. However, they are in full support of the presentation.

The Vice-Chair: We have about nine minutes remaining, so three minutes for the official opposition.

Mrs Witmer: Thank you very much to Lakeridge Health for being here today and sharing your concerns. Your concerns in many ways echo what we heard last week and this week. Despite the fact that the government wants to improve accountability and access, it appears that as people have done their analysis of this particular piece of legislation, it has the impact of doing exactly the opposite. You speak specifically about the fact that it's going to limit access for people in small communities. You've talked about locums, incentive recruitment bonuses and what have you. Is that what you mean when you talk about the fact that it's not only going to limit access but in particular it will have a more severe impact on small rural communities?

Ms Wright: Yes. Rural communities particularly have difficulty recruiting primary care physicians but specialists as well. Even to recruit primary care physicians, it's a general practice that there are certain recruitment incentives paid to physicians in order to get them to come to your community. I'm not quite sure how this legislation would affect that, but if it does affect that, then it would severely limit our ability to recruit physicians.

Mrs Witmer: We've certainly heard from physicians that because of the content of this bill and some of the provisions, they would consider leaving the province as well, particularly new physicians who obviously don't want to be bound by some of the provisions that are contained therein. So it certainly appears to have the impact of reducing accessibility to health care services even further than is presently experienced.

The other issue is accountability. Again, there is tremendous concern that the role of the local board of a hospital is going to change. Obviously with the minister having more power and the shift in power, the hospital board will be no more than an advisory board. If that's the case, what do you think is going to happen to the people who currently serve on those boards if they no longer are in a position to make decisions?

The Vice-Chair: Half a minute for an answer.

Ms Wright: It's speculation, obviously, about the effect that would have on the ability to recruit board members. I just wanted to also say that our board members are elected from a broad membership representing the community.

Mrs Witmer: A vote?

Ms Wright: A vote.

1710

The Vice-Chair: Mr Kormos.

Mr Kormos: Is there anything more you wanted to say in response to that?

Ms Wright: About the vote?

Mr Kormos: Yes, because he cut you off.

Ms Wright: That's his job, Mr Kormos.

The Vice-Chair: Yes, that is my job.

Mr Kormos: Don't use up my time, Chair.

I'm giving you some of my time now to finish your response.

The Vice-Chair: He's asking the same question.

Mr Kormos: No, that's not what I was doing.

The Vice-Chair: You presented it.

Mr Kormos: Let us do what we've got to do here. We'll move along more quickly.

Ms Wright: Our board members are elected by community members. This year we have approximately 700 members from the community. There is the potential to choose from a slate presented by the nominating committee and other members who are nominated from the community. I just wanted to let you know that.

Mr Kormos: I know a whole lot of hospital board members, and most of the ones I know work incredibly hard. Even the ones I don't agree with work incredibly hard at what they're doing.

Ms Wright: You're right. They do.

Mr Kormos: I acknowledge that, right off the bat.

What about, in a democratic society, democratically elected hospital boards, in the same manner and perhaps at the same time as we elect city councillors, trustees to the board of education etc?

Ms Wright: So I would have to run a campaign?

Mr Kormos: Yes. That's what these folks here—

Mr Kim Craitor (Niagara Falls): Signs?

Mr Kormos: If you're inclined.

Ms Wright: Do you think that's a good idea?

Mr Kormos: I'm asking you. You know what I think. I wouldn't be asking the question if I wasn't an advocate of it. I'm asking you, what's wrong with that? If people do that to be on the board of education, if people do that to become members of the Legislature, if people do that to become members of big-city and small-town councils—the stipend in some small towns is $3,000 or $4,000 a year—what about hospital boards?

Ms Wright: I want to know whether the hospital board would still be volunteers. Would this become a paying position, or would it continue to be—

Mr Craitor: It would become a political body.

Ms Wright: It would become a political body?

Mr Kormos: It is now, some would argue.

Ms Wright: I am a volunteer, so I do not get paid for what I do. I think it becomes a different business when you're paid for your work.

The Vice-Chair: Ms Wynne.

Ms Wynne: I'm just going to make a couple of comments, and then Mrs Mitchell has a question.

I just wanted to clarify the section 9 amendment. The wording—and you can get a copy of this on the other table—will be amended to permit payments by public hospitals and mental health facilities for insured services rendered in those facilities; for example, payments to hospitalists, laboratory physicians. That's the language.

Ms Wright: We understand.

Ms Wynne: As far as the incentive recruitment bonuses and locum coverage, the bill will be silent on those. They fall outside the scope of the bill, so there should not be an impact. There would not be an impact on those particular pieces.

Ms Wright: That's good to know.

Ms Wynne: I wanted to make that clear.

Mrs Mitchell has a question.

Mrs Carol Mitchell (Huron-Bruce): I just would like further expansion: You were talking about rural hospitals, and I also was reading your locations. I represent the most rural riding—maybe our definition of "rural" isn't quite the same. But I'm looking for an expansion. Because I come from a rural area, this legislation is so important to me, because it's the continuum of care and community health, and that's what we need in rural communities, when we simply don't have the same access to health care in our communities. So I must say that your comments here—I was quite taken aback. I look for further expansion of rural concerns.

Mr Brian Lemon: Certainly one of the major concerns is the ability to provide adequate incentive for physicians to work in hospitals when there is huge incentive in the fee schedule for them to work in their offices. Stemming the tide of physicians withdrawing from hospitals is a real threat in small communities. The critical mass is not in the hospitals to present them with lots of opportunities to earn money, so in a number of cases they are withdrawing their service.

The second element relates to the funding plan and performance expectations, which certainly are very graphically evidenced by Lakeridge Health. When we became responsible for both small and large hospitals, all the funding credits that came with the small hospitals were discontinued. The performance expectations of us are to manage our four hospital sites as if we were a single hospital operating on a single site. There's no recognition that our smaller sites are more costly to provide the same amount of care, because they lack the critical mass. So that's a real threat in the way government has applied the rules and so forth of this kind of direction.

Mrs Mitchell: I'm going to reinforce: As you knew, this is where we were going to go. Community health care is what works in our rural communities. Thank you very much for reinforcing the direction we're moving in for health care.

The Vice-Chair: Thank you very much for your presentation this afternoon. We appreciate your coming and presenting to us.

At this time, I would like to thank all the stakeholders and the presenters who came to make deputations today. I'd like to thank the committee members for their patience with me and all those who were associated with the logistics.

We're adjourned to this room at 10 am tomorrow.

The committee adjourned at 1716.

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Mr Jim Brownell (Stormont-Dundas-Charlottenburgh L)
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Mr Bob Delaney (Mississauga West / -Ouest L)
Ms Shelley Martel (Nickel Belt ND)
Mrs Carol Mitchell (Huron-Bruce L)
Mrs Elizabeth Witmer (Kitchener-Waterloo PC)

Also taking part / Autres participants et participantes
Mr Peter Kormos (Niagara Centre / -Centre ND)
Mr Rosario Marchese (Trinity-Spadina ND)
Mr Thomas O'Shaughnessy, senior policy analyst, health system policy unit,
Ministry of Health and Long-Term Care

Clerk / Greffière
Ms Susan Sourial

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Ms Lorraine Luski, research officer,
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