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# Official Report of Debates (Hansard)

**Thursday 26 February 2004**

# Journal des débats (Hansard)

**Jeudi 26 février 2004**

## Standing committee on justice and social policy

Commitment to the Future of Medicare Act, 2003

## Comité permanent de la justice et des affaires sociales

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

Chair: Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

# STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

# COMITÉ PERMANENT DE LA JUSTICE ET DES AFFAIRES SOCIALES

Thursday 26 February 2004

Jeudi 26 février 2004

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*The committee met at 1001 in the Best Western Cairn Croft Hotel, Niagara Falls.*

## COMMITMENT TO THE FUTURE OF MEDICARE ACT, 2003

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

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

## ONTARIO NURSES' ASSOCIATION, NIAGARA REGION

**The Chair (Mr Kevin Daniel Flynn):** Ladies and gentlemen, I call the committee to order.

The first delegation this morning is from the Ontario Nurses' Association, Niagara region. Jo Anne Shannon is with us from local 26.

I'll just explain the rules, Ms Shannon. You have 20 minutes, and you can use that 20 minutes any way you see fit. At the end of your presentation, if there is any time left, we will try to split that evenly among the three parties that are present here today with some degree of fairness. The floor is yours.

**Ms Jo Anne Shannon:** Good morning. My name is Jo Anne Shannon, and I'm a registered nurse working in the ICU of the Greater Niagara General site of the Niagara Health System. I am the bargaining unit president for the Niagara Health System and local coordinator for local 26 of the Ontario Nurses' Association. In that capacity, I represent 1,500 hospital nurses from Niagara, including the Niagara Health System and Hotel Dieu Health Sciences Hospital. I'm pleased to have this opportunity today to provide ONA's perspective to the standing committee on justice and social policy regarding Bill 8, the Commitment to the Future of Medicare Act, 2003.

First let me tell you more about who ONA represents. As you may be aware, ONA is the union that represents more than 48,000 registered nurses and allied health professionals working in hospitals, long-term-care facilities, public health, community agencies and industry throughout Ontario. ONA's primary responsibility is to safeguard the professional interests of our members. It is also the professional obligation of ONA to speak out on behalf of the public good and our patients.

At the same time, the public puts a great deal of faith in nurses, as indicated by numerous polls. This year, 95% of 1,500 respondents in one survey said they trusted nurses most, just slightly below firefighters.

Canadians have clearly indicated they share the same commitment as nurses to the preservation of our public medicare system. With this in mind, I'd like to talk to you about our concerns regarding the impact of Bill 8 on the future of medicare in Ontario.

During the recent Ontario election, the provincial government made a number of commitments regarding medicare. On introducing Bill 8 for first reading in November, it was heartening to hear Minister George Smitherman comment that Ontarians want to see "progress and real, positive change in health care versus more creeping privatization of health delivery." He also talked about the Liberal government building a health care system that is public, universal and accountable—extremely encouraging words for Ontario's nursing community. We fully intend to hold the government to this standard.

ONA believes one of the gravest issues facing our public health care system today is the chronic nursing shortage, which grows with each passing day. Just like their commitments to medicare, the Liberals made a commitment to hire nurses. To quote directly from their campaign literature, the Liberals told Ontarians, "We will hire 8,000 new nurses." While the government may have good intentions, we have yet to see concrete delivery on this promise.

By December 31, 2005, when the Hospitals of Ontario Pension Plan bridge benefit expires, 15,000 of Ontario's registered nurses will be eligible to retire. Within the Niagara Health System alone, 22%, or over 250, of our hospital nurses will be eligible to retire by that date. By 2008, if Ontario's nurses choose to leave at age 55, we could lose more than 30,000 nurses.

The 8,000 new nurses are desperately needed now. This issue must receive the necessary priority before Ontario's hospitals are forced on a widespread basis to involuntarily close hospital beds because there are not enough nurses to care for the patients. The nursing shortage must receive the necessary priority. This bill is not going to help Ontario deal with the current nursing shortage.

The health minister did announce a small first step on February 24: $50 million in funding for hospitals is to be targeted to increase full-time nursing positions and to improve the safety and working conditions of our nurses. But details are unknown and many questions remain unanswered.

The same goes for Bill 8 and medicare. We don't see the government acting on the specific commitments to protect and expand medicare outlined in the preamble to the legislation. Nurses support our public health care system. We want our patients to be able to rely on it. However, Bill 8 doesn't provide that guarantee, nor does it lay out a vision for rebuilding and restoring confidence in our public system.

During his February 16 presentation to this standing committee, Minister Smitherman admitted Bill 8 needed changes and later tabled a draft framework for amendments. While the draft framework provides some specifics, without actual wording it doesn't cover other concerns we intend to raise. Yet here we are today commenting on a bill that we know will change. This process is simply unacceptable to nurses. So ONA joins with the chorus of voices calling for the minister to table all of his specific amendments. Failing that, we urge the government to bring the amended legislation back to this standing committee following second reading for a detailed review.

The preamble to Bill 8 provides the government's vision for medicare in Ontario, confirming its commitment to medicare and the principles of the Canada Health Act: public administration, comprehensiveness, universality, portability and accessibility. It acknowledges, as did the Romanow commission's report, that primary health care, pharmacare and home care are vital to the future of medicare. It recognizes the importance of the principle of public accountability, which we interpret to mean accountability to the public. ONA supports this vision. Yet the health minister's public actions do not support the vision of medicare portrayed in the preamble.

In his remarks to the Legislature on introducing Bill 8, Minister Smitherman said, "Our new government has acted to ensure new hospitals in Brampton and Ottawa are publicly owned, publicly controlled and publicly accountable." To date, however, these negotiated deals have not been released to the public. This is not being publicly accountable. Indeed, when the deals are finally released, they will be final deals and not open to any public input process.

This secretive negotiations process, ostensibly in the name of protecting commercial confidentiality and competition, is the same rationale used to keep from the public domain contracts that are signed with for-profit home care providers under the managed competition system for bidding on home care contracts. This deplorable system that puts price before quality patient care remains intact under the Liberal government, plain and simple. It stands to reason that if making a profit is the goal, service will be rushed, rationed or reduced, and when that happens, patients suffer. These are some of the most vulnerable people in our society, including frail elderly and early discharges from hospitals, many of whom now require more complex care than ever before. This is not being publicly accountable.

Further, Minister Smitherman says the government "will soon move to ensure that private MRI and CT scan clinics ... are returned where they belong: to the public domain." That was in November, and this is March. We are still waiting for the minister to be publicly accountable.

Bill 8 could have been a great opportunity for the minister to put public uncertainty to rest and declare that there would be no expanded privatization of our public health care system, that further public-private partnerships involving our hospitals would be prohibited and that paying for private services such as medically unnecessary scans at private clinics would also be prohibited. We urge the committee to amend Bill 8 to clarify that further privatization of our public system is expressly prohibited.

Let me now talk more specifically about the model of accountability in Bill 8. The minister has said that all accountability agreements will be disclosed to the public. We also take this to mean that amendments will be made to section 29 to make it clear that all parts of any accountability agreements, compliance directions and any orders will be publicly disclosed. Accountability must include transparency, and this must not be left to the minister's discretion.

ONA believes that part III of Bill 8 introduces provisions that have the potential to undercut the provisions of a collective agreement. Obviously, this causes great concern to our members working in the health care sector. The language in Bill 8 is very broad and general and does not stop the government from prescribing unions as entities that may have to enter into an accountability agreement. In addition, the language used in defining the scope of an accountability agreement and the scope of the minister's discretion to issue directives is broad enough to encompass matters that touch upon collectively bargained rights. The minister's power to make orders for failure to enter into or comply with an accountability agreement or directive is also framed very broadly. The most significant details regarding the accountability measures and the minister's powers are left to be prescribed in regulations.

The minister has now indicated that solo physicians, group practices and trade unions are not considered health resource providers for the purposes of the legislation and as such would not be required to enter into accountability agreements nor be subject to any provisions of part III.

Hospitals, long-term-care facilities, community care access centres and independent health facilities would be subject to accountability agreements. We seek a further clarification from the standing committee as to whether home care providers are included as part of community care access centres.

In order to be crystal clear regarding the potential impacts on trade unions, we believe the amendment should delete the reference in subsection 21(1) that allows "any other prescribed person, agency or entity," through regulation, to be subject to accountability agreements. We also take the minister at his word that Bill 8 is not intended to impose additional accountability requirements on individual health care professionals, but that they would continue to be held accountable for their conduct through their professional colleges.

Let me now discuss other concerns we have with respect to part III. Bill 8 gives the government the power to create accountability agreements covering a wide range of issues. What may form part of an accountability agreement is defined very broadly in section 19. The definition is framed in such general language that it provides little real insight into the content or limits of an accountability agreement. Particularly in light of paragraph (d), an accountability agreement may touch on any matter that may be prescribed by the government. This does not provide our members with a great deal of confidence that accountability agreements could be prescribed to cover areas that would have a direct impact on their working lives.

**1010**

The minister indicated in his remarks to the standing committee that accountability agreements will be negotiated. Independence of governance structure—for example, executive board—will be maintained by requiring accountability agreements between the ministry and the health resource provider. The details of how this will work and who is able to make representations remain unclear.

This proposed amendment provides our members with more assurance that accountability agreements will not be imposed. However, we don't see the role for community involvement that the minister is willing to include in the preamble.

We are concerned about the ultimate scope of accountability agreements. Section 20 of Bill 8 sets out principles that the minister is to consider in administering all of the accountability measures in part III. However, this section does not impose any clearer limits on what may be included in any such agreement.

Some items, such as number 6, "value for money," cause us grave concern, since that term generally has been used most recently in the context of privatization initiatives in hospitals such as public-private partnerships. This is very worrisome to us.

Section 20 sets out that in administering part III of Bill 8, "the minister shall be governed by the principle that accountability is fundamental to a sound health system...." In administering part III, the minister is also required to consider the importance of the 12 matters identified "that the minister, in his or her discretion, determines to be appropriate in the circumstances."

Again, the factors to be considered by the minister are very broad. As a result, the minister has extremely wide discretionary powers to determine what may form the substance of any accountability agreement, even though such agreements are subject to negotiations between the ministry and the board of the health resource provider. The language in section 20 is certainly broad enough that an accountability agreement could encompass matters that touch upon collectively bargained rights.

It is for this reason that we urge the standing committee to consider an amendment that expressly precludes the minister from negotiating accountability agreements that would in any way override collective agreement rights and would prevent the ability to interfere with these rights.

Again, the minister has clarified in his draft framework that section 27 would only apply to CEOs, not trade unions or other employees, who are subject to an order under section 26. However, sections 22 and 24 in Bill 8 give the minister sweeping powers to issue directives to health resource providers or any other prescribed person.

The minister's ability to issue compliance directives is stated in the broadest possible language once again. What specific compliance measures may be prescribed are unknown until the regulations are drafted. On the existing language, it may be possible for the minister to issue directives or orders that affect collectively bargained rights.

Our final concern relates to what measures the minister may take where there is a failure to enter or comply with an accountability agreement or comply with a ministerial directive. The minister's power to make orders in relation to these failures to comply are set out in sections 26 to 28 of Bill 8. Once again, it is not possible to determine what nature of orders the minister may make under section 26, as the measures that may be ordered will be prescribed in regulations.

We therefore are seeking a further amendment to clarify that the minister's powers are not intended to be used to undercut collective bargaining. We note in particular that where a health resource provider's "funding is reduced, varied or discontinued" as a result of an order under Section 28, this could clearly have an impact on our employees and our members.

Part I of Bill 8 provides for the establishment of the Ontario Health Quality Council. While we support in principle the formation of an Ontario Health Quality Council, we question the value to Ontarians of a council that is restricted in function to monitoring and reporting on issues related only to quality and access.

We believe the council should be reporting on how Ontario's health care system measures up to the principles contained in the Canada Health Act. In our view, the council should have the ability to report on all parts of Ontario's medicare system as they relate to these principles.

Equally perplexing, the council has the power to report but not to issue recommendations. In subsection 5(4), the council is prohibited from making recommendations to the minister, except as it relates "to future areas of reporting."

This is even more disconcerting when we consider that clause 5(3)(b) lays out that one of the purposes of the council's reporting function is to "make the Ontario health system more transparent and accountable." We don't see how that purpose can be accomplished without the council having the statutory power to make recommendations rather than just reporting on access and quality.

A further concern is that details relating to the budget, operations and full powers of the council remain to be prescribed by regulation. We support a more inclusive process for the appointment of council members. Our preference is to have council members appointed through an all-party process or by a standing committee of the Legislature.

In addition, we support an amendment expressly stating the council will consult with and seek public and stakeholder input in the course of their duties. The council must be able to access the information it needs to meet its mandate. This process would carry added legitimacy to recommendations flowing from the council, if the standing committee adopts our amendment to permit the council to issue recommendations on what needs to be done to ensure the future of medicare in Ontario.

Part II in Bill 8 confirms the section 9 prohibition of physicians or designated practitioners from charging or accepting payment for more than OHIP pays for an insured service. We are concerned that clause 9(4)(b) does not close the door firmly on extra billing but may allow extra billing to be prescribed by regulation.

Section 15 confirms the existing prohibition against jumping the queue by paying extra for insured services.

Bill 8 does introduce two new changes regarding fees. Section 33 amends section 15 of the Health Insurance Act by prohibiting physicians and designated practitioners from opting out of the provisions of OHIP and receiving payment for insured services directly from patients. We support this change.

We also support the prohibition against block or annual fees in section 16 of Bill 8. Block fees for uninsured services, such as prescription renewal by phone, have become more common. Indeed, companies have been set up to manage block fee payments for physician practices.

We are concerned that subsection 16(1) does not fully ban block fees but allows for block fees to be charged if provided for by regulation. We support a full legislative ban on block fees. Patients must know the full cost of every uninsured service and must be able to pay for such uninsured services as they are used and not on an annual basis, paid in advance.

Registered nurses have long held that essential health care services should be delivered through publicly owned and not-for-profit organizations under the guiding principles of the Canada Health Act. The proliferation of private, for-profit delivery of health care services is a threat to medicare and must be stopped.

Our members believe that Bill 8 does not protect the future of medicare in Ontario. We urge the standing committee to adopt the amendments that we have put forth so that future generations may enjoy what we take for granted today: public medicare.

Relying on intention is not enough to guarantee that future. We ask that Bill 8 include specific prohibitions, as outlined. The future of medicare is too vital to our health and well-being to be left to good intentions.

Health care is a public service and a not-for-profit service. Nurses will vigorously oppose any legislation that results in the proliferation of privatization in health care in Ontario. Our vision is for an integrated health system that is publicly owned, funded and delivered, and accountable under the Canada Health Act.

We believe the Canada Health Act must be expanded to include home care, long-term care, pharmacare and reorganized primary health care. We don't believe Bill 8, as currently written, provides a firm foundation to build this future.

On behalf of the members of the Ontario Nurses' Association, I'd like to thank you for listening to this presentation. I wuld be pleased to answer any questions.

**The Chair:** Thank you, Ms Shannon. You've used up almost 18 minutes, so we're going to start with the opposition parties for two minutes. Maybe we'll have just one question this time.

**Mr Tim Hudak (Erie-Lincoln):** Ms Shannon, good seeing you again. You made an outstanding presentation. The only people who actually like this bill are the printers. There are going to be so many amendments for so many weeks to try to correct every mistake in this bill. Your presentation comprehensively outlined about seven or eight major problems with this bill. I don't have time to go into all of them.

What I wanted to concentrate on is the Ontario Health Quality Council. You point out that it actually has very little power to make any kind of recommendations to the system, that it's basically controlled by the minister, appointed by the minister and reports only to him. One suggestion that we're looking at is to make the health council come to the Legislative Assembly, to actually bring the report to the assembly as a whole, to the MPPs, just like what's happening with the Auditor General in Ottawa. Instead of hiding it with the minister, it would become public.

How would you feel about an amendment to make sure that the Ontario Health Quality Council reports to the assembly, as opposed to directly to the health minister?

**Ms Shannon:** I really can't comment on behalf of ONA on that amendment, but we definitely want it to be publicly accountable.

**Mr Hudak:** And the release should be to the public as a whole, as opposed to just going to the minister at his discretion for a release?

**Ms Shannon:** The most important part is that it actually has the ability to make recommendations.

**Mr Hudak:** Publicly.

**Ms Shannon:** That is the biggest problem that we see with it.

**The Chair:** There is still a minute remaining. Mr Kormos, would you like to use that?

**Mr Peter Kormos (Niagara Centre):** Just as we applaud the role of Ms Fraser up in Ottawa, we've called upon her to do an audit of the $5 million-plus that was paid out to Tory cronies, to Ontario Power Generation.

Thank you very much for coming, because I was here on the opening day, and the government was saying all these critics of this bill are all full of hot air, that everybody's wrong and they're right, even on the issue of queue-jumping. Just this morning, I'm driving down the QEW in my 10-year-old pickup truck and I'm listening to the radio. I've got the OMA telling the parliamentary assistant that basically she doesn't know what she's talking about when it comes to queue-jumping. Maybe legislative research could help us resolve this issue. Is queue-jumping a phantom, faux, a straw man as such, or is it a real phenomenon? Who is right, Ms Smith or the Ontario Medical Association? Neither of them is in my camp, so you can't accuse me of being anything other than impartial.

**1020**

**The Chair:** Thank you, Mr Kormos. Mr Craitor.

**Mr Kim Craitor (Niagara Falls):** First of all, thank you very much for coming out, Jo Anne. You and Kim were in my office a week or two ago, and I said to both of you that I thought it was extremely significant that you be here and that the committee hear your comments.

Just a couple of very quick things. First of all, there are some things I have learned as a new MPP. For example, previous governments, for whatever reason, didn't have these types of hearings after the bill left the House for the first time.

**Mr Hudak:** It's not true, Kim. You know that's not true.

**The Chair:** Order, please. I think we listened to you. You'll have your chance.

**Mr Craitor:** Obviously, the truth hurts sometimes.

The point I was making to you, Jo Anne, was simply that I felt it was significant for the committee to hear the comments you made to me and some of the concerns you expressed to me, even in my office. I do remember some situations, even with my local hospital here, when I stood in a room with you and the nurses, upset again with the previous government for some of the things they were doing to destroy our hospitals.

I just wanted to say thank you very much. There will be a number of amendments. There have been some put forward, but I know there will be some others, because of the input we're receiving from organizations like yours.

**The Chair:** Thank you, Ms Shannon. We appreciate your coming this morning.

## WEST HALDIMAND GENERAL HOSPITAL

**The Chair:** We're going to move on to our 10:20 delegation, which is from the West Haldimand General Hospital. Parry Barnhart, the vice-chairman, is with us this morning. Sir, you've got 20 minutes to use any way you see fit. If there is any time left over at the end of the presentation, we will ask you questions on a rotational basis. This time, the rotation would start with Mr Kormos.

**Mr Perry Barnhart:** Good morning, Mr Chairman and committee members. I am pleased to be here today before you to provide our comments and concerns with respect to Bill 8, the Commitment to the Future of Medicare Act, 2003.

My name is Perry Barnhart. I have served as a hospital trustee for the last 18 years. I have served as treasurer, vice-chair, chair, past chair and board secretary of the Haldimand War Memorial Hospital in Dunnville. Today I am here in my volunteer role as vice-chair of the board of governors of the West Haldimand General Hospital.

The West Haldimand General Hospital opened in 1964 and originally had 90 beds. The hospital now has 33 beds and provides acute and medical care, chronic care, 24-hour emergency services, primary health care services, a total of 10 other shared services with community partners, 13 specialist clinics and several health promotion programs. The hospital has been accredited for many years, and just recently it was successful again in receiving full accreditation. The hospital has a very strong auxiliary and an organized foundation. The hospital is located in network 4, with two other network partners, the Hamilton Health Sciences Corp and Haldimand War Memorial Hospital in Dunnville.

I might point out that the West Haldimand General Hospital's board of governors is supportive of legislation to establish the Ontario Health Quality Council and to enact new legislation concerning health services accessibility and to provide continuity in the health care sector. We appreciate the opportunity to be here today. I would like to state that the West Haldimand General Hospital supports the government's commitment to medicare and key aspects of Bill 8, including the adoption of the five key principles of the Canada Health Act and the inclusion of accountability as a sixth principle. However, we are very concerned, given the way the bill is drafted, that this legislation will have opposite effects and fundamentally undermine medicine in Ontario.

Regarding part I, the Ontario Health Quality Council, Bill 8 specifically prohibits board members and senior staff members of a health system organization from being members of the council. We do note that other organizations that represent physicians and nurses and other professional groups appear to be eligible for appointment to the council.

Further, it is unclear who is captured under the definition of a "senior staff member of a health system organization." We have raised the above issues because we believe it is important to ensure that the hospital

sector boards and administration perspectives are appropriately represented on the council or, in the alternative, that the principles that were considered in excluding hospital board members and senior staff members from council equally apply to the health system's other stakeholders that provide health care services or other major parties involved in the health care industry. We seek clarification of these issues and a reasonable balance of representation on the council.

Further, we are concerned that the proposed legislation should empower the council to make recommendations to the minister, including recommendations with respect to the minister's or ministry's responsibilities.

Finally, we believe that consideration should be given to putting in place a mechanism to ensure the independence of the members appointed to council. We want to ensure that any council reporting to the Legislature is not unduly influenced.

With respect to part II, accessibility, the board does have some concerns with respect to some aspects of the legislation. It appears, for example, that Bill 8 will prohibit hospitals from paying monies to hospitalists or physicians providing on-call services. I might advise that our hospital records indicate that over 60% of in-patient admissions are patients who do not have a family physician on staff. Therefore, the in-patient care for these patients is provided by physicians who are on staff. While the ministry has provided some funding—hospital on-call coverage, or HOCC, monies—the hospital does provide additional recoveries to physicians to ensure the continuation of in-patient care for these patients.

While it is not a serious issue for our hospital, it would appear to be a serious issue for many hospitals across the province. We do suggest, however, that any payments or fees paid to physicians to provide services to the hospitals across the province should be negotiated between the Ministry of Health and the Ontario Medical Association in their regular reviews of compensation, and that these negotiations be consistent across the province and included in the OHIP schedule of fees.

With respect to section 15, we note that Bill 8 prohibits a person or an entity from charging or accepting a payment or a benefit for conferring upon an insured person their preference in obtaining access to an insured service. This prohibition, together with the mandatory reporting provisions of Bill 8, and the sizable penalty set out in section 17 may create some difficulty to ensure that all employees and physicians adhere to section 15.

You will note that subsection (2) prevails. There is an obligation of reporting information. It is applicable even if the information reported is otherwise confidential or privileged. We suggest to the committee that a further review of section 15 and clarity with respect to some of the sections would be useful, particularly with respect to mandatory reporting and penalties for individuals and the corporation.

As to part III, accountability, we believe that rather than setting up a system of accountability in the health care sector, as the title suggests, part III of Bill 8 seeks to tighten the reins of the ministry over health resource providers, which includes hospitals. We believe the accountability measures undermine community involvement and the local voluntary governance of all hospitals in Ontario.

In particular, sections of part III provide the minister with the right to (a) require hospitals and hospital executives to enter into accountability agreements, (b) issue compliance directives to hospitals and hospital executives, and (c) unilaterally alter hospital executives' terms of employment. We suggest this fundamentally undermines the relationship between the CEO and the board and, in doing so, also calls into question the fundamental role of the board as the governing body of the hospital. The fundamental issue is the potential erosion of local volunteer governance that now ensures that our local community has a voice in accessing hospital services.

I'll now record our concerns regarding community involvement and governance. We suggest that Bill 8 undermines local voluntary governance of our hospital in two basic ways. First, by directing hospital boards to sign accountability agreements without negotiation or agreement, the government is removing an important check and balance in communities throughout Ontario, and particularly in our small rural hospitals. Second, by having the power to make an order affecting the employee of the hospital, the government is again usurping the role of the board in section 26 and 27. As a result of these changes, our community will no longer have a say in the hospital services they receive and how their local hospitals are managed.

**1030**

Unilaterally imposing agreements undermines governance and negates the Public Hospitals Act. Whereas it is determined that hospital boards are the "governing body or authority of the hospital," it undermines the board's responsibility in making decisions with respect to the hospital's administration and management. Further, we suggest it may well determine which services our hospital may be able to provide to our community. We suggest that our boards, composed of representatives from the community, signing an agreement that has not been negotiated or agreed to would effectively silence the voice of the community in making fundamental decisions about the hospital services in their community. We suggest that the minister and bureaucrats could unilaterally direct changes to health care services in our community that are not acceptable. We strongly suggest that accountability agreements must be negotiated.

All should be dealt with between the Ministry of Health and the board of governors, not the Ministry of Health and the CEO directly. The CEO is our only employee and definitely should be accountable to the board of governors. If Bill 8 is about accountability, the government has not tabled an agenda or rationale for the bill. Without such an agenda, we cannot hold the government accountable for their role in Bill 8 or for further upcoming amendments. We suggest that it would be difficult for a board of governors to have a commitment

to health care and a commitment to the government if both are not the same.

I might add that the hospital has an auxiliary that has 190 registered volunteer members. The auxiliary represents all service areas of our hospital and, in the last two years, provided almost 25,000 volunteer hours both in fundraising and serving our patients' needs. As indicated earlier, the hospital has been in existence since 1964, and to date the auxiliary has provided to the hospital a total of $862,617.39. We strongly suggest that without having community representation, this will compromise the hours spent and the monies raised for our community hospital, and the future of the hospital will be seriously compromised. West Haldimand General Hospital also has an organized foundation that has donated more than $1.2 million in new equipment and renovations over the past five years. These funds are donated locally by the community.

With respect to sections 26 and 27, providing the minister with the power to make orders affecting the employee of the hospital strips the board of its power under the Public Hospitals Act to determine the terms of employment of the senior executive members of the hospitals. If critical decisions with respect to the management of the hospital are made by the minister and the bureaucrats, and not by the local communities, this will erode public confidence in their local community hospital and again affect other volunteers throughout the community.

By putting in place mechanisms to have the CEO report to both the minister and the board and by granting the minister the right to unilaterally alter the CEO's agreement, the minister is interfering with a fundamental principle of corporate governance. The implication of this decision will seriously prejudice the board's ability to represent the interests of the community and to conduct themselves in their role on the board in a businesslike manner.

As suggested by one of our board members at our last meeting, it sets the hospital board of governors as puppets and would destroy the credibility of the board of governors in the community and hence compromise the ability of boards to find dedicated volunteers in the future.

We strongly suggest that the provision of Bill 8 that grants the minister the right to (a) require hospitals and hospital executives to enter into accountability agreements, (b) issue compliance directives to hospitals and hospital executives, and (c) unilaterally alter hospital executives' terms of employment all be deleted from Bill 8. Otherwise, Bill 8 will effectively convert public hospital corporations into government agencies.

We further suggest that the penalty provisions of the bill are inconsistent with the principles of volunteer board governance. Members should not be held liable or be subject to actions when they are acting in good faith on behalf of their community.

The ordering change of employment sections, 26 and 27, have been rejected by the British Columbia provincial auditor in his review of BC performance agreements as both detrimental to the governance of the organization and ineffective in improving performance.

With the regard to part IV, the Health Insurance Act amendments, subsection 40(3) of the bill would add provisions to the Health Insurance Act allowing the minister, upon the advice of the general manager and where the minister considers it in the public interest, to amend the OMA schedule of fees in any manner the minister considers appropriate. Currently, the Health Insurance Act provides that revisions to the schedule must be proposed by the OMA, not the minister. Such orders by the minister could result in unfavourable financial consequences to hospitals should the minister significantly lower the amount payable for certain insured services. We do not believe that the power to propose changes to the schedule of fees should be left to the OMA or to the minister without consulting interested parties. We also suggest that among the stakeholders, hospitals should participate and be consulted with respect to the schedule of fees that may affect them.

Our conclusions: We suggest that accountability agreements must be negotiated and that the independent nature of the relationship between the health care providers and the government be characterized by trust, mutual respect and collaboration, and that there is a requirement to respect community input through the role of the local voluntary governance of public hospitals. Also, we suggest that there must be due process for circumstances where an agreement cannot be negotiated or where there are disputes or misunderstandings. Where the agreements have been complied with, the bill should provide for government accountability.

It would appear that the accountability in Bill 8 is currently one-sided and is inconsistent with the government's commitment to a shared approach of accountability. Bill 8 fundamentally undermines the government's accountability to medicare, and the minister is no longer required to act in the public interest as defined in the Public Hospitals Act. We also suggest that Bill 8 excludes any legislative requirements to fund the system adequately, as set out in the accessibility provisions of clause 12(d) of the Canada Health Act, which, in the case of hospitals, stipulates that "The health insurance plan of the province must provide for the payments of amounts to hospitals with respect to the cost of insured services." We suggest that Bill 8 should define the key principles of the Canada Health Act and provide definitions for "accessibility," "universality," "medically necessary," "comprehensiveness" and "quality."

Finally, we suggest that Bill 8 must be amended to ensure that communities have a say in the services they provide and how the local hospital boards are managed; to ensure that both providers and the government are held accountable by Ontarians for health care they receive; and to ensure that Ontarians have access to the health care services they need, where they need them and in a timely fashion.

Lastly, from a very personal perspective, many hospitals have for many years had the benefit of very

stable boards, consisting of experienced and knowledgeable trustees. These people simply have a very committed interest to pure health care in their community as it affects the bigger picture. I am afraid if Bill 8 comes to fruition in its proposed form, many of these trustees will find themselves rendered useless in their roles and will likely cease to continue in their various positions on hospital boards.

The loss of this valuable asset to the hospitals, to the community and to the Ministry of Health will be devastating to local health care everywhere, especially to small urban hospitals in Ontario.

I'd like to thank you for allowing me the opportunity to present this.

**The Chair:** Thank you, Mr Barnhart. You've left us with about a minute and a half each for questions, starting with Mr Kormos.

**Mr Kormos:** You've talked about accountability, and I couldn't agree with you more. I was so heartened when the Ontario Health Coalition in Toronto the other day proposed direct election of hospital boards from the community the hospital serves, something I've believed in and advocated for a long time. What's wrong with that proposition, if anything?

**Mr Barnhart:** From a personal perspective, it doesn't bother me. Direct election of hospital board representatives would be fine. As to how the other board members would think about it, I don't know.

**Mr Kormos:** It would be the same way we elect city councillors or MPPs or trustees on boards of education. That, to me, is accountability.

**Mr Barnhart:** Except it goes back to a problem we've discussed on our board for many years, and that's payment. If a person is elected, they probably expect to be paid. We don't get paid, and we don't expect to be paid. It takes our accountability to a little different level. We're there because we really want to be there. We're not there for a particular amount of money.

**Mr Kormos:** You want to be there.

**Mr Barnhart:** That's right. We want to be there, but we don't want to be there for payment. That's what has always—anyone who is elected to any office is normally paid something. That's the only issue I have with it.

**Mr Kormos:** OK. Thank you.

**The Chair:** Ms Smith.

**Ms Monique Smith (Nipissing):** Thank you, Mr Barnhart. We appreciate your presentation today. Are you aware that the minister presented to this committee last week a framework for the amendments that are going to be brought forward with respect to this legislation?

**Mr Barnhart:** I've read a few of those amendments, yes.

**Ms Smith:** I'll make sure you have a copy. I'd just note that many of the concerns you've raised today are addressed in the framework for amendments, including a definition of senior staff with respect to the Ontario health council, a definition of a health system organization. Basically, we're looking at stakeholder groups, not boards of hospitals, so board members would be entitled to sit on the council. Payments to hospitalists—you were concerned about that—will be addressed in the amendments. Greater whistle-blowing protection with respect to queue-jumping will also be addressed. The fact that the accountability agreements will be between the board and the ministry, not the CEO and the ministry, will be addressed. The fact that the accountability agreements will be between the board and the ministry, not the CEO and the ministry, will be addressed. I think that will go some way to quelling your concerns about interference with governance. Some of your other concerns are also addressed. I'll make sure that you have a copy of this.

I just had one last question. Would you be in favour of negotiated accountability agreements between the ministry and hospitals?

**1040**

**Mr Barnhart:** Yes. Can I make a comment about your remarks? We had drafted this speech and rewritten it a few times. I realize, from reading the amendments on the weekend, that some of those things were addressed. However, those are only proposed amendments, and this was actually a written presentation. Because they are only proposed amendments, we wanted to make sure we got our point across.

**Ms Smith:** I appreciate that input. Thank you.

**The Chair:** Mr Hudak.

**Mr Hudak:** Thank you very much, Perry, for the presentation. The Chair and committee members may know that Perry served as a board member at the Haldimand War Memorial Hospital in my riding, in Dunnville, recently recognized as one of the top hospitals in Ontario.

I'm glad you're here. I think you made an outstanding presentation. Despite my colleague the parliamentary assistant's discussion on what is actually an outline of amendments, not actual amendments, I think what we're worried about on the opposition side is that it's written in the same disappearing ink their campaign platform was written in. I think it's important to keep pressing these issues. They could have come in at any time during these hearings and actually put amendments on the table. We could have altered the bill as we went along to assuage some of the concerns that small hospitals have.

I think you make an outstanding point, well put, that this bill, if passed, would make local volunteer boards of governors mere puppets to the Ministry of Health. I think that was well put by one of your board members in the presentation. I'd like you to reinforce a bit another concern you brought up that I think is important: small-town hospitals are having a great deal of difficulty recruiting doctors. Sometimes they have to make alternate funding arrangements to recruit doctors, particularly for emergency and on-call services. Can you discuss again the importance of that for communities, like in Haldimand county, and how this bill would interfere with them?

**Mr Barnhart:** In our community hospital in Hagersville, we only have really five or six doctors who provide

services in the hospital. Because of the lack of family physicians, well over half of our emergency visits are people who don't have GPs, so they come to the hospital and have to be served by our doctors. There has to be some kind of incentive available to do that. We have over 18,500 emergency room visits, and without enough GPs it's almost impossible to deal with that number of people.

**The Chair:** Thank you for coming today. It was appreciated.

## CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 7100

**The Chair:** Our next delegation this morning is from the Canadian Union of Public Employees, local 7100, Hotel Dieu hospital. Stephen Palmer, the president, is with us this morning—and somebody else, obviously. If you would, introduce yourselves for Hansard when you do begin. You've got 20 minutes. You can use that any way you like. At the end of your presentation we'll split the time amongst the three parties that are represented here, starting this time with the Liberals. I've got 10:45 and you've got 20 minutes.

**Mr Stephen Palmer:** Good morning. My name is Stephen Palmer and I'm making this presentation on behalf of the members of CUPE Local 7100, of which I am the president.

CUPE Local 7100 represents 530 service and clerical employees at the Hotel Dieu Health Sciences Hospital in St Catharines. The jobs we perform include paramedical services for the Niagara region, diabetic services for Niagara, addiction intervention, both male and female, regional dialysis services and a multitude of services provided by a full-service general hospital.

We bring to this committee the experience of front-line hospital workers, I myself being one for the past 33 years. Many of our members have served Ontario hospitals for decades. Although we receive little of the glory, our work is vital for the functioning of Ontario hospitals. Our members provide the core of Ontario hospital services even in the face of such diseases as SARS, West Nile and a multitude of other such illnesses. We are the backbone of hospital infection control. We have faced hospital-based infections. We have campaigned for public health care. We have fought privatization, still are going through hospital restructuring, and we are constantly called upon to defend the rights and dignity of hospital workers.

We have, over the past eight years, had to constantly live with the threat of hospital closures and job loss. We have dealt with stress day after day while always putting our patients and co-workers first, because the staff of Ontario hospitals are there out of a duty of commitment and loyalty to the people they serve.

The Ontario Liberal government introduced Bill 8 with great fanfare on November 27, 2003, less than two months after being elected. The members of local 7100 agree that Bill 8 holds some worthwhile goals, most of which are already set out in existing legislation. But the bill also creates some serious concerns for the health care industry. Bill 8's preamble is filled with noble sentiments. There is little that is new, however, and little that is not already present in Bill 8's predecessor, the Health Care Accessibility Act.

Minister Smitherman touted a promise made on P3 hospitals, which has already been broken, when he introduced Bill 8. While the Liberals campaigned against public-private partnership hospitals during the election, they are now implementing a similar model of P3 hospital in Brampton and Ottawa. Hundreds of jobs will be privatized, and well over a billion provincial health care dollars will be turned over to giant for-profit transnational corporations. We find it hard to see how Bill 8 puts an end to creeping privatization, particularly as we have learned that this government has allowed six other hospitals to investigate redevelopment using public-private partnerships.

This raises questions from our membership about how seriously we should take the government's stated purpose concerning Bill 8. Is there another agenda? A better start for Bill 8 would have been for the government to shut down the for-profit clinics and make P3 hospitals public facilities.

The part of Bill 8 that is of greatest concern to our members relates to part III, sections 19 to 32. Specifically, we are concerned about the broad powers of the Minister of Health to require accountability agreements or to issue compliance directives. While the government has made much of the accountability set out in the act, one must note that the accountability in this part of the act is accountability of health care providers to the government and not accountability of the government to the public it was elected to serve.

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

Under the provisions, the ministry can direct any health resource provider or any other person, agency or entity that is prescribed by regulation to enter into accountability agreements with the ministry. The term "health resource provider" is broadly defined. A trade union, for example, might well qualify under the broad definition of "health resource provider."

The ministry is also empowered, in section 22, to "issue a directive compelling a health resource provider or any other ... person, agency or entity to take ... any action that is specified in the directive or to comply with ... prescribed compliance measures." There is little limitation on the scope of such directives.

The ministry's discretion is as wide as the government determines it should be. These powers could be used for health care reorganization, hospital restructuring, privatization or other initiatives.

Section 27 of the bill even provides that where an order makes significant changes in a person's terms of

employment, including a reduction in compensation, these changes shall be deemed to have been mutually agreed upon between the person and his or her employer. Under the bill, a health care union and an employer could be ordered to address certain issues through collective bargaining and, in the event they fail to do so, could be ordered to reduce wages or benefits or eliminate no-contracting-out or successor rights language contained in our collective agreements. Just as bad, the minister could simply issue a compliance directive requiring the collective agreement protections to be modified or overridden entirely.

**1050**

Under part III of the act, hospitals could be ordered to consolidate services such as housekeeping, laundry or food services, and require collective agreements to be altered to facilitate these changes. Regardless of any restructuring, the minister could simply order a reduction in wages and benefits for our members. In a free and democratic society, we should not have to resort to counter-arguments to address such a potential threat to collective bargaining.

Taken together, all of part III could be viewed as an attempt to bestow upon the minister and the government virtually unlimited authority to order and direct fundamental changes to the health care system and to do so in a top-down dictatorial manner, without any traditional procedural safeguards or limitations.

The bill seeks to insulate the crown and the minister from any legal liability resulting from any actions taken in connection with accountability agreements or compliance directives. On the other hand, anyone who fails to comply with an order by the ministry relating to accountability agreements or compliance directives is subject to prosecution and if found guilty may be subject to a fine of up to $100,000.

Service and office employees are some of the lowest-paid employees working in the hospital system, and yet we are presently the main target of hospital privatization and restructuring. The privatization of hospital services in British Columbia has meant mass layoffs and a radical reduction in workers' compensation. Our livelihoods, our homes and our future retirement are on the line. We take any threat to our collective agreements very seriously. We hope this committee will too.

We have endured massive hospital restructuring under the previous Conservative government, and in our view it did little or nothing to improve the hospital system. It did, however, disrupt the lives of tens of thousands of hospital workers and their families.

We work in the dirtiest environment one can be subjected to, and we are under constant threat of any number of communicable diseases, some life-threatening. Still, we persevere. Constant changes and restructuring only add to the tremendous stress we find ourselves working under on a daily basis, stress that at times is passed on to the people we serve.

While the last round of hospital restructuring did little to improve the previous government's popularity, at least there was a process in place for some consultation with the community through the Health Services Restructuring Commission. Bill 8 raises the possibility of restructuring through ministerial directives, a much worse possibility. We cannot understand why the Liberal government would choose to proceed in such a high-handed and brinkman-like manner. It raises great danger for a health care system that has already been under great stress for a number of years. We had hoped the new government understand this.

We support many of the principles of Bill 8. Universal medicare is Canada's most cherished social program. It helps define us as Canadians. We are not sure why the government chose to introduce Bill 8, which gives such sweeping powers to the Minister of Health and Long-Term Care. However, legislation does not turn on the intent of the legislators; its power arises from the meaning of its words.

We would like to pass on to you in written form key changes required to deal with our concerns about part III of Bill 8: First, no trade union shall be required to enter into an accountability agreement or be subject to a directive; second, no collective agreement shall be the subject of an accountability agreement or directive; third, no accountability agreement or directive shall directly or indirectly affect the continued operation and enforceability of a collective agreement or amend its terms; fourth, no employer shall be ordered to enter into an accountability agreement which directly or indirectly interferes with the provisions of a collective agreement; and fifth, notwithstanding sections 21, 22, 26, 27 and 28, no accountability agreement entered into under section 21, compliance directive entered into under section 22 or order made under section 26 shall (1) directly or indirectly affect the continued operation and enforcement of a collective agreement, (2) try to amend, vary or discontinue the terms of a collective agreement, (3) require the parties to a collective agreement to amend, vary or discontinue the terms of a collective agreement and (4) directly or indirectly interfere with the ability of the parties to a collective agreement to comply with the terms and conditions of such an agreement.

CUPE and other health care unions have been told by the Minister of Health and the government not to fear Bill 8, and that its intent is not to override or interfere with collective agreements, as was the case with Bill 29 in British Columbia. We say, make the changes we seek and put trust back into government.

We also believe the government should reconsider the powers the bill may give to the Minister of Health to reorganize and restructure health care. The hospital system has already undergone extensive reorganization over the past eight years. Allowing the minister to unilaterally impose more is a recipe for strife and chaos that may well push hospital employees to the brink.

Canada is one of the most desirable places on earth to live, and our health care and the dedicated staff supporting it are one of the main reasons Canada stands out above most other countries. Slowly but surely our health

care system is being eroded. A once-envied health care system is now one falling into disarray from constant government interference and mismanagement.

On behalf of the 530 members of local 7100 that I have the privilege to serve, I would like thank you for your time and interest.

**The Chair:** Thank you, sir. You've left us with about six minutes. We're going to start with the government.

**Ms Smith:** I think she has—

**The Chair:** Oh, I'm sorry.

**Mr Palmer:** There's a continuance, Chair.

**The Chair:** OK, then you have six minutes left.

**Ms Lydia Mazzuto:** Greetings to the members of the committee and opposition members and members of the public who have come today. I sit here today as a member of CUPE 7100. I am a former executive member of the Ontario Health Coalition and a co-chair of the Niagara Health Coalition. There is an attachment that has been added.

**The Chair:** Could we have your name as well?

**Ms Mazzuto:** Lydia Mazzuto.

The attachment that has come with the CUPE 7100 presentation that Steve gave is entitled Bill 8: A Closer Look. This is a presentation component that we are doing to highlight some of the issues that we feel are very important and that the bill needs to address a little more closely. Those three key areas are: privatization; the importance of support staff workers in the health care and hospital sector; and the very important aspect of the uniqueness of individual communities, particularly the Niagara region.

Bill 8 is a proposed piece of legislation based on the provincial Liberals' election platform. Its primary goal was to enhance the Canadian health care act. While the legislation purports to defend the principles of the Canada Health Act, Bill 8 does nothing to defend or truly address comprehensiveness, accessibility, universality and the single-payer system.

Part I of the bill provides for the establishment of the Ontario Health Quality Council, consisting of nine to 12 appointed members reporting to the Minister of Health and Long-Term Care. This is an appointed council, not representative of a democratic council accountable to the public. There are no restrictions on appointing members who have a financial interest in for-profit health corporations to sit on council. Its purpose is not to provide accountability and monitor the prohibition of a two-tiered health system.

Interestingly, it would report and monitor, but not provide recommendations on, areas the bill's preamble defines as a primary focus of the bill: promotion and protection of the Canada Health Act. Restrictions on recommendations are only on future areas of reporting, not ones already approved by the minister. The minister need only table a "report" that presumably has to do with the council's own annual report within 30 days of receiving it. The public, again, is not privy to the council's submitted report, only the minister's response to it.

Contrary to putting an end to privatization, this bill invites it, reminiscent of hospital services privatization in British Columbia. Unionized workers there were laid off en masse after similar legislation was passed in 2002 that saw drastic reduction in salaries and, for many, the elimination of hard-won benefits. Hospitals already account for a decreasing share of health expenditures, in terms of expenditures per capita and overall share of costs.

We would caution the continuous move toward the privatization of hospital services by looking at and applying a private sector management approach in order to deal with reduced budgets. Private sector management approaches that mimic commercial management approaches, like total quality management, have already been seen in the hospital sector. With an emphasis on cost effectiveness and value-added business philosophies more suited to the hotel and tourism industry, hospitals and health care programs will suffer. In recent years, hospitals have implemented this odd approach to health delivery—again, an approach more suited to hotels than hospitals.

Instead of reducing services, some hospitals are already contracting out services to private, for-profit companies. A large number of hospitals purchase their laundry, cleaning, environmental and dietary services from commercial companies. Commercial competition has its drawbacks, especially when we can track the move of hospitals to reduce their own services until they are just a skeleton. This creates a long-term, even permanent, dependency on private companies who see profit value, not public value, as their bottom line.

**1100**

Interestingly, the motivations of profit-seeking corporations are in direct conflict with the principles of comprehensiveness, accessibility, universality and the single-payer system. Fluctuating administration fees alone are taking a toll on hospital budgets. Hospitals are already finding out that while services may seem cheaper at the onset when contracted out to companies with non-union employees, quality and consistency have already had their effect on patients.

Undoubtedly, front-line and support staff are a large part of hospital budgets, but equally so, the same people are cost-effective in themselves. Purposes varied, it is the establishment and consistency of qualified health care and support workers that help keep extra costs away:

—Cutting staff in order to close beds and discharge patients earlier, or not admit them at all, has often led to higher rates of readmission and significant declines in a patient's physical and emotional health.

—Qualified registered nursing assistants provide front-line care. RPNs have already been downloaded more responsibilities that were once only provided by registered nurses.

—Qualified unit aides support all aspects of care.

—Full complements of dietary staff help keep patients safe; for example, diabetic or pre-diagnostic patients from being served unsafe or improper food, which can cause harm and extended hospital lengths of stay.

—Cleaning and maintenance staff reduce rates of hospital-based infections. In the wake of international public health threats like SARS, it's very crucial to recognize this.

I'm going to just skip through a little bit.

The importance of the unique community needs of the Niagara region: Unique community needs are not addressed through this bill or its proposed unrepresentative council. Niagara region, like all communities in Ontario, is unique in its own identity. Our region is both rural and urban, and has industrial and commercial pockets, while still trying to maintain our prime agricultural, natural and protected lands, parks and conservation areas. Niagara has the second-largest senior population in Canada, and its current estimate of 17% is expected to increase significantly over the next several years. As our senior resident population grows, so will our health care needs.

According to 2004 demographics, Niagara's residents have a higher individual cost of health and personal care expenditures than many communities in Ontario. Much credible research like that of the World Health Organization supports the theory that income and poverty levels have direct impacts on an individual and their family's health. While some of our communities face an unprecedented decline in their income levels, effects on health care are at greater risk of declining too. Niagara has lost thousands of jobs and is currently facing thousands more lost jobs and declines in real income. This is a serious threat to the health of our citizens.

Niagara's unique geography embraces an international boundary with the United States. At one time, special needs as a tourism centre were the most recognized factors in specialized demands for our health care system. In recent times, both disaster preparedness and local and international public health challenges add to our discussion. In 2003, Niagara's chief coroner stated that disaster preparation should not be reduced to concerns of terrorism. Niagara's busy industrial sector and its proximity to the border and energy generation facilities mean the region needs to be ready for more common disasters such as chemical spills.

Niagara's hospital and its staff need to be ready and able for these very real concerns. We implore you to take our concerns seriously and make real and effective changes to Bill 8, changes that would truly support the goals of a strong public health care system.

**The Chair:** Thank you, Ms Mazzuto. That was about as close to 20 minutes as you could get. We appreciate that. If I hadn't interfered, you guys would have had it perfect. Unfortunately, there is no time for questions, but we do appreciate you coming today.

## PROVINCIAL COUNCIL OF WOMEN OF ONTARIO

**The Acting Chair (Mr Kim Craitor):** Hi, Kim. I like that name. You're here on behalf of the Provincial Council of Women of Ontario. The rules are pretty straightforward. You have 20 minutes. If you don't use up all your time, there will be time permitted for each of the three parties to ask you questions. Go right ahead.

**Ms Kim Stasiak:** It's a pleasure to be here today. Good morning to the members of the standing committee on justice and social policy, and thank you for this opportunity to come and to speak to you. I'm presenting on behalf of the Provincial Council of Women of Ontario. It was established in 1923, and I want you to know I am not one of its original members. I am presenting on behalf of our provincial president, Jacqueline Truax, who lives in Etobicoke.

The Provincial Council of Women of Ontario represents many thousands of citizens within this province whose aim is the betterment of conditions pertaining to family, community and society. Each year, Provincial Council of Women of Ontario affiliates research and develop policies in areas of concern, such as health, safety, education, the environment, land use, justice and senior issues, which are presented in our annual brief to the government at Queen's Park. The Provincial Council of Women of Ontario is composed of six local councils in London, St Catharines, Windsor, Hamilton, Toronto and Ottawa, and 13 very diverse province-wide organizations, such as the Elementary Teachers' Federation of Ontario and the Older Women's Network.

Provincial Council of Women of Ontario is also an affiliate of the National Council of Women of Canada, which was established in 1893 and has developed strong policies on health care. Provincial Council of Women of Ontario is committed to the principles of the Canada Health Act, believing that quality health care is for all Canadians and should remain universal, portable, comprehensive, accessible and publicly administered. Therefore, we are pleased to have this opportunity to present our views regarding Bill 8, and help realize what its title claims: a commitment to the future of medicare.

We actually want to ask you some questions about the bill. In order for Bill 8 to be fully supportive of the future of medicare and the principles of the Canada Health Act, as well as responsive to the health needs of Ontario citizens, it needs to clearly set out how it will enhance all the above-stated principles. A bill for the people should be well understood by the people it is to protect. With this in mind, we ask the following questions.

(1) What is in the bill to ensure public delivery of health services rather than public-private partnerships?

The discussion of more P3 hospitals, further private clinics and private CT and MRI services has not gone away under the newly elected provincial Liberal government. In fact, they are back on the burner again and making headlines. The Council of Women is concerned that public money may be used to pay rent or, as the revised government contracts state, mortgage payments to the private sector in these private-public health care ventures.

For hospitals, the risk lies in a reduction of hospital beds justified in the name of efficiency, reduction of staff in the name of cost savings, and decreased levels of

service for high interest and profit returns. This is 15% to 25% for private profits or 15 to 25 cents out of every health care tax dollar. If it goes for private partner salaries and stockholders' returns on investments, it is not going toward health care. How is this more affordable? How is this protecting accessibility and decreasing waiting lists that were prioritized under Bill 8?

**1110**

If Bill 8 is going to stop two-tier health care and add provincial protections for the Canada Health Act, it should include prevention of further private partnerships in this public domain. This has not been made clear or well defined in Bill 8. We support publicly funded and operated hospitals as a better investment for better care, for healthier communities and for a shared public well-being.

To back our view, we note the evidence from Great Britain, which showed that private-public partnerships led to actual staff reductions, fewer hospital beds, and decreased levels of service in the name of cost savings in the health sector. In fact, a 30% reduction of staff occurred and 26% of the beds were closed.

Also, our American neighbour has pursued health care in the private sector and actually reversed the shared public-private provision that we now have in Canada. In Canada we presently have an average 70-30 split of public to private sector, while the US has developed into a 30-70 combination of public to private. This was a relatively fast change of provision in the US in less than 10 years and people were left out, and they continue to be left out. Over 43 million Americans have no coverage, and over 100 million have inadequate health care coverage. It costs twice as much per American citizen to provide this private sector care. One of the richest and most powerful countries in the world rates higher than Canada in infant mortality rates, and while Canada ranks second in the world for life expectancy, the US rates 25th. This is not an indicator for such change here.

A significant risk factor for the private sector is the higher cost of borrowing. This, and the necessity to make a profit for investors, leads them to charge more on public mortgages or rents, take control of non-medical services such as housekeeping, kitchen, maintenance and laundry, and cut corners in actual service delivery.

Further risks of these private-public ventures are that it may well reduce public donations to hospitals as well as community contributions, that collective and individual money gifts to these facilities could be affected, and that it could discourage volunteer hours. Even corporate donations from local industries or business may disappear. When a private partner is taking profit out of the services, many will not add to this possible profit-taking. This could very well happen, and it may already have negatively affected TVOntario. In that case, rumours of privatization make the public nervous about donating until its future as a public broadcasting station is assured.

The accountability you want enshrined in this bill can only come with public ownership. Do not fall victim to the recent claims that ownership does not matter as long as we are still publicly administering the health care service or paying with our OHIP card. The private control over mortgage and non-medical support services will cost more and the public will reap the losses in health care.

Most important for the Provincial Council of Women of Ontario, these private-public partnerships could be the thin edge of the wedge for the actual dismantling of the Canada Health Act. With this concern are the world trade agreements and that the profits made in such hospitals can then be demanded by foreign investors. Our public and national control could be lost even further.

(2) What services is the government intending to preserve, and is cost control the only motive in Bill 8?

We have seen what has happened in our home care services when funding is the only consideration or motivation. The private sector appeared to offer a better deal and underbid the non-profit provider. This was an effect of frozen funding to community care access centres, who were forced to hire the cheapest service providers through the bidding process. This was compounded not only by the funding limitations but the increasing caseload as patients were discharged from hospital quicker and sicker. Hospital staff can testify that many of these patients came back into the hospital with problems of pain control, infections, or inability to cope without assistance in their everyday needs and living. This is well known. As well, longer waiting lists occurred, fewer patients qualified or were even allowed such covered service, many went without, and a higher, more complicated level of comprehensive care was needed in the community.

Cheaper was rarely better. The historically reliable VON and Red Cross often lost contracts because they could not pay health professionals or well-trained staff their deserved wages and ensure appropriate staff levels in order to underbid the many private, sometimes American, and often unknown agencies. Many nurses who remained were given unreasonable workloads and time restraints to do their treatments and care. This created stress, frustration and burnout. The cheaper agency used less-qualified staff. This added to patient dissatisfaction and distrust. Certainly this is a concern Bill 8 needs to address.

In Bill 8, discussion of funding appears mostly in the form of meeting government requirements, with actual penalties for CEOs and their administrations if budgets aren't therein adhered to. Hospitals can even lose their funding for such failures. This is cost control, but it's not accountability. Adequate budgets must be mutually decided, and the Ontario Health Council should have input.

However, local needs do vary, and even provincial requirements can change in the course of a year. SARS and what happened in the spring of 2003 is our best example and is certainly not a lesson we can take lightly. It cost lives of patients and professionals. Our hospitals were running on bare-bones funding that not only caused failure to maintain infrastructure; proper isolation rooms and units were also limited or non-existent because of bed and ward closures. We can barely meet the everyday

demands in our hospitals now, but when such an outbreak occurs we are unable to meet safe standards of care. Demands and control of budgets are not solutions unto themselves. We must assess and determine the needs on an ongoing basis. If the government desires spending accountability in our health care services, it must make sure the necessary dollars are there to provide the service, or nothing is accomplished in this bill.

Regulation of costs can be achieved by ensuring proper staffing levels for patient care. This prevents added costs we now pay for overtime hours worked, costs of recruitment measures as discouraged staff leave, or compensation costs for overworked and injured health care workers.

Another solution, and to support the publicly administered system we want for health care under the Canada Health Act, is to change appointments of boards of directors for hospital and other health care organizations to elected members. This is also true democracy within the system. Appointed boards of directors may be sincere individuals, concerned for the community's well-being, but rarely have prior knowledge of day-to-day operating and patient care issues. Elections would be more likely to look into the qualifications of a candidate for this position.

The other concern is that—and this is off the record—the CEOs have had choice in who was appointed on their boards. I know that the gentleman from West Haldimand General Hospital spoke to the fact that it was a volunteer position, and it is an important job. It was also very prestigious; it was an honour to be there. Sometimes the CEO recommended you. Well, if the same CEO who recommended you comes back and says, "I think I need a raise, Joe. I work very hard. You're going to do that for me, right?" it puts that member in an awkward position. Actually, it puts them in a position of conflict. So that is why I would like to see elections. We do want more democracy and transparency.

**1120**

**The Acting Chair:** You have a minute left, Kim.

**Ms Stasiak:** OK. How did that go so fast?

(3) How does Bill 8 ensure proper levels of care and coverage, and include meeting staffing requirements?

Bill 8 talks about regulations by the health minister in consultation with and provided by the new Ontario Health Quality Council. We're happy to see this and do believe the health council can begin a public process for further improvements and suggestions to help our cost savings, develop best practices, provide better assessment of patient outcomes and care, and also assist in continued quality health care for an ever-evolving system. These are more of the mandates that these councils need to have. It would also be good to look at electing these officials and making sure they have proper qualifications for the job.

Our system has been stagnant for years, with claims that exorbitant costs and limited funding are the reasons we couldn't keep up or improve. This is a myth. It costs more not to provide adequate funding. Late or delayed care or insufficient care in our hospitals, nursing homes and communities costs the government more. Lack of staff and services has done this over the years. Emergency rooms have become catch-bins to downed community service and non-urgent care due to lack of family physicians in the community. This is too expensive for routine problems. Primary care reforms must be brought in.

Neglect of untreated high blood pressure can lead to strokes and disabilities. Shortness of breath could just be a minor chest cold or it could be pneumonia or serious congestive heart failure. Instead of a simple water-reducing pill or antibiotic, it ends up that the patient comes into emergency in the middle of the night and is in ICU for a few days but his doctor's appointment isn't for a week. Long waits for knee or hip replacements due to arthritis mean longer recoveries and less independence. Diabetics can end up on dialysis if they're not monitored properly. Cardiac patients who have to wait for angiograms and angioplasties may have another coronary or heart damage. Cancer patients run the risk of advances in their disease. These complications cost and they're due to delayed care. Staffing and the availability of health professionals has become the issue.

Hiring full-time now will solve 50% of the nursing shortage. Providing improved work environments for nurses and doctors will retain and attract more. Hiring graduate nurses full-time from this year's nursing programs will immediately help your shortage concerns. This is not evident in Bill 8, but it is necessary.

Conclusion, finally: The Provincial Council of Women of Ontario look forward to the government's response to our many concerns with Bill 8. As the bill goes forward to its final reading, we trust that you will make the necessary changes to more clearly prevent further privatization of services, preserve key services that will save money in the long run and ensure good patient outcomes and provision of care. More important, we trust the final legislation will truly be a commitment to the future of medicare.

**The Acting Chair:** Thank you very much. Unfortunately, we don't have any time for questions. I'm glad you were able to get your closing comments in, in the last minute. Again, thank you very much for taking the time.

**Mr Kormos:** Chair, I know you know and Mr Hudak knows and I know, but the rest of the committee doesn't know that Ms Stasiak has been a driving force behind the survival of public health care here in Niagara region, and the folks down here are very grateful to her.

**The Acting Chair:** Well said, Peter.

**Ms Stasiak:** Thank you, and I trust you will be too.

## ST CATHARINES AND DISTRICT LABOUR COUNCIL

**The Acting Chair:** Our next presenter is the St Catharines and District Labour Council, Sue Hotte, who is the president, and Malcolm Allen.

**Mr Kormos:** Sister Hotte and Brother Allen.

**The Acting Chair:** Let me finish. Thank you, brothers and sisters, for coming. You have 20 minutes and, time permitting, we'll have questions from each of the three parties. I'll let you start off, Sue.

**Ms Sue Hotte:** Thank you for the opportunity to present.

The St Catharines and District Labour Council represents 36 union locals and 15,000 unionized workers in the area north of the Niagara Escarpment stretching from Niagara-on-the-Lake to Grimsby. We have long been involved in many economic and social issues in our communities, such as health care, and we welcome this opportunity to speak to you today.

We are all very concerned about the state of our health care system, a system struggling with huge financial shortfalls and shortages in medical professionals. The previous government's policies have resulted in the virtual elimination of organizations such as the VON, the proliferation of user fees and the establishment of private MRI and CT clinics and P3s.

The newly elected Ontario Liberals ran on a platform of change. They promised to invest in health care, education and other essential social services, to eliminate public-private partnerships, P3s, and for-profit MRIs, CT and CAT scans. They have followed through on their promise to reform the health care system with the introduction of Bill 8, the Commitment to the Future of Medicare Act, to replace the existing Health Care Accessibility Act.

Unfortunately, we have serious concerns with the present draft of Bill 8. We would like at this time to draw your attention to some of its major weaknesses and to offer our views on how some sections could be changed.

If we look at the preamble of the bill, it supports the principles of a publicly funded and administered health care system as currently found in the Canada Health Act. Unfortunately, it does not further the implementation of these principles. It leaves the door open for a two-tier system, extra-billing and user fees. There is also nothing in the draft legislation which addresses the concerns with pharmacare and primary health care.

**Mr Malcolm Allen:** Ontario Health Quality Council: The Ontario Health Quality Council, as outlined in part I, sections 1 through 6, is only to monitor and report to the public on the following: access to publicly funded health care services, health human resources in publicly funded health services, consumer and health status, health system outcomes, and continuous quality improvement. They do not have to monitor and report on whether or not they conform with the principles outlined in the preamble of the bill. These are (a) the principles of public administration, comprehensiveness, universality and portability as enshrined in the Canada Health Act, and (b) two-tiered medicine, user fees and extra-billing.

Our second concern regards the selection of the members for each council. There is no accountability to the public since the public will not elect the members. The process is neither open nor transparent. Decisions are made behind closed doors. Will the council be inclusive and have members from diverse groups such as patients, health care workers, patient advocates and others? Will one or more members be from the public or from the for-profit sector? Will all who have a conflict of interest with the principles of the Canada Health Act be excluded from the council? The Ontario health council should be democratically selected, and all decision-making should be open and transparent.

A third concern we have is that the Ontario health council cannot make recommendations as to how the health care system could be improved upon and how it is conforming with the principles stated in the preamble. This begs the question, why set it up, a powerless body? Is it only to placate those advocating for accountability and transparency? The Ontario health council must be empowered to make recommendations for future actions and directions which have a positive impact on our medicare system.

Opting out and extra-billing: We support and applaud subsection 9(2), which eliminates the right of a physician or designated practitioner to receive direct payment from patients for insured services up to the OHIP maximum. Unfortunately, subsection 9(4) gives the government the right to reverse Bill 8's regulations, thus opening the door to extra-billing and opting out. We support the ban on extra-billing and opting out.

**1130**

**Ms Hotte:** Looking at queue-jumping and P3s, we're very pleased with the part of section 15 which prevents queue-jumping. In other words, a person cannot pay for a certain test or procedure, for insured services, in advance of another person. Unfortunately, since the list of medically listed services is restricted, people who select those services are not protected from queue-jumping. For example, private MRI clinics are allowed to provide scans to those who wish to have one. These people are able to jump the queue and get one before someone who really needs it.

Looking at P3s, the newly elected government campaigned against the privatization of health care, and they should follow through on their promises. Public-private partnerships, or P3s, and the delisting of services should be stopped immediately. The decision of keeping the ownership of the Royal Ottawa and William Osler hospitals public through a mortgage does not change the private, for-profit character of a P3 organization. Experience in Great Britain and Australia of P3 hospitals has shown that the costs will be at least 10% higher. We are very concerned about the announcement that the West Lincoln hospital may be applying for a P3.

Private health care costs more than public health care. In order to attract investors and satisfy their shareholders, private corporations must make a profit and be competitive, at the expense of the patients. For example, the statement of ethics of Anagram ResCare Premier, an American for-profit health care provider for brain-injured patients in six locations in Niagara-on-the-Lake and St Catharines, informs us that it is "dedicated to assisting persons with acquired brain injury to reach their

potential. We do this by providing the highest-quality and most cost-effective community-based rehabilitation and residential services.... We are committed to creating a rewarding and challenging environment for employees and a reasonable return for stockholders."

Until recently, the 44 clients or patients in the six locations were served by one registered nurse, and this was only on the day shift. There are still no registered nurses on the evening and night shifts. This is certainly cost-effective and impacts the bottom line of this corporation. It raises many questions as to the quality of care these patients, or clients as they are called by Anagram, receive. Who gives out the medication? Are the patients over-medicated at night? It certainly is a challenging environment for the employees, as they must do the best they can with the training they received from ResCare Premier. I would like to add, if they don't do what they are told by their administrators and managers, they are at risk of losing their jobs, and they don't want to do something they're not trained for.

How accountable are for-profit companies? One only has to look at the fiasco of Royal Crest, a service provider of 17 long-term-care and retirement homes serving 2,400 seniors in Hamilton, Burlington and Oakville. In the past 10 years, this corporation received over half a billion dollars from the Ministry of Health. The owners made over $6 million, and now they're declaring bankruptcy. This would never happen if these facilities were publicly owned and administered. Furthermore, the government would have had at the very minimum an additional $6 million to spend on health care.

Private stand-alone MRI clinics are not publicly owned and operated. They drain money from the public health care system through third party billing. They deprive the hospitals of an important income source. They aggravate the severe shortage of skilled medical professionals as they are able to lure staff from the hospitals with promises of better salaries and working conditions. They also promote queue-jumping, as people will pay for medically unnecessary services.

Home care also shows us the negative impacts of privatization. Precious health care dollars are being spent on expenses surrounding tendering requests for proposals, preparing bids, evaluating proposals, monitoring, and of course profit-taking. The VON is still operating in the Niagara region, in part because of financial support from such groups as the local United Ways.

**Mr Allen:** Accountability agreements and compliance directives: We are extremely concerned with sections 19 through 32 of Bill 8. They cover the powers of the Minister of Health to compel persons to enter into accountability agreements or compliance directives. The present wording would allow the minister, if he or she wishes, to override legal collective agreements and other negotiated agreements. This goes against the democratic principles of our society and what the trade union movement stands for, more specifically, not only the labour movement within each individual local but under the umbrella of this particular labour council.

The powers granted to the minister are too broad, open-ended and unclear. For example, according to the provisions, the minister could direct any health care provider, other agency or person to enter into an accountability agreement. We would like to see provisions in Bill 8 which clearly explain what accountability would consist of. All Ontarians support a high-quality, fiscally responsible health care system, but it must be a publicly funded, publicly administered health care system. As representatives of the St Catharines and District Labour Council, we are committed to public medicare and oppose any language that supports a privatization agenda.

Sections 26, 27 and 28 of the bill are a direct attack on health care workers, who do a fantastic job in a financially starved public health system which is chronically underfunded and understaffed. The minister would have the power to unilaterally change a person's terms of employment. The minister could reduce funding, change funding or discontinue any terms of a contract or agreement of employment. Why would anyone want to choose a career in health care or stay and work under those uncertain circumstances?

Ontario is at risk of losing 6,000 RNs in the year 2004 and up to 23,000 RNs by the year 2006 due to retirement, burnout, finding employment in another profession or in another political jurisdiction. According to the CIHI RNDB 2002 report, Ontario already has the worst RN-to-population ratio in Canada. In 2002, it was 65 per 10,000, compared to 78.6 per 10,000 in the rest of the country. Here in Niagara, the Niagara Health System has been vigorously recruiting family doctors, nurses and other medical professionals in order to address huge labour shortages which impact on a daily basis on the quality of health care that people in Niagara are receiving.

Regarding trade unions' and employers' right to free collective bargaining, in the name of value for money or fiscal responsibility the minister could force them to reduce wages and benefits, or both, repeal their no-contracting-out language or their successor rights clauses. To us this is totally undemocratic and unacceptable.

Why does Bill 8 give the Minister of Health such sweeping powers to unilaterally dictate fundamental changes in the health care system without procedural safeguards, democratic input or transparency? Why does it give the government the power to prosecute anyone who does not comply with the minister's order? Why does this bill not allow people to take legal action against the minister or the crown? Is the answer to all these questions that the newly elected Liberal government wants to privatize as much of the publicly funded and administered health care system as possible? Is it because the Premier and the Minister of Health want to reinvent government and pave the way to the privatization of all public services? Given the powers and penalties in sections 26, 27, 28, 29 and 30, we call for their complete withdrawal.

In conclusion, we were hoping that Bill 8 would explicitly prohibit two-tiering for so-called medically unnecessary procedures, strengthen accessibility and pay

special attention to marginalized, equity-seeking and geographically remote communities. This community certainly isn't geographically remote, but I think the statistics you heard prior to us and the ones we presented to you show that we are in desperate need of servicing and yet, I would suggest, the last time I looked at the map we looked to be at the heart and centre of this province. Heaven knows what it's like to live in northeastern or northwestern Ontario. What kind of service is actually provided up there when you truly are remote?

**1140**

Recognize that for-profit health care hinders accessibility to health care, and have provisions on pharmacare and home care. We're really waiting to see and hear what this government's response is to those two components of health care. It seems a mute response at best.

There will be a lack of democratic participation and transparency because of the sweeping powers given to the Minister of Health. Ontario does have a debt. We recognize that. We go to the table every week. We understand the needs of employers. We understand their constraints. But our public services, including health care, have deteriorated because of the previous government's policies. Restructuring, efficiencies and the selling of public assets such as the LCBO or TVO are not the solution. The previous government's policies dramatically reduced the revenue available to the government. The solution is to increase the revenue stream and, in so doing, improve upon our medicare system.

Voters in Ontario rejected—and I stress "rejected"—privatization in the form of P3s. The evidence we have from Britain and Australia shows us that public services worsened under those particular aspects.

We urge the government of Ontario, in light of our comments, to reconsider this bill. We thank you for this opportunity.

On an anecdotal note, I'll mention about the British experience with P3s, since I happen to be a very old immigrant from that particular country; I came here as a very young child.

*Interjection.*

**Mr Allen:** I'm old enough.

**Mr Kormos:** He's at least as old as we are.

**Mr Allen:** That's right, and of course that's not that old.

In any case, the majority of my family still happens to live in Scotland. The last time I was there, five years ago, in the Strathclyde region outside of Glasgow, which encompasses the entire city of Glasgow, the human outcry against another P3 hospital was deafening. Not only my family but their friends were saying, "This has cost us not only time in waiting longer for the National Health Service to take care of us, but it has cost us more money. We are now paying greater taxes to pay for a so-called private-public partnership than we did when we built the old Glasgow General Hospital," which of course was a shambles by that time. What they got was this lovely thing up on the hill that looked beautiful, but it cost them a fortune to build, administer and run.

If you publicly fund a private institution that doesn't take any risks, has no competition—I'd go into business myself if that was the case, and I've never owned a business in my life. But if someone was going to give me a guaranteed revenue stream, ask me to take no risks and simply say to me, "You don't have to worry about collecting the debt. We'll send you the cheque every month. Don't worry about it. You pick the services that you like and you can farm out the others to the public sector because those are the tougher ones to do," why wouldn't I be lined up in a queue saying, "Pick me, pick me, pick me"? That's why they're lined up at this border, quite frankly, looking to say, "Pick me, pick me, pick me."

It's not British entrepreneurs that invested in and started P3s in the UK, it's American insurance companies. They are the masters at it. We have seen that they pay a higher per capita of GDP than any nation in the world. Are they healthier? If you look at the WHO reports about health worldwide, Americans aren't at the top of the list, and yet they spend the greatest amount of money.

Our assertion to you is that to follow the model of a P3 hospital and P3 partnerships in a publicly funded health care system will ultimately cost us money. "Us" is the taxpayer. We give you our taxes, and we ask you to administer them. We also have the right, as your electors, to give you direction. I believe that's what we're saying to you. I believe that's what you've heard this morning. I believe that's what has been said in this province for the past 15 years. It's incumbent upon you, I believe, as an elector, as part of this democracy—I'm also the holder of an elected office; I understand those types of pressures that come upon you. But at the end of the day it is we, the payers of this system and the electors and the people of the province of Ontario, who have an absolute right in this society to give you direction, and it's incumbent upon you to take it. From that point of view, you need to hear what we're saying around P3s, and that is no: no to the two that were proposed under the previous government; no, we don't want them; and yes, we want them repealed. We don't want any others, especially the one up in West Lincoln. You folks have said that's where we might see one. Guess what? If that's the case, you'll probably see a lot of others.

**The Acting Chair:** Thank you, Malcolm. You have conveniently used all of your 20 minutes. I was hoping we'd have some opportunity for some questions. I appreciate your comments. I thank you and Sue and the St Catharines and District Labour Council for participating. Certainly your comments will be looked at by this committee.

**Mr Kormos:** How many workers do you represent?

**Mr Allen:** We represent 15,000.

## WEST LINCOLN MEMORIAL HOSPITAL

**The Acting Chair:** The next presenter we have is from the West Lincoln Memorial Hospital. Welcome, Kathryn Curran, chair of the board, and David Bird, the

executive director. The format is 20 minutes. Time permitting, we'll be allowing for questions afterwards. Whenever you're ready, just go ahead and start.

**Ms Kathryn Curran:** Good morning, ladies and gentlemen. My name is Kathryn Curran, and I am the chair of the board of directors of the West Lincoln Memorial Hospital in Grimsby. We are a Niagara community that you would likely see as you pass by on the Queen Elizabeth Way on your way here to Niagara Falls.

West Lincoln Memorial is a 60-bed community hospital. It serves a catchment population of approximately 60,000 people who live in the Lincoln, Grimsby, West Lincoln and Stoney Creek areas. We offer a full range of services at the hospital. We see over 27,000 patients in our ER per year. We perform over 3,500 surgeries annually and deliver close to 500 babies, many delivered by their family physician. In partnership with McMaster University, we are a major training centre for family physicians and other learners.

We have ended our past four fiscal years with a budget surplus, and this year we are projecting a 6% surplus. As we have done in the past four years, we will use part of these funds to expand services and shorten wait-lists for our communities. Part of the surplus will go for capital development, as we are doing all this good work in a 55-year-old building.

With community and contractual partners, we have shared resources, reduced overhead and entered into joint buying agreements. We even make our own electricity and heat through an environmentally conscious, natural-gas-fired cogeneration plant. All of our cost savings through these partnerships have gone back into clinical programs. As an example, we have increased our total surgical volume by over 60% in the last five years.

I am here today representing my board, the hospital and the west Niagara community as a whole. As a board, we have discussed the provisions of the Commitment to the Future of Medicare Act. We had an ADM from the ministry come to our board and give educational sessions regarding accountability agreements. In general, we agree with the key provisions of the bill: establishing the quality health council, embracing the five principles under the Canada Health Act, adding accountability as the sixth principle and entering into accountability agreements.

We understand that the Minister of Health and Long-Term Care, the Honourable George Smitherman, has recently proposed some amendments to this bill, and we agree with the direction of the changes proposed. The problem is, the proposed amendments do not go far enough.

**1150**

We are deeply concerned regarding certain provisions of this proposed legislation, particularly as they relate to the role of our board, the role of the ministry and the role and accountability of the executive director.

As you have been told in other presentations, boards of hospitals of Ontario are made up of dedicated volunteers, and we are no exception. As a board of directors with 16 members, we have a community minister, our local Grimsby fire chief, physicians, three municipal town councillors, an auxiliary representative and several other elected and appointed members of our communities. Each director comes to the board as a highly trained professional, with years of experience and skills which each is prepared to bring to the board. In addition, each director is well known and knows well the members of our community.

Sections 21 and 22 of the proposed legislation offend us, as local representatives of our communities. We have a responsibility under the Public Hospitals Act, and we fulfill that responsibility diligently. To require us to sign an accountability agreement that we have no ability to negotiate is a bastardization of the term "negotiation" and destroys faith, not only with us but with our staff and ultimately our community as a whole.

We are very concerned regarding sections 26 and 27 of the legislation—other areas that also have not been substantially changed with the proposed amendments. Either we have accountability for the actions of our executive director or we do not. There should be no direct authority by the minister over our executive director if the minister is not directly accountable for all the actions of the hospital. This hybrid approach is harmful, it will not work, and you know it was harshly criticized in British Columbia when the model was reviewed by the BC Auditor General.

Bill 8 is one of the first major pieces of health legislation brought forward by the new Liberal government. We, the hospitals of Ontario, have been under the gun in the past year, trying to cope with SARS, the flu, West Nile virus, chronic working capital deficits and operating budgets that are finally settled five weeks before the end of the fiscal year. How are we supposed to interpret proposed legislation that appears to be a direct assault on our local decision-making? Does this give a good signal for future working relationships in an area that is priority one for the citizens of the province?

As a board of directors, we urge the government to make a decision: Either maintain and facilitate local governance of hospitals with boards that are responsible and accountable to their communities, or remove the boards and transfer the accountability directly to the minister. Don't dilute the authority and responsibility of present hospital boards. This dual accountability will cause unnecessary confusion and problems for the executive leadership of hospitals across this province.

Finally, accountability is a two-way street. With all due respect, where is the accountability of the Minister of Health and Long-Term Care in this legislation?

We urge you to consider our opinions and to continue working with the Ontario Hospital Association in drafting revisions to this bill. We are committed to accountability, but we also strongly believe in voluntary governance and local control.

Thank you for allowing me to present to you. David Bird, my executive director, and I would be happy to answer any questions you would like to propose.

**The Acting Chair:** Thank you, Kathryn. We have six minutes left, and we will start the questions with the official opposition.

**Mr Hudak:** Kathryn and David, thank you very much for the presentation. It was passionate and very well put.

For the benefit of the members of the committee, the West Lincoln Memorial Hospital serves a large catchment area in my riding of Erie-Lincoln. It does an outstanding job and has substantial community support, whether it's through the board of the hospital or through the volunteers who help make that hospital run, which has been manifested in a very successful fundraising campaign for a new hospital. Part of that is the belief in the local volunteer board making the best decisions for quality care, as well as for accountability.

You use very strong terms here, but I think appropriate. I haven't quite figured this out yet. Minister Smitherman is a smart man. I've seen him in operation in the House. I have a lot of respect for him. But you can't judge this bill by its cover. The way it was described in the Legislature is substantially different from what we've learned in these public hearings. In fact, this movement by the Ministry of Health to take over local hospital boards, to subvert the voluntary governance of the board at West Lincoln and get into a direct relationship with the CEO, is rightly rejected quite strongly in your documents.

They have committed to making amendments, after they were caught out on this, and we've been given promises by the Minister of Health that changes will occur, but we've seen promises by the Minister of Health before.

Despite the fact that they've brought forward some suggested changes, you still think they don't go far enough—sections 21, 22, 26 and 27 particularly. Do you have any advice for this committee and for the opposition members on amendments we can bring forward to ensure that the points you bring out about the board, particularly on accountability agreements, will be enshrined in this law?

**Mr David Bird:** I think it goes to the part of the presentation that says you need to make a decision. If you dilute the autonomy of the board, then there's going to be a big problem. That's not to say that there can't be accountability, and should be accountability. I think it's fair to say that hospitals in Ontario, through the performance reports that are going through the hospital, reported with the OHA, and basically through local governance, needing to report to the community on an annual basis, that needs to continue, but not to have something that appears to be rammed down our throats.

I guess I was a little surprised when we received from the ministry the notice that the recent funding increases—it came a couple of days ago and we thank you very much, because we need the money and we'll put it to very good use, but we're not sure about all the parts to it—are conditional upon making a notation that this funding is only with an accountability agreement, and I haven't seen any changes to it that makes it more palatable to us. So what do we do? Do we say to the community, "We're sorry; we're going to give up $1.5 million of funding that we know can really be used for the citizens of the community because we don't like the idea that the control could be taken away from the community"? We can't do that. So we're caught between a rock and a hard place.

**The Acting Chair:** Mr Kormos.

**Mr Hudak:** I'm just on a roll.

**Mr Kormos:** Thank you very much for coming. I just want to mention the funding, because I was pleased that Mr Craitor was able to announce in the press the funding for the local health system, but concerned that he indicated it would be of value to people in Niagara Falls, Niagara-on-the-Lake and Thorold, excluding folks from Port Colborne, St Catharines—Mr Bradley's riding—and perhaps Welland. It was perhaps a misquote, because from time to time I understand that happens.

Take a look at this bill. Take a look at section 26, the consequences of failure, which says, "in the opinion of the minister ... make an order ... for one or more prescribed measures," in other words, measures determined in the secrecy of the dark backroom, and then section 30, where there is no liability. In other words, a capricious minister could arbitrarily—Mr Christie is free right now. You remember Mr Christie, who was sent in by the last government to take over the Toronto Board of Education? This bill contemplates perhaps new work for Mr Christie to come in and take over the board of any given hospital or health service.

**1200**

There's no liability by the minister. There's no judicial review, because it's in the opinion of the minister. There are no safeguards. There are no checks and balances. This stuff is downright Soviet in its machinations. This is scary stuff. I commend you and other boards for standing up and hitting the nail right on the head. It's scary, scary stuff. I thought we had left all that behind when people voted for change, but they end up getting more of the same.

**The Acting Chair:** Monique.

**Ms Smith:** I'd like to thank you for coming and making your presentation today. I, unlike my colleague, actually have some questions, as opposed to making a speech, so I will get to them.

I wanted to congratulate you on your surplus budgets, as well as your shared resources and joint buying. I understand you're doing great work. That kind of cooperation between health care providers is essential, I think, to the lasting presence of those services in our communities.

You spoke of the BC auditor's report and the hybrid reporting approach. I wonder if you could elaborate on your views on how this legislation is in any way similar to the BC legislation.

**Mr Bird:** I believe the report of the BC auditor was critical of a dual accountability for the chief executive officer position and the health authorities. They felt it undermined and caused confusion in terms of who that

person is going to be accountable to and take direction from. It's great to have one boss, it's maybe a little bit greater to have two bosses, but when you have three or four or five, it's very hard to know who is paying the piper. Essentially, as an executive director, I would look to see who is most likely to get me fired. Is that a way to run a hospital?

**Ms Smith:** But you're clear that in the proposed amendments that have been put forward in the framework, the accountability agreements will be between the ministry and the board, and not the CEO? You're clear on that?

**Mr Bird:** I'm not sure what's going to be in those accountability agreements about that and what the reporting is going to be between the CEO and the minister.

**Ms Smith:** But the accountability agreements themselves, you understand, are going to be between the board and the ministry, and then there is also an expectation that there would be performance agreements between the board and its CEO.

**Mr Bird:** Under the amendments?

**Ms Smith:** Yes.

**Interjection:** We haven't seen them.

**Mr Bird:** Right.

**Ms Smith:** But you do understand that those are the—

**Mr Bird:** And those will be negotiated?

**Ms Smith:** What will be negotiated? The accountability agreements?

**Mr Bird:** Yes.

**Ms Smith:** We would assume that the performance agreements would be negotiated between the CEO and board. That's the relationship that's there.

**Mr Bird:** What if there's something in the accountability agreement that talks about the performance agreement with the CEO and mandates what has to be in there?

**Ms Smith:** The accountability agreements will be negotiated, so the board will have an opportunity to negotiate those provisions with the ministry.

**Mr Bird:** That's good to hear, because I think that's something I've been unclear about, that there will be negotiation, and it will be a true negotiation.

**Ms Smith:** The minister has stated in the numerous speeches he's given on this that they are negotiated accountability agreements.

**The Acting Chair:** On behalf of the committee, thank you for taking the time in coming out. We appreciate your comments.

## NIAGARA HEALTH COALITION

**The Acting Chair:** The next presenters are from the Niagara Health Coalition.

**Mr Kormos:** Chair, while these people are seating themselves, I know you and Mr Hudak join me in welcoming our colleagues to Niagara region. I mention that to demonstrate to the audience that there's no ill will between us. We collaborate, indeed.

Ms Smith, the parliamentary assistant, welcome to Niagara. Ms Smith, of course, is the author of the now well-known dress code resolution in the Legislature. She and I have more in common than many would suspect, because recently the Toronto Sun selected us as the worst-dressed female MPP and worst-dressed male MPP, respectively. But I was noted as being rumpled in a sexy sort of way.

**The Acting Chair:** Order. Thank you, Peter. I want to ensure that the presenters have sufficient time.

We have with us Diane Cormier, co-chair of the Niagara Health Coalition, and Sue Hotte, who is also a co-chair. You have 20 minutes. Time permitting, the remaining time will be divided equally among the three parties for questions. Go ahead whenever you're ready.

**Ms Diane Cormier:** First of all, I'd like to thank the committee for allowing us to make this presentation.

The Niagara Health Coalition is a member of the Ontario Health Coalition, which is a network of more than 400 organizations representing hundreds of thousands of individuals in all areas of Ontario. Our local members include the Council of Canadians; seniors' groups such as ARM, Retired Teachers of Ontario, CAW retirees; nurses; health care workers; 36 union locals; and concerned citizens in Niagara-on-the-Lake, St Catharines, Thorold, Lincoln and Grimsby. We are a nonpartisan group committed to maintaining and enhancing our publicly funded and publicly administered health care system in Ontario and in Canada. We work to honour and to strengthen the principles of the Canada Health Act.

Bill 8, entitled the Commitment to the Future of Medicare Act, was introduced late last fall as the fulfillment of the present government's promise to enshrine the Canada Health Act in Ontario law. It is to create a health quality council to monitor, to provide accountability and to prohibit two-tier health care.

Upon reviewing Bill 8, we found that not only does it not further the implementation of the principles of the Canada Health Act but it also does not improve democracy, transparency and accountability. We also found that it will not prevent the further erosion of the scope of medicare, privatization and profit-taking, and two-tiering for those services that have been delisted. We are also very concerned because the bill gives the Minister of Health sweeping powers.

Given our concerns, we would like to present the following recommendations which could strengthen the bill by implementing the principles of the Canada Health Act. In so doing, the present Liberal government would be able to fulfill its election promise on health care reform.

Rebuild a commitment to the universality, comprehensiveness and accessibility of medicare.

Ontario's public health system has been seriously eroded by years of cuts and delisting of services. According to the February 2004 report of the Niagara Health System, Niagara is even worse off than the rest of Ontario. The Ontario Medical Association reports that over 900,000 Ontarians have no access to a family

doctor. In 1999, our region had the second-lowest number of physicians per population than the provincial average. The ratio was 60 per 100,000 in Niagara, compared to 85 per 100,000 for Ontario. This means that 5% of our population is without a physician. Although the Niagara Health System has recruited 28 family physicians and 35 specialists since 2001, we are still underserviced by 75 physicians. This has led to a high rate of emergency use and overcrowding.

Between 1996 and 2001, the number of RNs and RPNs decreased 7.5% and 0.6 % respectively, compared to the provincial average of 3.3% and 2%. The effect of this is that in 2002, the ratio of RNs to population was 566 per 100,000, compared to the Ontario average of 695 per 100,000.

Over $100 million in OHIP services have been delisted over the last decade. This includes audiology testing. It now costs between $50 and $75 for each test and hearing aid evaluation. Many medications, such as Effexor, an anti-depressant, have been delisted. This impacts those who are on disability. Surgery for sexual reassignment was also delisted. We used to be able to have a yearly eye exam; now it is once every two years. Many people, especially seniors with failing eyesight, need to have an examination at least once a year.

**1210**

Funding cuts are responsible for the loss of 11 full-time positions for addiction treatment in Niagara in the past two years. Due to funding cuts, the Niagara Health System cannot deliver certain mental health services because it had to reduce its mental health staffing levels by 19. It is only receiving $13.29 per capita, compared to the provincial average of $51.76, to fund mental health services. Niagara, according to the Ministry of Health and Long-Term Care benchmarks, should have 736 mental health beds. We only have 188.

I'm going to ad lib here just for a second, if you will bear with me. The previous government eliminated the 2.25 nursing care hours per day a resident receives in a nursing home as a minimum care standard. Non-profit and municipally run nursing homes and homes for the aged might still maintain this minimum standard of care. Personally, I work in a privately owned nursing home. With the standard for minimum hours of care removed, that allows them to channel more of the money into their profits.

I work a night shift. My hours are from midnight to 7:30 am. Between the hours of 6 am and 7:30, I am responsible for attending to seven residents. In that hour and a half I've got to wake them, wash them, dress them, get them up, and there is always some other unexpected event that might occur which will take up that time.

Basically, for privately run facilities whose big concern is profit, it creates a heavy workload, and residents—how can I put this? We do our best to provide the care they deserve. I never leave at 7:30. I'm always there until at least maybe 7:45 or 7:50. But that's my personal choice, because I think these residents deserve as much time as I can give them. Sometimes I feel like I'm on an assembly line. I shouldn't feel that way, and these residents deserve better.

Carrying on, I'll skip to page 3.

The principles of the Canada Health Act are incorporated in the preamble of Bill 8. Unfortunately, the bill does not provide concrete initiatives to ensure access to the services which have been cut and to implement the sentiments outlined in the Canada Health Act. As noted in the preamble to the bill, home care and pharmacare are key components of rebuilding an accessible, comprehensive, universal public health system. Homemaking and support services, access to primary care, access to drugs and assistive devices, and a comprehensive OHIP list covering the people are also very important. We need real, concrete steps to ensure that all Canadians have access to a comprehensive range of medically necessary health services.

Prohibit two-tier medicine and extra-billing.

Fundamental to the universality of the public health system is the prohibition of two-tier medicine and extra-billing. The threat of two-tier health care has grown significantly with the privatization of the health system. User fees, service charges and two-tier access generate great revenue for the private health care providers. Furthermore, the delisting of services and procedures has allowed the growth of two-tier access for uninsured services. Some examples are as follows: Private laboratories can now charge for pickup and delivery. This affects long-term-care facilities and home care patients. Private MRI/CT clinics can provide medically unnecessary scans to those who pay out of pocket. Therefore, those with the least medical need can jump the queue. Inadequate home care budgets have led to massive cuts to home nursing, homemaking and personal support services. Those who are unable to pay for the services are more susceptible to ending up with preventable injuries and illnesses.

Bill 8 must be changed in order to, first of all, protect against two-tiering all the services which have been delisted, and secondly, stop the two-tiering for so-called medically unnecessary scans that are allowed in the private MRI/CT clinics. The present government campaigned against P3 hospitals and private clinics. It should fulfill its campaign promises to stop and reverse these privatizations.

We support and applaud the prohibition against physicians and other practitioners opting out of OHIP. However, we are concerned that the wording of the bill allows this protection to be reversed in the regulations, therefore providing less protection than we already have in Ontario law. Government should not allow physicians to extra-bill by regulation.

We are totally against block fees. We believe that Bill 8 should simply ban the practice. It violates the principles of the Canada Health Act, as it creates a barrier to accessibility. It is unnecessary, as physicians can charge on an item-by-item basis.

The threat to the future sustainability of medicare posed by private, for-profit corporations is critical. P3 hospitals put billions of dollars of public funds into the

hands of profit-seeking corporations. The veil of commercial secrecy makes it difficult for the public to scrutinize profit-taking and misuse of public funds.

The imposition of two separate sets of management under the same roof, one with a goal of providing a public service and the other with a goal of maximizing profit and growth, is fraught with problems. The higher borrowing costs, consultant fees, legal fees, high executive salaries and profit-taking drive up health care costs. Seeking to satisfy their shareholders, corporations seek new sources of revenue, imposing fees and service charges wherever they can. Contracting out and the hiring of poorly qualified health care workers may help the bottom line, but it certainly does not enhance the quality of patient care. British and Australian P3 hospitals all share the same characteristics: user fees for patients, fewer beds, lower staffing levels and no public accountability.

We can clearly see the effect of privatization in home care services. Since 1996 the Ontario government has been privatizing home care services. A managed competition model has meant that for-profit home care agencies have replaced non-profit home care providers. There is no public accountability for for-profit home care services. There are no province-wide standards for home care. Competitive bidding has replaced direct public funding. This practice has led to a freeze or a decrease in home care wages. The result is a large turnover in staff rates, as much as 60% per year, because the pay is very low and there are usually no benefits. Meanwhile the corporation or the owners are reaping large profits. One only has to look to Hamilton and the financial fiasco of the Royal Crest chain of long-term-care and retirement homes.

Non-clinical services such as food, laundry, maintenance, record-keeping, lab tests and diagnostics should not be privatized. They are essential to infection control, nutrition, diagnosis and recovery. They should be provided on a non-profit basis.

Similarly, the creation of private, for-profit clinics to deliver hospital services poses serious threats to the sustainability of medicare, because access to diagnostics is limited by the supply of equipment, such as scanners, and trained personnel, such as radiologists and technologists. The private clinics find their staff by poaching them out of public hospitals, leading to staff shortages in public facilities. They are able to access new revenue streams by promoting medically unnecessary scans. In addition, the private clinics take the less risky and less costly scans, leaving the heavier-burden scans to the public system, which has been deprived of personnel. Like ResCare Premier (Anagram) in the Niagara Peninsula, they also take third party billing patients and those on WSIB, depriving hospitals of this revenue. These clinics make profits not only from their clients but also at the expense of the public health system.

One only need look at the incredible increases in the cost of drugs—an area of the health system—to see the high costs and threat to public access posed by privatization. Since 1995-96, Ontario's drug costs have soared 130%, and the pharmaceutical corporations top the Fortune 500 list.

Fundamentally, the motivations of the profit-seeking corporations fly in the face of the principles of comprehensiveness, accessibility, universality and the single-payer system. The Canada Health Act calls for the public administration of our health system. Private hospital corporations, private long-term-care corporations, private labs and private home care corporations are a serious threat to the future sustainability of Ontario's health system.

**1220**

The Liberals' pre-election promise was very clear: They opposed privatization, and they were committed to rebuilding medicare. That being the case, Bill 8 should strongly show their commitment to the future of medicare. It must include concrete initiatives to roll back privatization and to prohibit future for-profit control of our health care institutions. P3 hospitals must be banned. The private diagnostic clinics must be returned to non-profit hospitals. The tide of privatization sweeping across our health system must be stemmed. The future sustainability of medicare and the application of the principles of the Canada Health Act depend on it.

We urge the government of Ontario to reconsider Bill 8 and, in so doing, to strengthen the legislation and truly support the principles of the Canada Health Act. Thank you for the opportunity to participate in this very important decision.

**The Acting Chair:** Thank you very much, Diane. We have three minutes left. I will start with Peter. You'll be entitled to one minute to ask your question and get a response, and we'll do that around the table.

**Mr Kormos:** That's time to inhale. Thank you very much. It's most appropriate that the person immediately following you is going to be addressing the issue of the VON and participation in home care. She's right there, waiting anxiously to get up to the table.

The issues are clear, and they aren't being addressed by Bill 8. I'm not going to ask you a question. Your report is comprehensive; it's complete. Do you know what's fascinating, though? Shelley Martel has been working on this committee and I've just been filling in from time to time. In all the hours I've spent—which hasn't been a whole lot—there hasn't been one single participant in these public hearings who supported the bill.

**Mr Frank Klees (Oak Ridges):** Not one.

**Mr Kormos:** Have there been any? I'm sure the Liberals will come up with one or two before it's all said and done.

I would like legislative research to tell us if there has ever been a bill that has required more amendments than this one, in the 15 and a half or 16 years that I've been at Queen's Park.

**The Acting Chair:** Thank you, Peter. I appreciate your comments.

**Mr Kormos:** Thank you kindly, Chair. I'm sure you do.

**The Acting Chair:** I always do. You're a wealth of knowledge. Ms Smith.

**Ms Smith:** Thank you for your presentation. We really appreciate it. As you know, we came out to the public for input on this bill after first reading and we are looking for this kind of input, so we appreciate your being here.

**Mr Hudak:** It wasn't voluntary, exactly.

**Ms Smith:** Of course it was voluntary. It was always the intention to bring this after first reading.

I won't let him eat into my one minute. I did want to ask a question, as opposed to giving a speech, like my colleagues again.

With respect to block fees, you said you oppose block fees. I just wonder, are there any circumstances in which you would support block fees? I think of a situation where there's a family that has a number of unlisted or not covered expenses and where the block fee structure would be well set out for them: "These are the fees, these are the options. You can pay for them individually or there is this block fee option. There are no strings attached. It won't mean that you can't have this doctor." All those kinds of protections would be in place. Would that be the kind of scenario where you could see it happening, or do you just not want to see block fees at all?

**Ms Sue Hotte:** No block fees. If they have to pay for services that have been delisted, my suggestion to the government is to make sure they get listed again. If they're in a situation where they need a great deal of health care—

**Mr Kormos:** Applause.

**Ms Hotte:** Applause.

**The Acting Chair:** Thank you very much. Tim, I'm going to let you have an opportunity to say a few words.

**Mr Hudak:** Other members were there in the assembly, but I'm sure that when Minister Smitherman introduced this bill, it was all motherhood issues about getting rid of privatization and two tiers. I don't remember him saying, "Do you know what? This bill is really screwed up, and there are going to be all kinds of amendments." Am I right?

**Mr Klees:** That's right. He did say it at committee.

**Mr Hudak:** He did say that at committee. OK.

**Mr Klees:** He was embarrassed.

*Interjection.*

**The Acting Chair:** Let's have some order. Thank you for your question.

**Mr Hudak:** Hold on a second; that wasn't close to a minute.

**The Acting Chair:** That's the minute. You took up your minute.

**Mr Hudak:** No, it wasn't even close.

**The Acting Chair:** Thank you very much for coming out. I appreciate it.

**Mr Klees:** You got shortchanged.

Chair, while the next presenters are coming forward, if I could, this is really for your benefit as well as the rest of the committee. I want to make it very clear for the record that the previous government put forward five bills to public hearings after first reading. I know statements have been made that somehow this government is treading on new territory, new ground. The fact is that it was the previous government that introduced the concept of putting a bill out after first reading. However, there was never a bill that was in such terrible condition as this one after first reading, ever.

**The Acting Chair:** Thank you, Mr Klees.

**Mr Klees:** Thank you for that opportunity.

**The Acting Chair:** You've very welcome.

*Interjections.*

**The Acting Chair:** Order. Let's show some respect for the deputants.

**Ms Kathleen O. Wynne (Don Valley West):** Sorry.

**Mr Kormos:** I want the record to show that chaos erupted—

**Mr Hudak:** From the Liberal benches.

**The Acting Chair:** Not from the Chair, though.

## ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 269, HAMILTON VICTORIAN ORDER OF NURSES

**The Acting Chair:** We'll start out by welcoming you. Thank you very much for participating. Sorry we're running a little bit behind. Lois Boggs, the president of the Ontario Public Service Employees Union, local 269, and the Hamilton Victorian Order of Nurses—you have 20 minutes and, time permitting, we'll then allow questions by the three parties. Go ahead whenever you're ready.

**Ms Lois Boggs:** My presentation is very short, and don't feel you need to spend the whole 20 minutes asking me questions when I'm done.

I'd like to start by thanking you for this opportunity to speak to you about Bill 8 and this government's decision to gather public opinion before passing a bill that is so important to us all.

I am a client service representative at the Victorian Order of Nurses, Hamilton branch, where I have worked for the last 18 years. I'm also the president of OPSEU, local 269, which represents all nursing and clerical employees in this branch.

I'm not here to speak to you about the whole bill. I don't pretend to know all about it. I do want to focus on the health quality council and community health care.

I want to talk to you today about the changes that have taken place in community care these last eight years and the devastation to our home care system. This is my story about the cost of privatization in community care.

Eight years ago the Victorian Order of Nurses administered the home care program. The visiting nursing visits in our region were contracted to two not-for-profit agencies: the Victorian Order of Nurses and St Elizabeth nursing. Home support was contracted by the Visiting Homemakers Association, which was another not-for-profit agency. The rate the government paid each agency

was negotiated provincially, and the three agencies worked well in collaboration with the home care program and delivered quality care to people in their homes as needed.

Then came the community care access centres, managed competition and divestment of direct staff. The Conservative government told us that community care would be better managed, more accessible and more cost-effective. We know now that nothing could have been further from the truth.

Agencies were forced to compete with each other for service delivery contracts, and new companies, many of them from the United States, went into a bidding war. Wages and working conditions of the front-line workers spiralled downward as not-for-profit agencies like mine struggled to survive. When the CCAC boards continued to run deficits and complained that this was not a more cost-effective system, they were quickly fired and replaced by new boards that were hand-picked by the Conservative government. Since that time, we have witnessed a dramatic reduction in service in every area of home care in this province.

Over 100,000 people are no longer receiving care in their homes. In-home nursing has been cut by 50% and home support by 60%. In the year 2000, my local had 220 members, and it saddens me today to say we have about 130 members left. My agency has lost 90 workers, most of whom were highly skilled community nurses. The Visiting Homemakers Association was forced to go out of business, and 500 personal support workers and homemakers lost their jobs.

The VHA, when it was in trouble, asked the CCAC to increase the visit rate and the CCAC refused. Instead, the CCAC allowed the Visiting Homemakers Association to close their doors after 75 years of service in our community and then contracted other agencies, most of them for-profit agencies, at a higher rate. Just last week the CCAC awarded the new contract for home support in our region. Comcare was not successful and has just had to lay off over 300 workers, and some of those workers were former employees of the Visiting Homemakers Association. When their company went under, they went to Comcare, and now Comcare has gone under.

**1230**

The Victorian Order of Nurses and St Elizabeth nursing still provide 85% of all visiting nursing visits, but both agencies have lost many workers and continue to pay low wages due to the competitive process. During the last RFP, the CCAC advised the nursing agencies that if they increased the rate for visits, there would be an identical reduction in the number of visits; for example, if the agency increased the rate for visits by 10%, the CCAC would reduce nursing visits by 10%. In other words, 10% of people requiring nursing care would not be eligible. The visits would disappear.

The Hamilton CCAC has a budget of nearly $50 million. I had the opportunity last week to visit the CCAC office and I got to observe first-hand their new office renovations. By the way, this is the third time the CCAC in Hamilton has renovated their office. "Obscene" is the only word that can describe how these health care dollars were spent on their new, state-of-the-art staff lounge or the room they've built that will soon be a fully equipped gym with a shower. I spoke briefly with a case manager and commented how nice the office was. She replied, "I know the office is nice. It's just too bad it cost somebody their once-a-week bath."

In 1997, my counterpart at the CCAC made approximately $1,000 a year more than I did. Today she earns $20,000 more a year than I do. And unless something changes for the community agencies—what you need to understand is that the CCACs have just finished negotiating a contract with their employees—by the year 2005, this office support position in the CCAC will earn more per year than a community nurse. This is not acceptable. These are examples of how our community health care dollars are being spent. Something has to change; it's just not right.

The CCACs have a large budget with no accountability to the public, and information is not accessible through the freedom of information act. While I admire your commitment to the future of medicare, I urge you to strengthen the bill and restore public confidence in our health care system. The public should have the right to know how health care dollars are spent, and they shouldn't be spent on a gym for CCAC workers.

I ask that you put in place public control, public governance and democratically elected boards. I ask that you restore full access to home care, including home nursing, homemaking and personal support. I ask that you put a stop to the competitive bidding and reverse the privatization of community care.

In closing, I ask that the health quality council be assembled through an elected process by groups that represent patients, advocates and front-line workers from the health care system. The council should be truly accountable and can make recommendations for change. No person who has a financial interest in for-profit health care should be allowed to sit on the council. In addition, the council should deliver an annual public report on the health care system.

**The Acting Chair:** Thank you very much. We have six minutes left, so each party will have two minutes to ask questions, starting with Ms Smith.

**Ms Smith:** I'd really like to thank you for coming to give us this presentation today. It's always helpful to hear from various groups. We haven't heard enough from the home care sector, so we appreciate that.

I wish I had more time, because I have so many things I wanted to say, but the CCACs will be brought into the accountability agreement framework that's outlined in this bill, so there will be more accountability and there will be agreements and there will be public disclosure. We were actually shocked that the information you referred to is not available under the FOI system, and we're certainly going to be looking at that.

I've met with the VON in my riding, and I've heard very similar stories and a similar passion to what you

expressed today, so we're very aware of the concerns that are out there with respect to home care. We had a very graphic presentation in Ottawa, which included props, which Mr Kormos would have greatly enjoyed, that set out all the different silos that had been built from one system, which just seemed crazy to us. So we appreciate that.

I hope you'll take the opportunity to take the previous government to task in their two minutes for some of the things they have done. But I did want to just read to you a portion of a speech that the minister made two days ago at the Economic Club of Toronto, where he outlined our vision for health care:

"Effective home care services are also very much a part of our plan for putting care in the community.

"Romanow calls home care the next essential service, and we agree.

"Nowadays, services that used to only be provided in institutions can be delivered at home. Home care can offer greater dignity and quality of life. Many prefer the independence of receiving care in their home, but too often this is not an option. And we know that home care is often less costly.

"We are too reliant on institutional care. We are going to change that.

"If what I say about investments in the community, in primary care and home care has a familiar ring to it, this should not come as a surprise. It's been spoken of constantly. But we aren't interested in just talking.

"As a first step to put care in the community, we will invest the federal health accord dollars this year in home care services, catastrophic drug coverage and the development of family health teams. This will help us build our capacity to care for people in their communities and integrate community services with institutional care."

So you've got the commitment from the minister, and you'll be seeing action on that shortly.

**The Acting Chair:** Mr Hudak.

**Mr Hudak:** It's nice to have the letter and the written commitment by the minister. I recall a commitment by the minister in this government to scrap the P3 hospitals. We've heard from many presenters today that not only have they gone ahead with the P3 hospitals, but they have more planned. There was an honest debate during the campaign. We had one opinion; the NDP had another. The Liberals' position is substantially different now in office than during the campaign. So we will look forward to Mr Smitherman actually putting action behind his words.

We've heard they are going to make substantial amendments to this bill, but we have yet to actually see the amendments. So we've heard a lot of promises but have seen no action and no promises being kept.

A particular concern that you brought up from the CCACs' point of view is the quality health council and making sure there is good and broad representation on that council. One of the issues we've heard too is their lack of consumer representation on that council. Do you have a view in terms of whether there should be guaranteed seats on the council for any particular group? I think you had talked about an elected council.

Second, with respect to the council, you talked about public reporting. One view expressed is that it should report directly to the Legislature as opposed to the minister. Do you have any views in terms of what they should be looking at? I think right now they're restricted to whatever the minister asks them to review.

**Ms Boggs:** I think they need to be looking at private fees, looking into where our health care dollars are spent, all that sort of stuff. I did read the bill. I didn't want to talk about the whole bill; I just wanted to talk about home care today. There are lots of things happening in our health care system that need to be fixed, but the most important thing, and the thing that I hope is important to every person in this room, everybody who has taken the time to come and talk to you, is that the public want to know. We're sick of not knowing where our health care dollars are going. Everybody is running a deficit. We don't know where the money is going. The CCAC is a prime example.

I will talk a little bit about who should be on the council. The original CCAC boards had consumers and different groups on those boards, and when those different groups complained, they were fired. So on this council I want people—not a guaranteed seat, or perhaps I do. Maybe I want somebody from the Ontario Health Coalition to sit there, so I know that what's coming out and what's being reported is the truth. That is what this should all be about, that we know where the dollars are being spent, we get the truth about where they're being spent and they are not being wasted on gyms and staff lounges.

I don't know if I answered your question, but things have gone so bad in the last eight years that they need to be fixed. I appreciate what you said, but they need to be fixed now. If you took all the money that every one of the 43 CCACs spends right now on administering the RFP process, following it, the whole process from beginning to end—I don't know if you'd need more money; just take the money out of the administration and put it right now, today, into the delivery of the service, and health care would increase in this province. It doesn't take a lot of money; it takes redirection of the money. In my opinion, the CCAC is getting quite a bit of money. It's just not going to client care, and that's what's disgusting.

**The Acting Chair:** Thank you. Wonderful answer.

We should be adjourning, Peter, but I'm going to allow you the two minutes as well.

**Mr Kormos:** I appreciate it.

Thank you very much, Sister. Look, I can't quarrel with you. The problem is that just as the last government, when CCAC boards displeased them, fired those boards and put in their hand-picked cronies, their hatchet people, their little marionettes, one of the fundamental problems with this bill is that it enables the minister to do the same to hospital boards if the minister "is of the opinion," and the boards, who are the victims—no, the patients, the

public, who are the victims, have no recourse through the courts.

So I suppose, in this debate between people who were in the former government and people who are in the present government, the frightening thing for me is how much these two governments are similar rather than how they are dissimilar. The Liberals have demonstrated an uncanny ability to campaign like New Democrats but govern like Tories. So your message today is well put and appreciated.

What we want is accountability. Maybe publicly elected boards are the way to go. If you believe in democracy, you won't have little appointed boards, you won't have little backroom deals being struck by small, little cliques, be they cliques of members of a hospital or cliques of government backroomers who appoint their political cronies.

**The Acting Chair:** Thank you for those questions, Peter.

**Ms Boggs:** Can I just make one more comment?

**The Acting Chair:** I will allow you to make another comment, and then we will be recessing. Go right ahead.

**Ms Boggs:** The problem is that the CCAC board members who were hand-picked by the Conservative government are still in place today. There has been no move by your government to change that.

**The Acting Chair:** I thank you for your sincere, emotional and excellent presentation.

*The committee recessed from 1242 to 1350.*

## ST JOSEPH'S HEALTHCARE HAMILTON
## HAMILTON HEALTH SCIENCES CORP
## ST PETER'S HEALTH SYSTEM

**The Chair:** Ladies and gentlemen, if we could call the committee to order again, I'd like to call St Joseph's Healthcare Hamilton, Hamilton Health Sciences Corp and St Peter's Health System. Make yourselves comfortable. The rules are that you've got 20 minutes. You can use that any way you see fit. If there is any time left over at the end of the presentation, we'll apportion it between the three parties for questions. The floor is yours.

**Mr David Borsellino:** My name is Dave Borsellino, and I'm the chair of the board of trustees at St Joseph's Healthcare. I'll introduce Bob Jones, from Hamilton Health Sciences Corp, and Urmas Soomet, from St Peter's.

Thank you for the opportunity to be here today and make a few comments. I'd like to kick off with perhaps a few introductory comments, and then I would ask Bob Jones to step in and talk about a few specific issues that we have.

First of all, in terms of who we are—I think there's a handout—it talks a little bit about the total budget, the total number of beds and employees. In the interests of time, I'll leave that to you to look at at your leisure, but it just describes who we are.

I think the more important question is, why are we here today together? The answer to that is, first of all, that we are aligned in supporting the philosophy of Bill 8, particularly with respect to the issues of transparency and accountability. I think, though, as we go forward and look at the importance of leveraging the value of the health care dollar, the other thing we're aligned on is that we believe collaboration is an essential part of going forward. We've taken some steps toward that in the Hamilton community among our hospitals.

As we've started down that road, there are some things we have seen. We've seen that the restructuring commission work that was done some years ago has left us a little bit of a by-product: an every-man-for-himself type of approach. I think if you come through a process that from an institutional point of view is survival-based, you tend to hunker down and look within your own organization. As we try to move into collaboration, there are a lot of issues around trust and working together that take some time to implement. So we're in the process of attempting to do that, brick by brick. One of the things we feel is important as we go through that process is that part of it is having a shared vision, a shared set of goals and objectives that you're trying to achieve, and in the final analysis, it's really measured in terms of outcomes.

We're also aligned in terms of coming here today and feeling that this collaboration effort also has to exist between the hospitals and the ministry. As we go forward, we are going to have this issue of shared goals and vision, and when it comes to the issue of accountability, there has to be mutual accountability. This is something we have to come to together, and it's going to be one of the keys in terms of going forward. So we do have some concerns about that.

I'd like to turn it over to Bob Jones for some of our further comments.

**Mr Robert Jones:** Thanks, Dave. The handout, I think, has been provided. I'd just say that in preparation for today's meeting with you, we've gone through various iterations of this presentation and have distilled this down to what we believe are the really key components. We know you've heard from many other organizations like the OHA, of which we are members, and the Ontario Council of Teaching Hospitals—two of us at least are members there. We didn't want to reiterate a lot of that; we just want to focus on the themes we've provided for you here today.

First of all, picking up on Dave's introductory comments, the accountability agreements in our view have to be negotiated and have to reflect that interdependent nature of the relationship of trust, mutual respect and collaboration between the health care providers and government and, furthermore, respect the community input through the role of local, voluntary governance of public hospitals. Those are two fundamentals that we feel very strongly about.

In terms of due process, the handout we provided says, "Bill 8: No dispute resolution mechanism," and that's "a must between partners." Perhaps rather than refer to it simply as a dispute resolution mechanism, what we're saying is that if this is going to work effectively in terms

of providing better governance, better accountability and ultimately better patient care, there may not be a dispute but a circumstance can arise during the course of an agreement where underlying assumptions can change, significant anomalies or events can occur, either provincially or locally or even within an institution. That may be to the benefit or the detriment of either party, but in any event, when those things change, there needs to be an articulated means by which the parties can communicate, review and if necessary revise those agreements based on those anomalies.

In addition, we say in our next slide that we think the amendments should include a guarantee of governmental action in the public interest. We think that caveat is extremely important. It exists elsewhere in legislation in terms of the ministerial authority that the Minister of Health has, and we think it's an important concept that should be replicated in Bill 8.

Recognition of board responsibility and authority: Again, it goes without saying that we believe strongly in local governance and local board responsibility in that regard. As an adjunct to that, it's very important that there be clear roles and responsibilities for both the hospitals and the ministry. We understand that an opportunity for misunderstanding exists in the complex system of hospitals and health care that we have, even with the best intentions of the parties. To the extent that we want to avoid that and effect positive outcomes, these roles and responsibilities need to be absolutely clear.

The next point is the assurance that the minister will receive necessary support from other branches of government in order to deliver on his or her commitments to the hospitals. What we're really driving at there is that we see this as more of a continuum of accountability, that in fact this deal might be through the Ministry of Health but really it is with the Ontario government. In order for the parties to act responsibly, meet the needs of the system and deliver on the accountability agreement, there has to be sufficient funding and there have to be the proper assurances, therefore, that that will not be an issue that interferes with the fruition of those agreements.

Finally, in terms of the materials we've provided, we say that the amendments should include that providers and government are held accountable to Ontarians for quality health care. We certainly believe in that. We're supportive of that. We agree as well that Ontarians have timely access to the health care services they need. We endorse the efforts to ensure accessibility and enhance accountability, but we cannot support the bill without the revisions we've talked about.

We believe that an amended Bill 8 must strengthen Ontario's proud history of community governance—the right for communities to govern their health care facilities—and to protect medicare and its principles.

We believe that communities want to partner with government to deliver better health care but not be unilaterally directed by Queen's Park to act without sufficient community input.

That's the essence of the principles and the ideas we have to provide to you today, based on our experience and our belief in terms of where we might go in the future.

**The Chair:** Thank you very much. I appreciate the summary and the brevity of the paperwork.

**Mr Jones:** I thought you might.

**The Chair:** If they gave out funding based on giving good summaries, you guys would be winners.

**Mr Jones:** We gladly accept the award.

**The Chair:** You've got about three minutes from each party for questions, so we'll start with Mr Hudak. You weren't really here for the presentation but you could probably catch up with it real quick. Do you want me to go to Ms Martel first?

**Mr Hudak:** Do you know what, Chair? I appreciate the issues the gentlemen brought forward. Having had the chance to sit on this committee and review the bill, I understand the concerns that hospital boards have brought forward on Bill 8.

There's an expression that you can't judge a book by its cover. Well, we certainly can't judge this bill by its cover and what are described as a lot of motherhood issues. Actually, when you look at the details, it's substantially different from the description the minister brought forward upon first reading.

Hospitals from across the province have come forward with very serious concerns about the imposition of the power of the Minister of Health upon hospital boards. In fact, the West Haldimand General Hospital described it as making board members puppets.

The West Lincoln Memorial Hospital described that there is still a great deal of concern about exactly what these accountability agreements are going to entail and if they are in fact creating a hybrid model where the CEO is going to have to respond both to the board and the Ministry of Health. In fact, they asked the government to make a decision: either maintain our system of local governance and the CEO responds to the board, or the Ministry of Health takes over the boards altogether, if that is the true intention of this government. Make one decision one way or the other instead of creating a hybrid model.

Perhaps you gentlemen could describe a bit more the concern with respect to accountability agreements, how they affect day-to-day operations, and the position they will put the CEO or other administrators in if they do have to follow some sort of hybrid model and answer to two masters.

**1400**

**Mr Borsellino:** Just maybe a couple of comments on that. I stand back from this a little bit further and look at this issue of mutual accountability. Ultimately, it still has to be measured by outcomes. In a lot of situations where we're trying to address a particular problem, the first thing that people rush to is structure. In my view, based on my past years in a business environment, structure comes last. You have to have some shared idea of where you're trying to go and how you're trying to get there.

We welcome the concept of accountability, but accountability is always a two-sided situation. So in terms of the role of the board going down the road, I

think that's still left to be sorted out. When you look at things, for example, like trying to move from what we have to a whole new environment with respect to the effectiveness of health care, it's going to be a journey. It's not going to happen overnight. We need to be able to plan; we need to be able to execute over a period of time.

When we deal with situations like multi-year funding and being able to put together a set of goals and objectives over a period of time that are not going to change every time we turn around or get into a situation where you're halfway through the year before you even know what your funding is, those types of situations will not result in this being successful in terms of outcomes. So it's really around how we get an agreement on both sides in terms of the direction that we're heading and the tactics we're going to use.

**The Chair:** Ms Martel.

**Ms Shelley Martel (Nickel Belt):** Thank you for being here today. You said in your presentation that you want the government to provide for due process, and you point out the dispute resolution mechanism which is the proposal the OHA has put forward. You will know, of course, that in the draft framework for proposed changes that the minister gave to the committee via the parliamentary assistant last week, there isn't a place for a dispute resolution mechanism.

What remains, even in the proposed document, is that at the end of the day the minister has the unilateral right to issue a compliance directive or an order. How do you feel about that? Clearly you have a proposal. This is not a proposal that the minister was even prepared to entertain as late as last Thursday, despite whatever negotiations have been going on behind the scenes. Where does that leave the three of you as chairs of various boards?

**Mr Urmas Soomet:** Excuse me, I've lost my voice overnight, but I'll do my best. This is really no different than what we've already got. Hamilton has seen supervision from the Minister of Health. That exists already; that potential exists. So even the minister's changes leave that situation unchanged.

From our perspective, when we talk about accountability agreements, it's probably better to think of them framed as partnership agreements and developing commonly shared ideals of where we want to end up and how we're going to get there, and then use the agreements as a framework to get into that process.

**Ms Martel:** If that's the case, why would you be supporting the dispute resolution mechanism?

**Mr Soomet:** We still believe there's a need for some flexibility for dealing with changing circumstances and forcing agreement in some fashion.

**Ms Martel:** Force versus forcing an agreement; is that what you're saying?

**Mr Soomet:** We need a situation where we can arrive at agreements that are mutually acceptable. The current situation is not completely satisfactory. It exists today and may exist in the future; who knows?

**Mr Jones:** If I might add to that as well, perhaps to reiterate, while it's referenced as a dispute resolution mechanism, and that in part may be the purpose, part of what we're looking for is a recognition, notwithstanding parties of good intention and goodwill coming together and coming up with an agreement that exists over a period of time, that things change. If some of the underlying assumptions on which the agreement has been made change—not for any inappropriate reasons; they simply do—then you need a formula, you need a recognition of the right of either party to come back and revisit the agreement in light of those changes and, if necessary, review and revise. That's really what we're driving at.

**Ms Martel:** And that doesn't exist at present, not in the current bill and certainly not in the framework that the minister released last week. So if we don't see some changes before March 11, which is the next date that I expect we'll see something from the minister, where will that leave the three of you and your boards?

**Mr Jones:** Certainly we would look for those changes to be included, if at all possible. We're not here to try to suggest each iteration of this and how many iterations there might be going forward. But ultimately, in whatever form this takes, we would certainly be looking for those types of provisions to exist.

**The Chair:** Ms Smith.

**Ms Smith:** Thank you very much for your presentation. Certainly, this being the last of eight days of hearings, brevity is very welcome. We appreciate that. Plus my briefcase is getting way too heavy, so this is very nice.

I wanted to just comment on a couple of your points. You talk about the negotiated accountability agreements. On Tuesday the minister made a speech, as you may be aware, to the Economic Club of Toronto on changing roles in health care and spoke about predictable funding and accountability agreements. You talked about the need for stable funding. Is "predicable funding" a similar term? Is that something you welcome?

**Mr Jones:** Absolutely.

**Ms Smith:** In view of the way the minister structured it, in the sense that predictable funding and accountability agreements are kind of going hand in hand, do you see that as a positive step forward in the hospital structure?

**Mr Jones:** Yes. We're absolutely supportive, as we said at the outset, of the notion of mutual and appropriate accountability. As a concomitant piece to that, the predictability of the funding is absolutely a key piece, because absent that it's very difficult to be held accountable for outcomes when you're not sure of the types of revenue or the amount of revenue you have to work with.

**Ms Smith:** I was interested in your discussion about dispute resolution. When you enter into an agreement, let's say, between the three of you on some joint project or joint effort in the Hamilton area, would your dispute resolution provisions be included in the agreement itself?

**Mr Jones:** I understand that we do have some agreements. I am not an expert in that area, but I do believe we have some articulation agreements. Certainly as teaching hospitals we have them with the universities, and in there are provisions that recognize the fact that there may be

circumstances that change during the course of the agreement, whether they be disputes or simply material changes in the underlying assumptions or the criteria or the circumstances under which the agreement was made. My short answer is yes, I believe that exists, and I've certainly seen agreements where that exists. That would be the type of thing we'd be looking for.

**Ms Smith:** Do you foresee that as being part of an accountability agreement?

**Mr Borsellino:** I think part of the issue there as well is, if you and I were going to enter into some type of mutual accountability agreement to achieve some goals or objectives that were going to be executed in some kind of environment, we would have some principles and understanding that we set out to accomplish, and we would try to capture that as best we could in words. We could have a situation change external to what we were trying to accomplish. If we have a change in that external environment, this is really to provide an opportunity for us to sit down again and say, "What were we really trying to accomplish? Given this unforeseen circumstance, how do we now execute this in the spirit of the original accountability agreement?" as opposed to just saying, "I've done my part."

**Ms Smith:** That's great. That's exactly what I was thinking. In the framework for change that we outlined, in section 22 we talk about including "notice and other due process provisions, including time frames for notice, to address development of accountability agreements, issuance of compliance directives and orders," and as an example they list "discussion process, meetings, exchange of documents/information, representations that the minister has to consider before issuing a compliance directive or an order."

Within that kind of framework, if there was a change in circumstance that wasn't allowing you to meet an objective in your accountability agreement, could you not see that you would have an opportunity in this process that's going to be outlined in the amendments to bring it up for discussion, to put it before the minister?

Maybe we're talking about different worries, but what I see as a worry is if you've got an accountability agreement and you've got all your objectives, it's all set out, and then something like SARS hits and you've got to rejig the way you do things in order to address that concern. Do you not think that what is set out in our framework for change for section 22 would allow you to make those representations to the minister in dealing with your accountability agreement?

**The Chair:** It will have to be a very short answer.

**Ms Smith:** Sorry, it's a very long question.

**Mr Borsellino:** I think history will tell. A lot will depend on how the ministry responds to those types of situations. Our concern is that it isn't explicitly outlined. So we're unsure at this point in time. That's why we wanted to voice that opinion.

**The Chair:** Thank you, gentlemen. We do appreciate your being here today.

**1410**

## CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 4800

**The Chair:** Our next delegation is from the Canadian Union of Public Employees, local 4800, Juanita Maldonado, vice-president of St Elizabeth Nurses. Greetings. Please make yourself comfortable. As with all the groups appearing before us today, you have 20 minutes to make your presentation. You can use that time as you see fit. If there is any time left at the end of the presentation, we'll apportion it among the three parties. The floor is yours.

**Ms Juanita Maldonado:** Good afternoon. I'm a little nervous, so you'll have to bear with me.

**The Chair:** These people are pretty friendly. I'm just getting to know them. No one has gotten bit yet, that I've seen, anyway.

**Ms Maldonado:** I'm very glad to hear that.

My name is Juanita Maldonado. I'm here as a representative of CUPE local 4800. We represent Hamilton Health Sciences. We're also a very diverse bargaining group, because our local encompasses community care as well as the hospital sector. We're one of the largest hospital locals in Ontario. Our service and trades members work at the General, the Henderson and MUMC, and we've recently acquired the cancer centre. I am vice-president for the St Elizabeth Nurses community care organization.

Just to give you an idea of what our members are about, we range from plumbers to electricians to carpenters. I represent a clerical bargaining unit. Hospitals have a professional sector, business clerks, social workers and RPNs.

We bring forward today a message from the local. We are front-line workers, and we wanted to give you an idea, more or less, of how we see this bill affecting what we do every day. I'm hoping that once I tell you a few first-hand experiences, it will give you an idea of why we are concerned.

We have had first-hand experience dealing with hospital infections. We've had an Ebola scare. We've dealt with SARS. We have the MRSA concern in the hospitals. We've had to face the possible closure of the Henderson, which we fought and were successful in keeping. The emergency room at the Henderson is very important, and we were successful in keeping that.

The reason I am here today is because we are concerned about the bill and the fact that it can open up our collective agreements. That's the bottom line. We don't want to risk our wages and losing our benefits. I was grateful today for the amendments and to see that one of the amendments refers to trade unions not being involved in that. I'm sure our lawyers will be looking at that and advising us as to the details.

One of the things that goes hand in hand with what this bill does is that when you start talking about collec-

tive agreements, you also start talking about contracting out and privatization. They are all very closed linked. That is a grave concern when you start talking about the effect that lack of funding in the hospitals has and how that spills over into the community and affects people who do not have the resources to stay at home and have care.

I want to tell you three stories. One is the story of a gentleman in our Hamilton community who became a quadriplegic 20 years ago. This gentleman has been fighting for a service that is essential for him to live his life in a way that you and I would take for granted. Andy has allowed me to tell his story. He has continued to be on the CCAC's cutting list. At a time when perhaps a service may not seem essential because the CCACs are in a position where they have to continue to save money and seek places where they can eliminate services, this gentleman has continued, without dignity, to fight for something as simple as allowing him the service to live in a basic fashion every day. I'm not going to get into the details of it; it's quite humiliating. This is a gentleman who paid taxes his entire life and, due to a terrible, unfortunate accident, is now fighting for nine hours of essential nursing service a week. It's disgusting. I don't think we're doing a very good job of taking care of our own, and I'd like to hear what this committee has to say about that.

St Elizabeth Nurses is a not-for-profit organization. Any of the money the company I work for takes, it puts back into the system. It goes to education, better equipment and maintaining the services we really need as essential in the community, so that people can lead lives that are really effective and independent, and that will cost the province less than if we keep cutting.

I'm asking that we take a serious look at Bill 8 and how it is reinvesting in our health care system. I'd like to know, is it part of the general erosion of what's continued at this time? The nursing shortage in our community is something we have to address. We cannot put dollars into lining the pockets of corporations that are coming into this country to take what is ours. If we don't stop and reinvest it in a publicly funded system—I would be very interested to know how changing the act as it stands right now would do that.

A large portion of what seems to be targeted are service and clerical employees, and I really don't think we're going to save a lot of money if we do that, necessarily. I think it's important for us. CUPE has always been willing to sit at a table and talk about what could be beneficial. We've been vigilant about supporting and being there when there have been cutbacks, even for the people we work for, because we believe—I was so grateful to hear those gentlemen who sat up here before me, because I really felt like I'm not alone, coming from Hamilton. We do want to work together. It is collaborative, there is no question. But we need to be honest about the way we spend our money, and we need to be honest about what this bill is doing. Anything that gives unilateral decision-making ability to one person scares the heck out of me. I don't understand that, and perhaps somebody can enlighten me that way.

We support many of the principles. Universal public medicare is Canada's most cherished social program. Medicare means we don't have to spend a lot on health care insurance, and if we're not spending it on health care insurance, it means we can spend it in our economy and keep the money here. A healthy economy is what we need. That leaves us all more money to spend on ourselves. Canada's health care system is an economic asset.

Our 3,600 members sent me here today, and this is the message they would like me to convey: Please follow through on the amendments suggested by CUPE. Our collective agreements were negotiated fairly and within a process that no bill should be legally allowed to interfere with. But most importantly, we want this government to work with the health care community. Let's focus our energies together on protecting our most valuable resource. The onus falls on this government to do that.

Just before I conclude, these attached amendments are what our legal buffs are suggesting. I'd like to read them to you: No trade union shall be required to enter into an accountability agreement or be the subject of one; no collective agreement shall be the subject of an accountability agreement or a directive, and neither would it affect the continued operation and enforceability of a collective agreement; and no employer shall be required or authorized to enter into an accountability agreement that directly or indirectly interferes with its ability to comply with the provisions of such agreements.

I really appreciate the fact that you listened to me today. Thank you very much.

**The Chair:** Thank you, Ms Maldonado, you did wonderfully. You've left each of the parties about three minutes to ask you questions, and we're starting with Ms Martel.

**Ms Martel:** Thank you very much for coming today. I'll try and deal with three of these points. The minister has said there will be changes that will deal with collective agreements; he hasn't said there will be any changes with respect to compliance directives. I just want to make the distinction, because the minister would still have the power to say to a hospital, "We want you to amalgamate your housekeeping services and your food services, and maybe we'll get you to amalgamate your clerical services while we're at it," which would still result in an impact on health care workers and their jobs in the hospital sector. So while there might not be changes in the front door through the collective agreement, there certainly remains the possibility that your members and others could be affected because of compliance directives. Are you worried that the minister still seems to have unilateral ability to issue directives that could still result in changes, in loss of position, loss of staff, even changes in people's wages if it's contracted out and successor rights don't apply? Are you worried that that provision still remains in the bill?

**1420**

**Ms Maldonado:** There's not a lot I'm not worried about when it comes to a lot that comes out of the min-

ister's mouth. I'm concerned, because almost every time anybody has said something, it never comes to fruition. Yes, I'm certainly concerned. There's always been a backdoor. It didn't matter which way we looked at it. We've come to a place now where we can look at the rest of the country and see what has happened and hopefully learn from that, which is why we've been proactive and tried to educate. There are parts of the country where they have had direction from ministers, even though they had made agreements, to go ahead and take away from members, but we were still successful through mobilizing the public. When you speak to the public, they are the ones who will make a difference as to whether things happen. That is what I am counting on. I am hoping that, with things like these forums, they will listen. Not only that, it is the state of our health care system; it's not just what our wages are. That's not the only issue, necessarily. Yes, the compliance directives are a big concern. I haven't had a chance to look at the other amendments, but the fact that you say that's still not addressed is a big concern.

**Ms Martel:** You said it's changing. How is changing Bill 8 going to stop public money going into private companies that provide health care? The bill's not going to do anything about that. That's the sad part about this bill. It's got a preamble that talks about government support for public health care, but it's the same government that is allowing private hospitals to be built in the province using private financing instead of public money. It's the same government that's allowing the private, for-profit MRI and CAT scan clinics to continue. It's the same government that's allowing competitive bidding in home care to continue so that not-for-profit agencies like St Elizabeth, or VON in my community, lose the contract to a for-profit company and some of the money that should go into patient care goes into their profits instead.

The reality of the bill is that it does absolutely zero, nothing, nada to stop privatization of health care services, and that's the shame of it. The preamble is certainly important, but the rest of the bill does nothing to support the glowing words in the preamble, and that's a shame.

**Ms Maldonado:** But CUPE will be there to watch that. That's OK.

**The Chair:** Ms Smith.

**Ms Smith:** We're certainly delighted to have Ms Martel back this afternoon. We've missed that speech, Shelley.

**Ms Martel:** You'll hear some more this afternoon.

**Ms Smith:** I'm sure.

I wanted to really thank you for coming out today. It's great that you were able to come and give us your perspective. Certainly, bringing it down to the actual particulars of a particular client you have is very helpful.

We have had a couple of presentations on the CCACs and the cuts to the CCACs, and we're aware of concerns around those. The act we're presently discussing will impose accountability agreements between the CCACs and the Ministry of Health. I think that will go some way to opening up the process at the CCACs, because those accountability agreements will be public and will force the CCACs to be accountable for the funding they're receiving. So I'm hoping that will go some way to deal with some of your concerns.

You also talked about the nursing shortage, and I just wanted to highlight for you the fact that the minister made an announcement two days ago about funding for hospitals and tied part of that funding directly to targeting exclusively the creation of full-time nursing positions and improving the health and safety working conditions for nurses. So there is a recognition that we do need to make investments in nursing in the province and we're moving forward with that.

You have talked about the amendment framework, that you were aware of that. There was also a letter that went to Sid Ryan last Monday from the minister, after he made his statement to the committee. Did you see the letter to Sid Ryan of CUPE?

**Ms Maldonado:** Sid spoke on Tuesday.

**Ms Smith:** But last Monday the minister wrote to Mr Ryan because of the comments he had made. He was very emphatic that Bill 8 will not allow for opening collective agreements or threaten job security. The intent of Bill 8 is that accountability agreements are established only with boards of directors of publicly funded health care institutions. Bill 8 cannot open collective agreements. He also notes, and I note for you as well, that collective agreements are protected by various pieces of legislation in Ontario, including the Labour Relations Act. So while Ms Martel would raise the fear that directives under this scheme of accountability agreements may allow for changing of collective agreements, of course you know that the Labour Relations Act protects collective agreements from being opened up mid-term.

**Ms Maldonado:** Why would the minister say, then, that it would only affect current collective agreements? If we were already protected by that, why would he say that? I don't understand.

**Ms Smith:** Your collective agreement is in place until it's negotiated again, right?

**Ms Maldonado:** Right.

**Ms Smith:** So at some point there will be a negotiation, and at that point it's up to the parties to negotiate. He's not going to speak for every collective agreement into the future. I assume that's why he made that statement.

**Ms Maldonado:** That's what I'm saying: If my collective agreement is already protected by another act, why in the bill would it possibly mention that this bill would not affect current collective agreements?

*Interjection.*

**Ms Smith:** Exactly, because Mr Ryan is trying to convince people that this act would in fact allow for the opening of collective agreements.

**Ms Maldonado:** The initial act does say that. Sid didn't tell me anything initially. So why—

**Ms Smith:** The bill as it's written—and we've acknowledged that, but in the framework for amendments we've made it perfectly clear that the bill does not

apply to unions. There will not be accountability imposed upon unions and it will not affect collective agreements.

**The Chair:** Mr Hudak.

**Mr Hudak:** I think we all appreciate that the minister has written a letter. The concern is that it's going to be in the same sort of disappearing ink that his campaign platform was written in. I think you've got a right to be suspicious of the government's intentions in this area. They made all kinds of promises on P3 hospitals. They made all kinds of promises about what this bill was going to be about. Once you open up the pages and look into it, there is a tale that is going to be all motherhood and apple pie in this legislation, but when union leaders, hospitals, doctors and nurses saw the bill on their desks, there was a whiff of something but it wasn't apple pie.

There is a hidden agenda in this bill that this committee has cottoned on to and we're actually going to see scores and scores of amendments. We haven't actually seen anybody who likes this bill. The only group that likes this bill are the printers, because of all the amendments they're going to be printing in the next couple of weeks. Let me ask you, why do you suppose the government brought forward this kind of legislation and described it as something entirely different from what CUPE and other groups have brought forward to be the true impact of the bill?

**Ms Maldonado:** Because I'm standing here representing 3,600 people, I'm afraid I can't answer that question honestly.

**Mr Hudak:** No problem. I didn't want to put you in a difficult spot. Given your conversation with the parliamentary assistant, there seems to be a level of distrust about what exactly the intentions of the government were with this particular bill.

**Ms Maldonado:** If this government was my boyfriend, I would have dumped him a long time ago.

**Mr Hudak:** In fact, the particular issues you've brought forward—and my colleague Mr Klees brought forward a motion to immediately bring those into the bill to protect collective agreements, in Sault Ste Marie, I believe it was. It was voted down by the Liberal government members. So until we actually see this brought forward, the real amended changes, I'm going to remain very suspicious about what this government's intentions were and why the description of the bill bore no resemblance whatsoever to what is actually in it.

**The Chair:** Thank you for coming, Ms Maldonado. We appreciate your input.

**1430**

## CLEMENT BABB

**The Chair:** We have two people coming forward in a row who are individuals. As a result of what transpired at the subcommittee, we said we would give individuals 15 minutes for presentations. This will be a 15-minute presentation, Mr Babb. You've got that time to use as you see fit. Any time that is left over from the presentation we will split among the three parties.

**Mr Clement E. Babb:** Good afternoon. My name is C.E. Babb, from Burlington, Ontario. I'm essentially going to read my presentation to you. I want you to know that I am representing myself and not a group.

One comment: I am greatly concerned about the title of the act, the Commitment to the Future of Medicare Act. Reference to the future is an escape from that which is before us today. We must have sound health care now. We, the people, don't need promises for the future of health care, of medicare. What do I recommend? The Commitment to Sound Health Care Act.

Number two, I want to talk to you and caution you about the first part of the bill, the Ontario Health Quality Council. I recommend that this part be deleted from the bill. Why? Because the Ontario Health Quality Council sounds too much to me like predecessor activities which have borne little or no fruit.

What do I mean here?

Number one, the National Forum on Health of the 1990s was a complete bust and waste of time and energy, an effort undertaken because the Chrétien government, including Health Ministers Dingwall and especially Allan Rock, wouldn't and couldn't knuckle down and take action about health care across the land. This worthless effort was shut down suddenly, after three years, because of an election, so there was no payoff.

The Romanow commission was another bust in my opinion—and mine alone—with $15 million spent over 18 months, between April 2001 and November 2002. What's the legacy? In my opinion, nothing. Well, not exactly. The legacy is the illusion of leadership, of action, of decision. Yes, Romanow did a magnificent job. He consulted, researched, listened, talked and produced solid reports. But what's been done? Nothing; just meetings, conferences and the like. More and more planning; more and more planning.

Just the other day was the meeting of the Premiers out west—they yakked about health care, among other things—and this summer they and federal leaders will get together again on health care.

Then there's the National Health Council, chaired by Michael Decter. This has an annual budget of $10 million. This group has met and then will issue a report annually, just like the Ontario Health Quality Council is supposed to do. What I am afraid of, with Bill 8's Ontario Health Quality Council, is that this high-sounding concept will engender more and more delay and will permit present and future governments, when faced with a difficult issue, to say, "Well, we'll get to that, but first we have to wait till the council completes its report, which, by the way, will be completed six to eight to 10 months from now."

Please do not let this piece of legislation continue delay after delay, study after study, annual report after annual report. Smitherman and McGuinty need to get on with it. Provide sound health care now, not in the future.

**The Chair:** Thank you, Mr Babb. You used up about five minutes, so that leaves us about three minutes for

each of the parties to ask you questions, starting with the government side.

**Ms Smith:** Thank you, Mr Babb. We appreciate your taking the time to come and speak to us. I was interested in your comments about the Ontario Health Quality Council and the National Health Council. One of the things we've provided in drafting this legislation and creating the Ontario council was to ensure that we have one member who is also our appointee to the national council, so that we know what they are doing and there is no duplication; that they actually are complementary. Do you think that's a good idea in creating the council?

**Mr Babb:** That presupposes that there is a validity and a worth to the National Health Council. I, for one, don't think there is. I have to amend that and just simply say, yes, there are probably some good things that can and should be done, but I don't want to see those things done at the cost of simply getting on with it, organizing health care. That's what ministries and departments and all that kind of stuff are for. Why the hell do they need to go off to some retreats and conventions and meetings and all this kind of stuff? Their job, your job, the ministry's job is to provide health care. I give you my money—my neighbour Willard gives you my money—and you're supposed to do something concrete with it, not fart around on a bunch of conferences and councils and this kind of stuff.

**Ms Smith:** I think the Minister of Health would agree with you. In fact, he gave a speech two days ago where he spoke about the Romanow report and the various studies. He said, "The Romanow report has set out, in clear and compelling terms, what our health care system needs. It's time to take the necessary steps to get us there." He outlined in his speech a number of steps that we're taking to reform our health care system. I'll make sure you get a copy of this speech before you go, because I think it will give you some comfort that action is being taken on a number of fronts.

**Mr Babb:** Thank you very much for offering that. I must tell you that on the Monday before, I tried and tried to find out where the minister was making his speech, about six telephone calls, and nothing happened. Nobody was able to tell me when and where, and I learned after the speech was over that it was held at the Economic Club, wherever that was.

*Interjection.*

**Mr Babb:** Sixty-five? That's OK. I would have a way of getting in and just listening, I'm sure. Or 65, it would have been worth it.

**Ms Smith:** I understand. Well, I'll get you a copy of the speech. I think my colleague, Ms Wynne, had something else she wanted to add.

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

**Ms Wynne:** In every sector that we're dealing with right now, there's a lack of a plan, and there's a lot of fracturing that's gone on. The Ontario Health Quality Council is an attempt to get a handle on what's going on, report to the public and move forward. What would you do in order to get a handle on some of those issues, set some standards and hold institutions accountable? How would you do that?

**Mr Babb:** You're talking about setting standards in the future?

**Ms Wynne:** I'm saying setting some benchmarks, setting some goals, holding institutions accountable right now, because the money Mr Smitherman announced this week is going to be tied to some accountability measures. How would you do that, if not through having some body that was doing the thinking about that?

**Mr Babb:** I would think that body would be the Ministry of Health. Good grief, there are a gazillion people on the staff there. You've got thousands of qualified people.

**Ms Wynne:** So you don't think it would be helpful to have people from the community and folks who are close to the grassroots having some input into that?

**Mr Babb:** Why do it now? Why not do it before?

**Ms Wynne:** We weren't in power before.

**The Chair:** We're going to go to Mr Klees.

**Mr Klees:** Sir, your point is very well taken. Ms Wynne says, "Wouldn't you want to have some people from the community involved in accountability?" Well, we have that now. It's called the board, first of all, at the local community level, volunteer people from all sectors of the community who sit on boards of hospitals, the very boards this bill is undermining. We've heard from chairs of boards here who have said to this committee, "If this bill goes through, you will have a resignation from every member of the board, because what you're doing is giving the authority to the minister to reach through the board and to basically take single-handed control of everything that goes on in your local community hospital."

**1440**

Then, in addition to that, as you so well put it, there are the thousands of employees of the Ministry of Health, and what are they doing? The question we've asked around this committee table is that with all of the accountability you want to drive down to the hospital, where is the accountability measure for the Ministry of Health? What are they doing with their time? And what is there in this bill—not one single sentence—about how the minister or the ministry are going to be held accountable to the people for their role in ensuring efficient, effective and quality delivery of health care? I'd be interested in your comments on that.

**Mr Babb:** I have too many, but I just think that's a big rub. To me, accountability of the ministers—Wilson, Clement etc—has been horrible. I don't know exactly how it can be done, but certainly not an inquiry, certainly not a commission.

Just a couple of things: When Romanow and Allan Rock came off the Hill down to the National Press Club in 2001, I was there yelling at the guy, "All you're going to do is delay, delay, delay." So he went in and so forth. On the day, November 27, when he did the same thing and came out of the press club after he'd finished delivering his report, I was that old fart standing there, "Delay,

delay, delay," and he said, "It's up to you," meaning it's up to the public. It's not up to the public; it's up to the politicians to get cracking on health care.

**The Chair:** Ms Martel.

**Ms Martel:** Thank you for being here today. I expressed my concerns with respect to the health quality council in an exchange I had with the minister when this bill was introduced. I said to him my concern was that it was going to be a body with reports, like many others, and nothing will be done. Cancer Care Ontario—I've used this example before and I'm going to use it again—issued a report in 1999, or the Provincial Auditor did, that said treatment for cancer should be done in four weeks, and we still aren't meeting that objective. That was 1999. So I'm not very interested myself in having a report produced that is just going to have a bunch of recommendations that never get implemented. That's the first thing.

The second thing—and Ms Smith, the parliamentary assistant, is going to correct me if I'm wrong in this at some point in the afternoon, but I think this is what she's talking about when she says the minister, in his speech, talked about what the McGuinty government has already done with respect to going forward on Romanow. She'll correct me if I have the wrong paragraph, but I think it's the right one:

First, "We have quickly moved to redefine our relationship with the federal government on the basis of cooperation, and we played a key role in ensuring the establishment of the National Health Council." So what?

Then, "We appointed Dr Sheela Basrur as Ontario's chief medical officer of health and now all Ontarians will benefit from her remarkable abilities as she leads the renewal of public health in our province." I think it was interesting when they appointed her that they did not also say, as they promised in the election, that they would make the chief medical officer of health's position independent of government. She's not, and now she's an assistant deputy minister, so I sure hope she's not going to be co-opted by the bureaucracy.

Third, "When a Toronto hospital discovered a problem with the sterilization of medical equipment, I directed all hospitals to conduct an audit of infection control practices. A process that brought cultural change to hospitals." You'll note what the minister didn't do was pass a regulation so that ministry inspectors can go into hospitals and actually independently audit their process of sterilization, nor did he provide any additional funding to hospitals for infection control practitioners, despite the recommendation for that in the interim SARS report that was released in December, a report that was commissioned by the former Minister of Health.

Fourth, "We've taken decisive actions to protect our seniors in long-term-care facilities by conducting unannounced annual inspections. And my parliamentary assistant, Monique Smith, is conducting a top-to-bottom review of long-term care to make the system more transparent and responsive to the needs of our seniors." I wish, with respect to long-term care, the government would just go forward and put back the standards that used to be in place in long-term-care facilities; standards, for example, of having a nurse 24 hours a day, seven days a week, having a regulation with respect to the minimum hours of care—it was 2.3 when we left government; the Tories trashed that, and now there is no standard—or even put back a regulation to say that people in a nursing home will get a bath once a week, because there's no regulation with respect to that right now.

So I appreciate the review, but I'd really like to see the regulations that could be passed at cabinet on a Wednesday morning to ensure that we have standards, regulations, for quality of care.

If I read the wrong part I'm going to be corrected, but I just thought I should make a point of saying that in terms of the health care issues that are facing us, that's a pretty short list. I don't see much change there.

The real problem I have is that if you look at the preamble that talks in glowing terms about health care, it's great, but when the rubber hits the road, there's nothing in the bill that, for example, changes home care, ends competitive bidding or even puts more money in, despite the Liberal election promises. There's nothing that talks about pharmacare for catastrophic drugs, to put that into place. And there's certainly nothing, and I've said this over and over again, that ends private sector involvement in health care, like getting rid of the P3 hospitals, getting rid of competitive bidding in home care or getting rid of the private, for-profit MRI clinics. So there's a big disconnect between the preamble and the rest of the bill.

**The Chair:** Thank you, Mr Babb, for travelling from Burlington to see us today.

## HENRY BOSCH

**The Chair:** Our next delegation is also an individual, Henry Bosch. Make yourself comfortable. Welcome. The same rules apply: 15 minutes to use any way you choose. Any time that is left over we will split among the parties. If you could identify yourself for Hansard, that would be great.

**Mr Henry Bosch:** Thank you for inviting me to speak here today. My name is Henry Bosch and I am a paramedic in Niagara. I am also the vice-president of the Ontario Council of Hospital Unions representing southern Ontario.

I have read Bill 8 and I am alarmed at what I read; specifically, the accountability section, part III. In this section you call for the employer, known as the service provider, and the bargaining agent or entity, known as the union, to enter into accountability agreements or face fines of anywhere up to $100,000. You are in fact asking both the employer and the union or bargaining agent to police each other to keep the hospital fiscally responsible. This is not the role the two entities were ever set up to do. They are for service delivery and quality assurance; that is, we deliver professional services to the public so that the public gets the type of health care it deserves.

In your Bill 8, you give the Minister of Health the appearance of ultimate power. By this I mean that he or she can issue an order of compliance, mainly based on fiscal responsibilities, and is neither liable nor accountable for his or her actions. We, the public, see this as an abuse of office.

Your government seems to try to equate a balanced budget and debt reduction to equally accessible health care. The health and welfare of Ontarians should not be attributed to dollars saved. Health care over the years has been slashed and reduced to near bare bones, and now your government, in the guise of Bill 8, is looking to allow many services now delivered publicly to be delivered by private, for-profit companies.

I find it hard to listen to the money angle. By this I mean that you claim hospitals spend too much of the public taxpayers' money and that your government feels that most hotel services, as you call them, in hospitals can be provided by private, for-profit companies, and thus save the taxpayers money and somehow reduce the debt. I don't quite see how a private company doing the work of the public sector can be cheaper. We all know that every contract has a built-in profit margin.

That leads me down another path. For example, if it costs the government $1 million to provide a service in a hospital and you are able to contract it out for $900,000, it would appear that you have saved $100,000, but I ask you, at what cost to the health care service? As we all know, you need to factor in the profit margin of approximately 15% to 20%. So we are only looking at approximately $700,000 to $750,000 to provide the service at the same level as the public sector.

If I can, I'd ask you for a moment to recall Bill 29, introduced and passed in BC, which closely resembles your Bill 8. In that instance, the services contracted out are leading to an increase in infection rates in hospitals and a decrease in cleanliness of hospitals, becoming totally unacceptable and bordering on absurd.

Even at present levels of staffing in the hospitals in Ontario, the SARS epidemic of last year was overwhelming on staff, as well as resources in the health care sector. So imagine, if you will, that the services in the affected hospitals were being delivered by the private sector. I will let you draw your own conclusions.

Bill 8 essentially lets all these concerns addressed previously become closer to reality, and all at the cost of health care to Ontarians.

Your Bill 8 speaks of making health care facilities in Ontario fiscally responsible. I am quite certain that you could poll the people of Ontario and ask them one thing: Would you like to see the provincial government use your tax dollars to bring down or lessen the debt or would you like to see your tax dollars spent on accessible health care, education and other public services? I think they would choose the latter.

**1450**

To champion for a debt-free province at the cost of public sector services is wrong, but to try to introduce legislation such as Bill 8 to try to achieve this is not acceptable. I think all Ontarians would agree that some sort of accountability in the health care sector is needed, but to try to take it out of the pockets of some of the lowest-paid employees in the hospitals by a form of union-busting is unacceptable.

I am not sure if you know this or not, but most people who enter the health care field in some capacity, be it housekeeping, dietary, clerical or even nursing, do so to embark on and make it their career. The wages, benefits and pensions are structured so as to make the health care sector a viable and sustainable career, not a stepping stone to something else. If Bill 8 is passed and not amended, you are paving the way for private health care service delivery.

Please amend Bill 8 to reflect the comments and concerns you are hearing in these public hearings and also those concerns of the unions, doctors and other agencies that daily deliver health care. Thank you for listening.

**The Chair:** Thank you very much, Mr Bosch. You only used up about six minutes, so that leaves about three minutes for each of the parties. Our sequence this time begins with the official opposition.

**Mr Hudak:** Thank you, Mr Bosch, for your presentation and your concerns about Bill 8. I apologize that I missed the opening. The part I caught was dedicated to public health care as opposed to private involvement in health care.

My recollection was that the then campaigning Liberals, now governing Liberals, made some very strong comments about eliminating private care and closing the door to private care. Do you remember them making promises like that, and how did you interpret that as a voter?

**Mr Bosch:** I remember hearing it from Campbell, McGuinty and Charest, and in all three of those provinces right now they're having a problem with private coming in and trying to do the work of the public sector in health care, education and stuff like that. So yes, I did hear it but I don't see it. I read the bill. Like I said, the first part is nice, and then the further you get into it, the way I see it, it paves the road for private, for-profit companies to come in, and I don't see how you can still offer the same level of care at a lower rate.

**Mr Hudak:** It's your recollection that McGuinty at the time had said he was not going to have private health care in Ontario. How does this bill gel with what you saw as McGuinty's campaign promises?

**Mr Bosch:** It doesn't.

**Mr Hudak:** It's sort of the opposite.

**Mr Bosch:** Yes.

**Mr Hudak:** In terms of private care, do you see any role in the health care system for private provision of care or are you positioned against it in its entirety?

**Mr Bosch:** I would have to look at which section you're talking about, but mainly the core services that hospitals and health care provide should be provided by the public, because it is public money. Why should someone make a gain off my tax dollars when I'm paying for

what I thought was a service? Like I said, being in health care, I've noticed it go all the way down to bare bones.

**The Chair:** Ms Martel.

**Ms Martel:** Thank you for being here today. You referenced compliance directives at the start of your remarks. Do you want to tell me what your concern is in that regard?

**Mr Bosch:** They alluded earlier that these compliance directives and accountability agreements won't affect current collective agreements. I have a problem with the fact that it could be imposed upon you down the road: "You're not complying with this, so we're going to come in and make you comply."

When you look at the thing, it says there that even if the Minister of Health comes in and signs an order, 28(a), I believe it is, says that it's mutually agreed upon by both parties. In the health care sector, if you want to save money, if the hospital is trying to become fiscally responsible, that's what collective bargaining is. We fall under HLDAA, so we're at the mercy of the binding arbitration process, and that's how we feel we can get it. We go through redeployment and stuff in other ways and that's how they make their budgets. We fight with them to make their budgets at the end of the year, but it shouldn't be up to us to please them. The government shouldn't have the ultimate power to come in and say, "We're now going to tell you where you're going to cut." Usually it falls on the backs of the lowest-paid workers, because they usually get the service in the clerical end first. That's the problem there.

**Ms Martel:** Yes, we've heard from people that it's usually not upper management that might have to take a cut in pay.

**Mr Bosch:** Yes, there is that possibility too, but I haven't seen much happen in the last 19 years.

**Ms Martel:** So your concern really has to do with the arbitrary nature of it, that there doesn't seem to be a whole lot of room for negotiation if you look at the bill and you see in so many sections that the minister has the power to do anything, at any time, anywhere, and for any length of time as well. I can tell you, there isn't much of a change in that with respect to the proposed amendments that the minister has put forward either.

**Mr Bosch:** I just saw them now, when I came in. I'll look at them more closely, but just looking at the front, it doesn't seem to even address half the concerns of health care.

**The Chair:** Ms Smith.

**Ms Smith:** Thank you, Mr Bosch. We appreciate your being here. I'm sorry to hear that you hadn't seen the proposed amendment framework. The minister, however, has made it clear in a number of addresses and in a letter to Sid Ryan of CUPE that the accountability agreements that we're discussing do not apply to trade unions, they will not be required to enter into them, and the collective agreements will not be affected by them.

I was interested in your comments that this bill reflects Bill 29 in BC. I don't know how familiar you are with Bill 29 from British Columbia, but I just wondered how this bill in any way reflects things like right to reorganize, service delivery, multi-work-site assignment rates, contracting out outside of the collective agreements, employment security and labour force adjustment agreements, health care labour adjustment society, layoffs and bumping, what parts prevail over collective agreements. Are there any things like that addressed in this bill that you've seen?

**Mr Bosch:** No, it's quite the opposite, actually. It says that they can come in—like I say, with a compliance order he can strip collective agreements. That is the way we read this.

**Ms Smith:** I've actually seen the legal memo from Sack Goldblatt Mitchell; I think that's what you're referring to.

**Mr Bosch:** Yes. I've got it here.

**Ms Smith:** In fact, it doesn't say that this bill will allow you to strip collective agreements.

**Mr Bosch:** There's the possibility.

**Ms Smith:** It's even more couched than that, and I think that is a stretch of an interpretation of this bill. This legal memo—it's not an opinion—was provided prior to the amendment framework and prior to the minister's stating that unions and collective agreements would not be affected by this bill. I'm not really sure that it can hold water. I wonder why you feel so strongly that this bill reflects the situation in BC.

**Mr Bosch:** On the side of the contracting out, what Bill 29 allowed the government to do there was to come in and carve out collective agreements, carve out sections. Laundry was privatized. What they did was people were offered jobs back, and the jobs they were offered back were at $9 an hour with no pension, no benefits. That's why I allude to that most people who enter health care enter it to make it their career. At that point, in BC, in the hospitals affected, Kelowna and all that—what's happening is, it's a stepping stone for another career now, and that's why I referenced there that the infection rate and cleanliness are going down, because you're only going to get what you pay for. That's why health care professionals, be it the service side, the clerical side, or the professional side, all do their jobs to make it a career. I believe it was two and a half weeks ago that the doctors pulled out of Nanaimo.

**Ms Smith:** Have you seen a copy of the letter to Sid Ryan from the minister with respect to the bill?

**Mr Bosch:** No.

**Ms Smith:** I'll make sure you get a copy of that before you go.

**Mr Bosch:** It's probably at home. I'm on that same mailing list.

**The Chair:** Thank you, Mr Bosch. The time has expired. We do appreciate your being here, and your input this afternoon.

I'm going to let Mr Craitor introduce the next delegation.

**1500**

## ONTARIO CHIROPRACTIC ASSOCIATION, NIAGARA FALLS CHAPTER

**The Acting Chair:** The next presenter is from the Ontario Chiropractic Association, the Niagara Falls chapter. We have Dr Ted Mangoff and Dr Joanne McKinley. Good afternoon. You have 20 minutes. Any time that's left over will be divided between the three parties to ask you questions. I have two names here, so maybe you could just introduce yourselves as you speak so we could have that for Hansard. Whenever you're ready, go right ahead.

**Dr Ted Mangoff:** Do you want to do introductions?

**The Acting Chair:** Why don't we do that and then we'll have it officially in Hansard.

**Ms Patricia Dziarnowski:** Patricia Dziarnowski.

**Ms Kim MacGregor:** Kim MacGregor.

**Dr Mangoff:** I want to take the opportunity to thank the Chair and the members for allowing us to appear today. I understand you've already met with a couple of members of our profession so hopefully I won't be repeating a lot of their information.

Basically the reason we're here today is, first, to reiterate the need for chiropractic inclusion in the proposed bill that's under current consideration and for any changes that are proposed for the health act like accessibility.

The second thing is to establish a commitment on the part of the government to ensure continued access of chiropractic care to the public at large and to maintain it as a component of the Ontario health care system.

Third and most important, we want to present input on the value of these services from a patient's perspective and how any barriers to care that currently exist affect our patients.

There are just a couple of points I wanted to make about doctors of chiropractic. We serve a large and growing population in the province. I believe about 15% are currently under chiropractic care and over 50% have at some point consulted a chiropractor.

We do provide safe, effective and evidence-based care with a high degree of patient satisfaction and value. As well, we provide good value for the dollar. Chiropractic care costs are a lot less relative to the traditional medical stream, such as a hospital or family physician. So those are a couple of the points.

Care has consistently provided a quick return to work as well as return to normal activities of living, so we do have effective treatments and I believe can aid the government in saving some money in that respect.

Most of these points have already been cited in some ministry studies such as the Wells report and the two Manga reports. Those were conducted as late as 1993 and 1998.

To hit home with this, we want to make sure that chiropractic is included and that access to care is maintained for the public in Ontario.

I just wanted Joanne to address a couple of points on accessibility and then hopefully hear from the two patients we brought with us today.

**Dr Joanne McKinley-Molodynia:** Thank you for letting me address the committee also. I'm here because accessibility within my practice is of particular importance because I'm located in a low- to mid-socio-economic area. It's a real barrier for patients to access care because of the lack of funding. I don't know how many of you know that OHIP pays $150 per year, from April to the end of March. That's $11.75 for the initial visit and then $9.65 for subsequent visits. That's about 15 visits a year. We are allowed to charge a fee on top of that. If you have a patient who comes in with an acute condition, that small amount, $150, can be used up quite easily and then they're responsible for the extra charge. If they don't have the financial resources to cover that, then as a practitioner you have to decide, "I'm going to make special arrangements for that patient," but you can't do that for everyone. That leaves them with the option of seeking care elsewhere.

What do they typically do? If they have even come to your office in the first place, if they can afford to come and then they have to stop care, they're going to go back to the family doctor. They may go to the emergency department. If they're on Ontario Works, they may use the Ontario drug benefit program. But these are all extra costs to the system that could have been absorbed a lot cheaper if they had stuck with the chiropractic care, if it wasn't such a huge barrier to them.

Another thing they might choose to do is do nothing. If they're a working person, they're going to miss time from work; they're going to be less productive. It's just a huge waste of human resources.

The future of medicare has got to include chiropractic care. Like Ted mentioned, there is the Manga report that has shown how cost-effective it is. It's kind of hard to understand, when the government has done studies that show how cost-effective it is, why it's not going to be included from the get-go.

I've brought two patients, Pat and Kim, who have been with me and have definitely had economic barriers to care. I just want them to go over their stories.

**Ms Dziarnowski:** Joanne has offered me six months' free chiropractic care for my presentation here, so that is very generous of her and I appreciate it. Seriously, I had a whiplash injury at the age of nine that was left untreated and I've had problems with my neck and shoulder as an adult, so I've been using chiropractic care for quite a number of years.

The fees charged above OHIP have been a hindrance to me on a couple of occasions, one when I exceeded the maximum yearly amount and then another when my husband was unemployed. I was only able to continue treatments because Joanne waived the fee until I was able to make the payments myself.

I chose to go that route and try and maintain my own health rather than resorting to drugs and going to my family physician. I would also use other alternative ther-

apies if there was some funding or partial funding available through medicare. I believe allowing individuals to choose lower-cost alternative therapies like chiropractic care by providing better funding would ease some of the burden on the present health care system and benefit everyone.

**Ms MacGregor:** I'm Kim MacGregor. I came to Joanne because of some back, hip and foot problems that came about from my pregnancy. I was unable to get out of bed in the morning. I had pain every single day. I couldn't go for walks, I couldn't lift my daughter and, more important, I was really limited because of that in my job opportunities. I'm a daycare worker and I have to lift children all day long. That presented a big problem for me. I actively pursued alternative care. My goal was to avoid being medicated, X-rayed or possibly have surgery. I've been able to do that through Joanne, through corrective and preventative chiropractic care. By doing that, I feel I've saved the province a lot of money. I was in a lot of pain. It was very difficult to get around and Joanne helped me with that.

I now have increased mobility. I can go for walks pain-free and this has made me a more productive and viable employee.

I believe medicare should include chiropractic care. I believe modern medicine should be about choices and I don't feel those choices should be taken away from me. If chiropractic and other types of alternative care are not included, those choices will be taken away from me.

I'm a single mother and I'm laid off. I have no financial resources to sustain chiropractic visits on my own. Limited funding has been a financial barrier. I've hit that limit, as we've heard from Pat, and I had to suspend my care for a while. But through Joanne—again, she's given me a break in the fees.

Also, not everyone can be as lucky as I to have a Dr Joanne in my life. She's literally given me the shoes off her feet so that I could have proper foot care for walking, which was part of my care. She did that; she gave me her shoes.

*Interjection.*

**Ms MacGregor:** I could cry. She's been a wonderful help to me.

**Dr McKinley-Molodynia:** I have to tell you what happened. I'm a runner, and when my running shoes are no good for running, they're still good for walking. So I do that.

In closing, these are people who have come to my office and that's great and I can give them a break, but, as I said, we can't do that for everybody. There's a huge percentage of the population that is not even coming into our office for the kind of care that we can provide that's cost-effective because it costs them money. That's maybe the whole fault of the way people look at their health care and what they're responsible for. But, yes, there is this true financial barrier. Inaccessibility because of finances really needs to be looked at.

**The Acting Chair:** Thank you very much. We have six minutes left. Starting with Ms Martel from the NDP, you have two minutes.

**Ms Martel:** Thank you for being here today. There are probably two points: (1) that you don't appear in section 10 of the bill, which would lead you to assume that you don't appear anywhere in terms of priority in the health care system; and (2) full coverage, by OHIP essentially, for chiropractic care. Let me just deal with the two of those.

You should know that that section of the bill, part II, actually came from a previous act. It was even in place before I got here, and I got here in 1987. So this goes back to 1986. Essentially, that whole section 10 was lifted from that previous act. I can't explain to you why all the other regulated health professions were not included at that time, but you shouldn't take from that that the ministry and the government are somehow cutting you off from participation in the health care system.

So there certainly has been a suggestion that we can either (1) change that section so that we don't list any of the health care professionals, or (2) change the whole section and include all of the regulated health care providers, which should be about 21 or 22, so that everyone sees that they are listed and can enter into agreements with the government. I'm not sure where we'll end up on that in terms of what amendments might come forward, but clearly something has to be done so that the regulated health professionals don't think they are excluded for some reason that they can't understand any more.

Second, with respect to the broader issue of full OHIP coverage for chiropractors, that is a big issue. It's a significant funding issue, and I wouldn't pretend to tell you that this committee has grappled with that, because we really haven't. I wouldn't expect that it would be something that would come forward through this bill. So I think the most that we can tell you is that the current situation will not be changed in any way, shape or form in terms of the current relationship. What that relationship will be in the future, especially in terms of funding to deal with the barriers to access, is a question that I just can't answer for you at this point in time, but it is very legitimate. We've had good presentations. We got summaries of the reports that you referenced in one of the other presentations so we could understand the cost-effectiveness and the reality around that, but I don't know where that broader discussion will take place and how it will end up, to be honest with you.

**1510**

**The Acting Chair:** Ms Wynne.

**Ms Wynne:** Thanks for coming here today.

Actually, as Ms Martel said, we have heard from the chiropractors on this issue and we understand. Just so we're clear, subsection 10(3) deals with the possibility of the minister entering into agreements with other groups. So not only are you not excluded in this language, but there's every possibility that you could be included. So it really does come down to that issue of, "Are we going to list everybody? Are we going to change that language in a bunch of different places in legislation?" Maybe that's where we have to go, but that's not what we've done here and that doesn't exclude you.

The Lieutenant Governor in Council may make a regulation providing that the minister may enter into an agreement under subsection 10(1) with a specified person or organization other than an association mentioned in subsection 10(2), so it's absolutely possible that you would be included in that section. That's the best we can say at this point. It's not exclusive, but it's not as inclusive as you would like it to be. We understand that.

Did you want to comment on it?

**Dr McKinley-Molodynia:** Considering we're the third-largest provider of health care—

**Ms Wynne:** I know. I understand. I love my chiropractor.

My colleague has a question.

**Mr Shafiq Qaadri (Etobicoke North):** Actually, it's more of a comment.

First of all, as a family doctor myself, I think really the model that we in the government are attempting to adopt is one of collaboration, co-operation. Frankly speaking, in respect of the patients you've brought, which is great—it really brings this story to life—we family physicians are really probably too busy and overwhelmed. As you know, there's something in the order of about a million Ontarians without access to a family doctor. So I think we in the government very much appreciate and value the contribution of your members, the Ontario Chiropractic Association, on a shared care model for the betterment of the health of Ontarians. So thank you very much for your presentation.

**The Chair:** Mr Hudak.

**Mr Hudak:** Thank you, Dr Mangoff and Dr McKinley, and two patients and friends who made the presentation. It was a very good presentation—touching, as well, with the particular circumstances. I think it's great that you're here. You made a point about the bill. You think it's an important one that the government has responded to. I think it's important to continue to get your points on the public record, whether through these committee hearings—I know chiropractors on a regular basis meet with their MPPs. I encourage you to continue doing that. I know other professions have their own days at Queen's Park where they get a chance to interact with members of all parties about their particular issues.

A question for TC: Is that the Wells and the Mangoff report that you had referenced today?

**Dr Mangoff:** Close enough.

**Mr Hudak:** Maybe a bit down the road, eh? Just for the public record, maybe you could discuss a bit in terms of where you see chiropractic care not only maintaining strong quality in the system but saving the taxpayer dollars. Could you describe that a little bit? You started to get into it, but I think it's important to put it on the record.

**Dr Mangoff:** Joanne did touch a little bit on that. One of the things is that without proper access to our treatment—finances are one of the biggest barriers—where are they going to go? Generally, either they don't receive treatment at all and then the condition regresses or progresses to the point where they have time off work or they can't care for family or whatnot; or, secondly, they are under care and midway through their care they run out of funding and they can't afford to continue on and they drop out midway, which will lead them, again, either to the emergency room or their family physician or no care at all.

Essentially, that is where the savings lie: If a person presents to the emergency room, the costs are a lot greater there than, say, the $24-odd that we receive for a visit. Part of that is the OHIP funding, which is really $9.65. So most of the patients in the office would pay a $15 co-payment. There are a good majority who can't afford that, so they go into the medical stream, which is more cost-intensive. That's where you are spending most of the money. Looking at the productivity aspect of things, getting back to work sooner so that less time is lost, there is better productivity in that respect. That's where the costs are going to be reduced and that's where the savings are going to be found, as far as chiropractic goes.

The member did mention collaboration in the medical community. It would be excellent; we'd love that. We're starting to see a lot more of that over the last couple of years. I'd welcome referrals back and forth. It allows the medical doctor to do what they do best. It allows us to do what we do best. The patient gets better overall. So everyone wins, for the most part. That's where I see the most cost savings: in just allowing them to continue their course of care to completion, or entering it altogether.

**Dr McKinley-Molodynia:** To add on to that, just from a diagnostic point of view, because we are trained to identify biomechanical problems, and that's what most low-back—specifically, the Manga report talked about low-back problems. That's what we're trained to look at. If you go into a family physician's office, first of all, they are way too busy so they do a brief examination, typically, and then they may send you for an X-ray which you may or may not need. Often you don't need that X-ray. So that's another cost. Then, if they are not sure after that, there's a referral to the orthopaedic specialist, and that's another cost. There are a lot of costs that don't need to be incurred if you know where to go in the first place, if you know to go to the chiropractor if you've got that type of back pain.

**The Acting Chair:** Thank you very much. We appreciate your coming out. On behalf of the committee, I appreciate your input.

## NIAGARA FALLS AND DISTRICT LABOUR COUNCIL

**The Acting Chair:** The next group, for 3:20, is not here, but the 3:40 group is here. That's the Niagara Falls and District Labour Council, with Julius Antal, who is the president. You have 20 minutes and, time permitting, there will be an opportunity for each of the parties to ask you questions.

**Mr Julius Antal:** By way of introduction, my name is Julius Antal. I am the president of the Niagara Falls and

District Labour Council, representing 2,700 workers from 24 affiliated unions representing workers from all walks of life, including the medical services staff. We have long been involved in economic and social issues in our community, such as health care, and welcome the opportunity to speak. I'll try to move along rather quickly so that, if you have any questions, I may be able to direct some answers.

Bill 8, titled the Commitment to the Future of Medicare Act, was introduced last November to fulfill the Liberal Party's promise to the people of this province to enshrine the Canada Health Act in Ontario law, to create a health quality council to measure the effectiveness of health care and to ensure accountability and prohibit a two-tier system.

**1520**

We do not believe that this bill, as it is currently written, enhances a universally accessible, publicly funded health care system based on the principles of accountability, transparency and accessibility. Our intention is to proceed through the major sections, pointing out weaknesses and offering our views for change.

The preamble recognizes that our system of publicly funded health care services reflects fundamental Canadian values and that its preservation is essential to the health of Ontarians today and in the future. It confirms the enduring commitment to the five principles of medicare: administration, comprehensiveness, universality, portability and accessibility, as currently codified in the Canada Health Act.

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

The Ontario Health Quality Council outlined in part I, sections 1 to 6, of Bill 8 is supposed to (a) monitor and report to the public on access to publicly funded health care services, health human resources in publicly funded health services, consumer and population health status, and health service outcomes, and (b) support continuous quality improvement.

Given the preamble's commitment to the principles of the Canada Health Act, we find it alarming that the Ontario Health Quality Council does not include reporting on the extent, or otherwise, that the Ontario health care system complies with the principles of public administration, comprehensiveness, universality and portability as contained in the Canada Health Act. Further, it is not required to report on issues relating to two-tiered medicine, extra-billing and user fees. Each one of these issues is fundamental to the health care system and of primary importance to the public.

The council is to be composed of between nine and 12 members, all of whom are to be appointed by cabinet. For all the public knows, representatives from the private, for-profit sector could be appointed, using this to erode our public, not-for-profit system. It is our strong view that for-profit providers, given their blatant conflict of interest, should be excluded from this council.

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

Opting out and extra-billing: The section of Bill 8 extends the prohibition against extra-billing by eliminating the right of physicians and other designated practitioners to opt out of the Health Insurance Act and receive direct payments from patients for insured services up to the OHIP maximum. These provisions in subsection 9(2) seem to strengthen the prohibition on extra-billing and opting out. Yet a further subsection of the bill, 9(4), contains language that may well open up the possibility for the government itself, through regulation, to allow extra-billing and opting out. We cannot leave such an important issue to be decided by regulations that may be passed by cabinet with little or no public input.

Queue-jumping: Here Bill 8 proposes a new section, section 15, limiting the ability of individuals to jump the queue. In this respect, an insured person cannot pay to obtain better access to insured services, nor can a practitioner charge for granting better services to an insured person.

The main problem with this section is that it prevents queue-jumping for insured services only. Yet more and more pressure seems to be forthcoming, due to financial considerations and private interests, to delist services. As the list of medically listed services is restricted, this provision would not be applicable and those seeking delisted services would not be protected from queue-jumping. The major threat therefore is not the occasional queue-jumping abuse but rather the ongoing shift from public to private, for-profit health care services. It is our view that this shift must be stopped and reversed. The newly elected Liberal government campaigned against the privatization of health care and should follow through on its commitment to the people of Ontario.

Currently, the most insidious form of privatization is what is termed public-private partnerships, or P3s. The P3 projects of the previous Conservative government, from Brampton to Ottawa and others in the planning stages, should be immediately halted, along with the delisting of services. It has been estimated that such private models can be expected to cost at least 10% more than public sector equivalents. So in addition to the evidence from other such experiments in Britain and Australia that suggests P3 hospitals would include a deterioration of hospital services and diminished accountability, Ontario simply cannot afford a private health care system. Making the operation of a hospital private but keeping the ownership public through a mortgage doesn't substantively change the private, for-profit character of a P3 organization.

Already, private MRI and CT diagnostic clinics operate outside the public system and drain money from it through third party billings, such as WSIB and third party insurance, thereby depriving hospitals of lucrative revenue. Further, such private clinics have depleted trained personnel from our public institutions, creating opportunities for those with financial resources to leapfrog the waiting lists.

Home care provides a further example of the negative impacts of privatization. The privatized delivery of home care through competitive bidding adopted by Ontario is redirecting precious health care money out of patient care and into ballooning administrative costs, and this despite sending labour costs and people's living standards into a nose-dive. Ontario's home care system is rife with duplication, inability to utilize staff efficiently and additional expenses surrounding tendering requests for proposals, preparing bids, evaluating proposals, monitoring and, of course, profit-taking.

Block fees: Many physicians across Ontario have charged patients for uninsured services by charging an annual or block fee. Typically, such services include telephone advice, renewal or prescriptions by telephone, completion of various forms etc. Such block fees have, to date, been largely unregulated, although there are significant guidelines outlined by the College of Physicians and Surgeons of Ontario.

The proposals in Bill 8 specify that the government, not the physician, will determine whether and under what circumstances block fees can be charged. It is our view that Bill 8 should simply ban the practice of block fees. It violates the principles of the Canada Health Act, as it creates a barrier to accessibility and is unnecessary, as physicians can charge on an item-by-item basis for uninsured services. A system that allows block fees is open to abuse, and patients compelled to pay these fees have limited options with the shortage of family practitioners, especially in our area.

Accountability agreements: The most important, controversial and potentially dangerous sections of Bill 8 are contained in part III, sections 19 to 32. They cover the powers of the Minister of Health and Long-Term Care to compel persons to enter into accountability agreements or compliance directives. These provisions have been drafted in such a broad manner as to give the minister unprecedented authority to require individuals and organizations to comply with ministerial initiatives. Potentially, these steps could override legal collective agreements or other negotiated agreements as well as labour legislation within the province.

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

Not only is there little limitation on the minister's authority under such circumstances, but there is also little explanation in the proposed legislation as to what accountability actually consists of. As defined in Bill 8, clause 19(a), an accountability agreement is an agreement establishing performance goals and objectives, service quality, accessibility of services, shared and collective responsibilities for health system outcomes, value for money and other prescribed matters. In short, an accountability agreement can cover anything the government wants it to cover.

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

Further, according to section 20 of Bill 8, the minister, in exercising his or her powers, is to "be governed by the principle that accountability is fundamental to a sound health system," and is thereby to consider a list of matters such as fiscal responsibility, value for money, a focus on outcomes and any other prescribed matters. We are very much in favour of a high-quality health care system and desire value for money and fiscal responsibility as much as anyone, but terms such as these are all too often used as code words in the private sector. As representatives of the Niagara Falls and District Labour Council, we are committed to public health care and are opposed to such language if it is to mean advancing a privatization agenda.

**1530**

The sweeping powers of the minister and the breadth of the directives are further revealed in sections 26, 27 and 28. Section 27 enables the minister to unilaterally change a person's terms of employment and, if this isn't bad enough, "the change shall be deemed to have been mutually agreed upon," and, further along, "the change does not entitle the person to any sort of payment or compensation, despite any provision to the contrary in his or her contract or agreement of employment."

Section 28 gives additional unprecedented powers to the minister, enabling him or her to reduce funding, vary funding or discontinue any term of a contract or agreement of employment. Again, such dictated changes are deemed to have been mutually agreed upon.

These sections should be repealed in their entirety. They are in opposition to democratic practices, such as elections; transparency, such as public reporting on finances; increased community control; and any genuine accountability.

Under the provisions of part III of Bill 8, there is a distinct possibility of severe repercussions for trade unions and collective agreements. Trade unions and employers could be directed to address certain cost saving measures; for example, through collective bargaining. Should they fail to do so, they could face an order requiring them to reduce wages or benefits, or both.

Alternatively, they could be confronted with an order to repeal their no-contracting-out language or their successor rights clause.

In the name of value for money or fiscal responsibility, hospitals and health care employees could be compelled to consolidate operations such as laundry or food services and change their collective agreements to facilitate such changes. An alternative avenue open to the minister would be to simply order a compliance directive requiring collective agreement protections to be modified or overridden.

Admittedly there are counter-arguments to the misuse and unfairness of such a sweeping exercise of ministerial fiat, but why does the bill take us down this road when it is so obviously as undemocratic as it is unnecessary? Why should the vast majority of Ontarians who value public health care have to resort to counter-arguments to address the potential threat to free collective bargaining?

While the motivation of the government is not entirely clear, part III of the bill can only be seen as an attempt to grant the minister virtually unlimited power to unilaterally dictate fundamental changes in the health care system without procedural safeguards or democratic input, far less anything approaching transparency. Despite the comforting words of the preamble, Bill 8 is more reminiscent of the Conservative government's omnibus Bill 26 than it is of the five principles of the Canada Health Act. It even takes the further step in section 30 of seeking to insulate itself from legal liability arising from public opposition in the form of actions taken in connection with accountability agreements or compliance agreements. No one will be allowed to take legal action against the minister or the crown under the provisions of this bill upon its passage. At the same time, the government is free to prosecute anyone not complying with an order by the minister.

The powers and penalties in the bill are all stacked on one side, and it is not on the side of those who want democratic representation and transparency in a health care system supposedly designed for the people. Unfortunately, we are left with little alternative but to call for a complete withdrawal of this section of the bill.

In conclusion, an accountable health system must include: (1) democratically elected boards, open memberships and diverse representation on boards governing health care sectors; (2) whistle-blower protection; (3) transparency regarding delisting and defunding; (4) democratic governance of the OHIP list; (5) meaningful restrictions on commercial secrecy and full public reporting on finances within the health care institutions and sectors; (6) public consultation, meaningful input and public debate about changes to the health system; (7) full public disclosure of fees, service charges and other out-of-pocket costs; (8) duty of the minister to provide stable, multi-year funding; (9) representation of diverse populations on all boards and other governing bodies; and (10) meaningful input of health care workers and users at every level.

The threat to the future sustainability of medicare posed by private, for-profit corporations is critical. P3 hospitals will put billions of public funds in the hands of profit-seeking corporations for whom a veil of commercial secrecy obscures public scrutiny over profit-taking and misuse of public funds. In the endless search for new profits, corporations will seek new sources of revenue, imposing user fees and service charges wherever possible. The motivation and means for increasing two-tier health care are increased. The result is that the scope of services offered under the public system will be reduced. Beds and staff are cut, patients face new fees, two-tiering increases, public accountability and access to information is reduced, democratic control is reduced and costs rise, as well as executive salaries, as more of the health system is governed by profit margins and rates of return for investors.

The people of this province elected a government committed to outlawing two-tier health care in Ontario and stopping the creeping privatization of health care. This must also include non-clinical services and privatizing them in facilities. It must be made clear that medically necessary services include those services that support a patient's daily living, including food, laundry, maintenance, record keeping, diagnostics and therapies. We need to respect our sick and elderly and provide the best quality care possible.

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

The current government ran on a platform of stopping the Americanization of our health system. The pre-election promise was very clear: opposing the creeping privatization and commitment to rebuilding medicare.

Any legislation purporting to show this government's commitment to the future of medicare must include concrete initiatives to roll back privatization and prohibit future for-profit control of our health care institutions. P3 hospitals must be banned. The private diagnostic clinics must be returned to non-profit hospitals. The tide of privatization sweeping across our health system must be stemmed. The future sustainability of medicare and the application of the principles of the Canada Health Act depend on it.

Privatization in the form of P3 hospitals is not reinventing government; it was the path rejected by the people of Ontario, and all the evidence from other jurisdictions tells us it will lead to far worse public services. We urge the government of Ontario to reconsider this bill.

Thank you for allowing me to participate, and hopefully I have still left time for some questions.

**The Acting Chair:** Unfortunately, you didn't. Your presentation was right on track, exactly 20 minutes. We appreciate your comments. They will certainly be looked at by all of us.

For committee members, we're going to recess for five minutes, and then the 4:40 group will be able to present. Then we'll go back on track after that.

**Mr Antal:** Mr Chair, may I have maybe 30 seconds? There was one issue I wanted to—

**The Acting Chair:** You can have 60 seconds.

**Mr Antal:** The question kept arising about the collective agreements and the new amendments to the agreements. Being from the private sector, we have found that any legislation needs to be strengthened in order for some of the things that are being put forward to work. I come from a plant that closed a year ago. I'm still working there, even though it's closed. It's a publicly traded company. Without giving power to the labour board to actually make commitments and decisions on the livelihood of workers, we need to button down every word within any legislation that is proposed. Thank you.

**The Acting Chair:** That will be looked into. Thank you very much.

## ONTARIO ASSOCIATION OF SOCIAL WORKERS, NIAGARA BRANCH

**The Acting Chair:** There's a change of plans. The 4 o'clock group is here, so we're going to continue on. That is the Ontario Association of Social Workers, Niagara branch, John Stob.

**Mr John Stob:** There's no waiting around here.

**The Acting Chair:** Thank you very much, John. The process is that you have 20 minutes to speak, and if there's time left over after your presentation, that will be used to allow the three parties to ask you some questions. Just proceed whenever you're ready.

**1540**

**Mr Stob:** First of all, I want to thank everyone here on the committee for the opportunity to present this brief this afternoon and to introduce myself. My name is John Stob, and I've been a partner in the family counselling firm of Lidkea, Stob, Venema and Associates for the past 25 years. We provide counselling to the people of Niagara region—family, marriage and individual—through private practice referrals and through employee assistance programs. I'm here today to present a brief on behalf of the Ontario Association of Social Workers. Has the brief been passed around? Do people have a copy?

**The Acting Chair:** Yes, thank you.

**Mr Stob:** OK. Then what I'll do is simply read the brief to the committee.

The Ontario Association of Social Workers is a bilingual membership association incorporated in 1964, with over 3,000 members to date. Practising members are social workers with university degrees in social work at the doctoral, master's and baccalaureate levels.

The OASW is one of 11 provincial and territorial associations of social workers which belong to the Canadian Association of Social Workers, which is in turn a member of the 76-nation International Federation of Social Workers. The OASW has 15 local branches across Ontario. Our association embodies the social work profession's commitment to a civil and equitable society by engaging in social action related to especially vulnerable and disadvantaged populations, and taking positions on important issues. Today's brief is prepared by the Niagara branch of the Ontario Association of Social Workers.

Bill 8 is titled the Commitment to the Future of Medicare Act. It was introduced in the autumn as the fulfillment of the Liberal Party's promise to enshrine the Canada Health Act in Ontario law, create a health quality council to monitor and provide accountability, and prohibit two-tier health care. As it stands, in our opinion, the bill does not further the implementation of the principles of the CHA, nor does it provide improved democracy, transparency or accountability. Further, it does not prohibit the further erosion of the scope of medicare, the increasing problems of privatization, profit-taking and two-tiering for those services that have been delisted. Further, it gives the Minister of Health sweeping powers without clear intent or democratic control. This brief is an attempt to highlight some local examples from Niagara of how the current medicare system is insufficiently supporting needy persons, and also the need for improved and enhanced services.

As the president of the Niagara branch of the Ontario Association of Social Workers, I am pleased to have the opportunity to address the standing committee on justice and social policy and provide comments regarding Bill 8, the Commitment to the Future of Medicare Act.

We in the OASW are in agreement with the values identified in the preamble of the act. We support the belief in a consumer-centred health system that ensures access based upon need, and not on ability to pay.

In his remarks of February 16, Minister Smitherman emphasized a belief "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" daily "relevant, it must evolve to encompass a full continuum of care, including primary health care, home care and pharmacare."

We strongly support a true systems approach to collaboration between consumers, health service providers and government. As social workers, we want to emphasize that access to a continuum of care includes giving people access to the tools that will enable them to make healthy lifestyle choices and changes.

What do we mean by "the tools"? We mean access to health teaching and education, offered by a multidisciplinary team of health professionals. For example, physiotherapists not only treat, but also educate in the best approaches to body mechanics. Occupational therapists enable individuals to optimize their independence and activities of daily living. Dieticians focus on healthy diets and teach people how to adapt to specific needs in their daily living requirements. Social workers provide stress management, coping techniques, problem-solving advice and skills and, often most importantly, advocacy.

Ontario citizens need to have access to these and other professional services, combined with the medical skills of family physicians and nurse practitioners. These services could be delivered in a publicly funded system, publicly governed at a community level, also accessible seven days a week at the community-based level. This is not a new model. Community health centres have existed in Ontario for years. They fit with the principles enshrined within the act. Financially, they provide the best value for the health tax dollar. Administratively, all staff are salaried. This would address the issue of block fees. Yet the act falls short of identifying or strengthening the role for such models. As for accountability, the effectiveness of such service models has been shown in many other previous presentations. Such settings provide a stable, consistent, supportive and empowering environment for all citizens, but are especially effective for those experiencing low income, mental illnesses or chronic, long-standing medical conditions.

Part II of the act replaces the Health Care Accessibility Act and identifies penalties for higher charges or block fees for insured services. The current draft does not seem to address problems of accessibility and affordability for uninsured or delisted services. The onus also appears to be on the consumer to file a complaint regarding unauthorized payment requirements. For many of Ontario's citizens, this would indeed be a very difficult personal step to take.

In keeping with the intent of legislation of universality and access based upon identified need, we suggest that the act, or the accompanying regulations, address a yearly open review of items which have been delisted, done in the context of identified needs for those in especially marginal or low-income brackets.

We are concerned that the language speaks of "pharmacare for catastrophic drug costs." Will this leave the door open for further decreases to current drug benefit programs for the elderly and/or low-income citizens of Ontario? Why does the wording focus on "catastrophic"? Who will define catastrophic versus non-catastrophic drug costs?

A recent locally publicized example might help to shed some light. A week ago, a woman was admitted to a local hospital here in Niagara. Her medical condition had worsened, because she had not taken the medication prescribed for her. She had not filled the prescription. Although she was covered for the cost of the drug, she could not afford the dispensing fee. Thus, she stayed away, and she became yet another person competing for an expensive, high-demand, acute-care bed. This situation was totally preventable if she had known enough to ask the pharmacist to waive the fee, or if the practice of dispensing fees simply did not exist. Perhaps if this woman had been a member of a community health care centre, she might have been supported, spoken to, educated and encouraged to ask the right questions.

In Niagara, homelessness has increased since the reductions in welfare, brought in by the previous government and the lack of building of social housing. This has a direct impact upon the health care system. The most vulnerable and chronically ill, and those with long-term mental illness, often present at the emergency departments of local hospitals. It is a simple, basic tenet of primary health care: If there is no stable, supportive community, vulnerable people move frequently and more often than the general population and correspondingly suffer more health care problems, thus causing more demand upon an already overloaded hospital system. Currently, it is estimated that Niagara stands in need of 548 more affordable housing units and 66 more case managers to provide ongoing support.

**1550**

Part III of the act outlines expectations of accountability and delineates specific circumstances of accountability for health resource providers. We suggest that the expectations be expanded to include accountability for said providers to work together in a consumer-centred approach.

Here in Niagara, there is an excellent example of such co-operation. There is a consortium of mental health service providers funded by MOHLTC dollars. The Canadian Mental Health Association, Gateway Residence, Oak Centre, regional public health and the Niagara Health System have devised a working model to deliver services to mental health clients in need of both moderate and intensive support. CMHA is the lead agency administering the funds, Gateway and Oak Centre provide supportive housing, public health provides nursing support to clients and the Niagara Health System provides community crisis care. Since the beginning of this consortium, 80% of the clients are staying housed, reducing the amount of moving around, and episodes of crises therefore have de-escalated—clearly lowered. These individuals are no longer being seen in the high-cost and high-demand in-patient mental health beds.

However, there is still the issue that many of the clients are unable to either find family physicians or, if they do, are often faced with a cost of $50 to $90 to have the medical portion of their application for the Ontario disability support program completed. Again, a primary health care service model would comprise a basic low-cost model of care providing stable, supportive, accessible and effective medicare.

In summary, as the members of this committee review the findings of the consultations and determine specific recommendations, please ask the questions: What real difference will the act and the regulations make to the people of Ontario, both in the present and future? How will the act make a difference to the lady who could not afford the cost of the dispensing fee and therefore ended up in an acute-care bed? How will it make a difference to the woman forced by circumstances to stay in hospital rather than at home for lack of funds to buy a special $15,000 wound care mattress? Will the legislation specify the accountability to ensure that the funds follow the need?

The important issues are to ensure a true continuum of services, working together, where services are both

accessible and affordable to clients who need them the most. This concludes the presentation we've prepared.

**The Acting Chair:** We have a minute and a half for each of the parties to ask questions, and I'm going to start with the government.

**Mr Brad Duguid (Scarborough Centre):** Very quickly, on page 3 of your draft, you talked about accountability and the need to use accountability agreements or an effective accountability system to ensure that providers work together in a consumer-centred approach. I thought the example you used was an excellent example of a success story that we see very infrequently and something that we want to encourage. In his speech yesterday, the minister talked about improving access to family physicians and other members of the primary care team as one of his three key priorities. He's also talked a lot about the need for provision of community-based services. The key to getting there is to have an effective accountability system in place to ensure that we can move all the players along in the same direction. Would you agree with that?

**Mr Stob:** I would agree 100%. Our belief is that primary health care at the community-based level is clearly the most effective and the most beneficial in a direct way and prevents people climbing up the ladder of the system. Any system that can be put into effect that presses that working together, benefits all in the community.

**Mr Duguid:** That's good. That's exactly why the government is moving very succinctly toward that kind of model. I think it's important that we have the tools to be able to ensure compliance with the vision we're moving forward with in the health care system. I appreciate that, and I appreciate your bringing this excellent example to our attention, because that's the model I think we really want to move toward for the future.

**Mr Stob:** We're together on that.

**The Acting Chair:** Mr Hudak.

**Mr Hudak:** Thanks for the presentation. You're actually a lot more toned down than most of the presentations we've seen here before the committee today. I was going to say my friend Mr Antal had pointed out a number of serious flaws in this bill. We've seen the government members backpedalling so fast on this they're going to set a record for Ripley's museum just down the street.

**Mr Stob:** Perhaps if we'd had more than two days to prepare, we might have done the same.

**Mr Hudak:** You'd get more riled up.

I think the central point of your argument was that accountability is a two-way street. If the government is going to put fines on health care providers for accountability agreements and such, then they have a duty to follow through with some of the funding and make sure that people can afford it. You talked about pharmacare for example, which was referenced in the preamble but was absent from the bill itself.

With respect to the community health model or the process begun with the family health networks, for example, group practices and that sort of thing, would your vision be to expand that to a variety of health care providers?

**Mr Stob:** Absolutely. Our vision would be that much more interventive and educational support would occur at the grassroots level, clearly meaning that a whole lot of upward movement into the system, which is increasingly expensive, can therefore be avoided. We support any system that can be put in place which presses that working together within a community between various agencies. We think it is really crucial to (a) meeting needs and (b) watching our tax dollars.

**The Acting Chair:** Ms Martel.

**Ms Martel:** Thank you for making your presentation here today. Let me focus on the woman who couldn't get her prescriptions filled because she had to pay a copayment. Some seniors in this province now pay a $2 copayment based on their income, and others have the privilege and pleasure of paying the dispensing fee, and that again depends on their income.

Here's my concern: If you look in the preamble, it says this bill is going to "continue to support the prohibition of two-tier medicine, extra billing and user fees." At the same time it says that, the government is quite openly musing about the possibility of changing criteria for the Ontario drug benefit plan so that wealthy seniors, rich seniors—however the government is going to decide that—will now have the privilege of paying for their prescription drugs.

I think if the government moves in that direction, you're going to see a whole lot more people in the emergency department seeking care, because they can't afford to pay for their prescription drugs. As far as I'm concerned, there's a direct contradiction between this bill that we're dealing with and the government openly talking about changing the ODB plan, for example.

The second point I'd like to make is, the preamble also says, "recognize that access to primary health care is a cornerstone of an effective health system." My view is that if community health centres were a priority for the government, they would be appearing in this bill. I say that because this government is getting federal money for primary health care. They've got the dollars now from the feds. They don't even have to find it in their own budget; they're getting it from the feds for primary health care.

The former government focused all their money on family health networks, which didn't work. Most doctors did not switch and move into FHNs. I wasn't very thrilled with the FHN proposal anyway, because I didn't think they made the best use of other health care providers in the system who have scopes of practice and a role to play. My concern is that, although we talk about primary health care, although we're getting federal money for primary health care, we see no movement to date on more community health centres etc. If this were a priority, I think the government would be moving on this now, because they actually have the money to make it happen right now.

**Mr Stob:** I couldn't agree more. Along with it, of course, we would like to encourage that language be put

into the bill so the emphasis is clearly and legally there. I think without that kind of pressure, it's not going to happen by itself, and it needs to be pressed.

**The Acting Chair:** Thank you for attending. We appreciate your comments.

**1600**

## HALTON HEALTHCARE SERVICES

**The Chair:** Our next delegation comes to us from the centre of the universe—Oakville. I'd like to call forward the delegation from the Halton Healthcare Services. Would you come forward, Mr Madon, and introduce the people you have with you today. The rules are you've got 20 minutes. You can use that any way you see fit. At the end of your presentation, we will use the remaining time shared among the three parties. If you would introduce yourself for Hansard, that would be wonderful.

**Mr Shavak Madon:** Thank you very much, Mr Chairman and members of the committee on justice and social policy. I know I'm going to have a very sympathetic hearing, because the chairman is from my hometown.

**The Chair:** Anything you want.

**Mr Madon:** I would like to begin by thanking you for the opportunity of being here today. My name is Shavak Madon. I am the chair of the board of directors of Halton Healthcare Services, representing Oakville-Trafalgar Memorial Hospital and Milton District Hospital. Joining me here today is Barbara Burton, our past chair.

We realize this is the last day of hearings and, as such, I'm sure some of what we are about to say you must have heard already. However, I am also sure it is worth repeating.

We would like to start by acknowledging the process by which you are gathering feedback. When Bill 8 was introduced in November 2003, the government indicated their openness to suggestions and their interest in hearing from stakeholders, a commitment that has been upheld.

We believe this bill is a work in progress. By seeking input, listening carefully and learning from others' experiences, we are confident that the components of this bill will evolve to a point where the government, health care providers and, most importantly, the residents of our communities who rely on our health care will benefit from the fundamental principles of the bill as it is based.

The board of Halton Healthcare Services supports the overarching principles of Bill 8. We support the key provisions of Bill 8, including the establishment of the health quality council, embracing the five key principles of the Canada Health Act, and adding accountability as the sixth principle and thereby strengthening the provisions governing medicare. We support enhanced accountability, including the development of negotiated accountability agreements between the government and hospital boards.

However, like our colleagues across the province, we have some serious concerns that we feel must be addressed prior to the enactment of this bill. We believe the communities of Milton and Oakville must continue to have a voice when it comes to the health care services they receive and how their local hospitals are managed. We are concerned that this voice may be silenced should the authority for determining service availability and restrictions be removed from the agendas of our board of directors and instead set by a centralized provincial process.

We understand that amendments have been made to the original wording of Bill 8 regarding the accountability agreements. While we have not seen the specific amendments and the wording changes, we are encouraged that the minister has agreed to negotiate the details of the agreements. Agreements that accommodate the need for dual accountability, from the board to the government and the government to the board, are essential and will be received more openly than those which only focus on the accountability of the health care providers.

We cannot stress enough the need for two-way mutual accountability. As our legal counsel has advised, "The bill does not reflect a collaborative or negotiated process, but rather, allows the Ministry of Health and Long-Term Care to unilaterally direct health service providers to enter into vaguely defined accountability agreements and further, to issue broad compliance directives. Accountability agreements must truly be negotiated, not compelled by legislation."

At Halton Healthcare we don't have to look back far in our history to provide you with an example of the impact of provincially set directives being imposed without community consultation. In 1998, the Health Services Restructuring Commission issued a preliminary direction that would negatively impact the pediatric and obstetrical services available at Oakville-Trafalgar Memorial Hospital. In a community that is experiencing unprecedented growth and an influx of young families, our board knew that this type of provincially set direction did not reflect the needs of the community. Fuelled by our commitment to quality community health care services and overwhelmingly supported by the residents of our community, our board was able to change that directive and maintain these services.

Our hospitals were founded by members of our communities, by community leaders, business people and those interested in the health and well-being of their families, their friends, their community. The same commitment that founded our hospitals 50 years ago still exists within the communities, the boards and the associations which guide and support our organization today. These people help us keep our finger on the pulse of the community. They help us fulfill our mission.

Our board of directors must maintain its autonomy. We believe that unilaterally imposed contracts will reduce our governing boards to advisory boards, will undermine community involvement and lead to a gradual erosion of community support and involvement in community health care. Ultimately, this will impact our associated volunteer and fundraising organizations.

Many of our volunteers and our major donors support Halton Healthcare because of their commitment and

belief in community hospitals. We are concerned that this support will be lost if our hospitals are converted into centrally operated entities. We recommend that this bill establish a better balance of accountability with local autonomy and decision-making.

While performance agreements are becoming common in the public sector, there is no best practice or benchmark standard to which we can aspire. However, there are other national examples of performance agreements. We encourage this committee to seek input from those who have first-hand experience with accountability and performance agreements, such as those introduced by the Ministry of Health Services in British Columbia in July 2002. The BC Auditor General's May 2003 review of these performance agreements provides a wealth of information and recommendations that are based on actual experience. One of the lessons we can learn from BC is that the process for establishing performance agreements should not be rushed. Enough time should be allowed for full collaboration between the negotiating parties to ensure local community and governmental needs are met.

**1610**

Our board of directors strongly supports the concept of accountability agreements being developed between the minister and the board. The board will then hold its employees accountable, even in extreme circumstances. We do not believe that it is in the best interests of the public to allow the Minister of Health and Long-Term Care to have control over the senior executives of a hospital corporation. Our CEO and chief of staff are accountable to our board, and we hold them to the highest standards. A dual reporting structure involving the minister and the CEO and the board would undermine the checks and balances that we have in place and would not support a collaborative environment.

We know that in the public interest the minister already has the authority, as outlined in section 9 of the Public Hospitals Act, to intervene with the appointment of a supervisor. Bill 8, as we understand it, will provide the Minister of Health with the power to unilaterally change employment agreements with senior hospital executives without the approval of the Legislature or basing the decision on public interest. Our board does not agree with the transfer of power or the ability to command control and impose such dire consequences. The BC experience speaks volumes.

The BC Auditor General noted that performance results should be used initially as a point of inquiry, rather than to impose heavy-handed consequences. The BC report states that, "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 managing the board on behalf of the ministry, rather than reporting to the board."

Finally, the auditor's report states that penalties imposed where standards are not met are not effective. Again I quote directly from the report, "Everyone we interviewed spoke about their main motivators being pride and professionalism, traditional values of the public service culture. These were seen as stronger motivators than financial penalties or rewards. Also, many spoke of the most desirable incentive they wanted: the right to make decisions and manage independently."

There is no doubt in our minds, and we are sure you'll agree, that we should all be striving for a more collaborative process based on a relationship of mutual trust and respect so that our work in this area is fair and realistic.

Our last point today concerns the need for clarification of health care acts which will govern our hospitals. The Public Hospitals Act is written to support the patient-physician relationship, which is the primary health relationship. Today, Barbara and I are also representing the voice of 250 physicians working with or through the medical advisory committee. We are concerned that quality of patient care is put into jeopardy if our hospital board focuses time and energy on achieving the standards of performance agreements and ceases to hear the medical service issues.

Furthermore, section 20 of the Public Hospitals Act very clearly states that we must provide service and treatment to those who arrive at our facilities seeking care. I quote the section as it states, "Where a person has been admitted to a hospital by a physician ... and such person requires the level or type of hospital care for which the hospital is approved ... the hospital shall accept such person as a patient."

Contrary to the Public Hospitals Act, Bill 8, as it is presented today, could force hospital boards to reduce and limit services. The question is, which supersedes, the bill or the act? Multiple acts and bills result in overly complex relationships and, in this case, appear to result in contradictory directives. Realistically, our hospital could experience loss of services to our patients and physicians if the board is required to meet a restricted volume requirement of a performance agreement. This would be contrary to the requirement of the Public Hospitals Act to provide treatment. We respectfully ask the committee to review this area of concern and eliminate the ambiguity and contradiction and add clarity to the legislative environment.

In conclusion, we are a strong community organization that is committed to the principles of the Canada Health Act. We have a strong commitment to quality improvement, a commitment that is vital to the success of our health care organization and the industry as a whole. Our board is motivated by the pride and professionalism in the job that we do and the job of our health care providers. We believe in accountability and we are eager to prove ourselves. We will do so not because of the danger of punitive measures and disciplinary actions, but because of our commitment to meet and exceed our communities' expectations. It is our desire to live up to those expectations that will continue to ensure we are

successful in our quest to provide quality health care service. In your consideration of Bill 8, as you review the suggestions and recommendations that have come before you, we urge you to consider actions that will add value and accountability, not complexity and unilateralism, to our health care system. Thank you.

**The Chair:** Thank you, Mr Madon. You have left time for about one question from each of the parties, starting with the official opposition. Mr Hudak, you have about a minute.

**Mr Hudak:** Thank you for the presentation—very thorough and well put, particularly with respect to the accountability agreements and the role of the board if this bill were to pass.

You referenced the BC model. I think the deputy minister actually had been part of the BC health care system. Maybe that's where this idea had come from. But they've been caught out, with the actual writing of the bill being at great variance with the way the Minister of Health had described that bill.

I'm sure you've been in contact as well with the equivalent of the Ontario Hospital Association in British Columbia and such.

**Mr Madon:** I'm sure the Ontario Hospital Association must be in contact. We as a hospital have not been—with the BC auditor.

**Mr Hudak:** You mentioned what the auditor had found there. I'm just wondering if the hospitals themselves in British Columbia had raised objections to the BC model that the Ontario Liberal government appeared to be putting on Ontario's hospitals.

**Mr Madon:** I don't think I can speak on behalf of what the community hospitals have done in BC. But I'm sure, based on what the BC Auditor General has said, that changes are bound to come.

**1620**

**The Chair:** Ms Martel.

**Ms Martel:** Thank you for being here today. Let me just focus on your point at the beginning, "While we have not seen the specific wording changes"—made by the minister—"we are encouraged that the minister has agreed to negotiate the details of the agreements." You would want to take with you today a copy of his February 19 proposal to this committee which sets out the proposed amendment changes; not the actual wording but the proposed direction he wants to take.

I think your legal counsel and yourselves, as a board, would still have two tremendous concerns. Number one, it still makes it very clear that despite the minister saying the agreements will be negotiated, section 22 still allows for the minister, at the end of the day, when the negotiations are over, if they fail, to unilaterally impose a compliance directive or an order, which is a far cry from negotiation.

Secondly, you raised the point about the CEO and who is the master—you know how we used that word—of the CEO. It's very clear that the minister, in section 23, at the end of the day will also still have the ability to apply a compensation clawback or any other financial remedies from a CEO. So the minister is still trying to assume an employee-employer relationship with your CEO.

I encourage you to take that and show it to your legal counsel, because I don't think your concerns will have been met.

**The Chair:** Is there anybody from the government side to speak?

**Mr Bob Delaney (Mississauga West):** Our Chair is from Oakville, so he gets to say the nice things. My job is to see if I can ask you a tough question, but in light of your very helpful brief, I'm afraid that's impossible.

What I'd like to ask you is this: Much of the application of Bill 8 deals with defining effective measurements to set high common standards so as to assist all institutions in knowing how well they're performing. I'd like you to think a little bit about the operations at Halton Healthcare Services. Could you give me just one example of a best practice or a specific area that you're familiar with that you think you could showcase in such a system of effectiveness measurement to demonstrate how effectively you use people, time and money?

**Mr Madon:** One example I can obviously give you is our emergency department. I'm so proud of it. Many times, quite a few hospitals would say, "We cannot take any new patients," whereas in our case, if anybody comes to our door, we are never going to turn that person away, even if we have to bring a stretcher, put the stretcher in the corridor and look after that individual. That's how we manage our government dollars, which is so important. We look after everyone possible.

**The Chair:** Thank you for coming today. It's a long drive, but it's a nice day. We appreciate your input.

## HALDIMAND WAR MEMORIAL HOSPITAL

**The Chair:** Our final delegation today, and of our entire hearings at this point, is from the Haldimand War Memorial Hospital. Mr Walker McQuatty is the chair of the strategic planning committee. You have 20 minutes to make your presentation as you see fit. Any time that is left over will be split among the three parties. I'll let you get settled before I start the clock.

**Mr Walker McQuatty:** I'm a member of the board of trustees of the Haldimand War Memorial Hospital. I'm a past chair of the board. I've been on the board 14 years now and will probably be on it for about another year. Thank you for letting us have this opportunity to have input. At the end of the day, I'm sure you've heard most of what I have to say already. There is a report that I've circulated. I don't know that I'll get through everything in the report within the time. I'll just mention that this report is sort of a joint effort by members of our board. Our board is very interested in what's happening with Bill 8 and has wanted to have input.

If I can briefly give you a little bit of background about our hospital, we're in Dunnville. It's a small town in southern Ontario. The hospital itself has been in existence since the 1930s. We give 27 different primary health care services. We also have shared services with

other hospitals. We have various clinics and we provide many programs in the community. Our hospital has been very innovative. We have a pilot postpartum outreach program in the town, we have a health promotion program within the town, and other hospitals have come to look at what we've done.

In Haldimand county there are two rural hospitals. I think earlier today you had a presentation from West Haldimand General Hospital, and we're basically networked with West Haldimand.

In our county we have a rapidly aging population. There are some figures in the report. We're expecting an increase of about 45% in those over 65 years of age, and in the zero-to-19 age group, we're expecting a decline of about 80%. So there's a huge shift in the population of our county.

Mr Hudak is quite familiar with our hospital and has been very helpful to us. At the moment we're into a very major initiative: We are adding a 64-bed long-term-care facility at the hospital facilities, adjacent to the hospital. We're working on the development of a primary health care centre in conjunction with the hospital. We are also working on developing an assisted living complex for senior citizens in conjunction with the hospital, and sharing services. We're doing those things with a view to the aging population we're dealing with, and we've tried to be very proactive in the community.

We have an active hospital auxiliary—22,500 volunteer hours in the last five years—that has raised over $137,000 for the hospital in the last five years. We also have a very active health care foundation in the community. It's not a hospital foundation but it raises money for all the health-care-related items in the community. It has so far donated over $4 million to our hospital, which we think is quite a lot for a small community.

As Mr Hudak and maybe some others will know, hospitals have participated in a report card in the last few years. We have, on several occasions, been one of the top five hospitals in the province in the report cards.

Our board is made up of local people, community people, professionals, school teachers, housewives—just people with a variety of backgrounds, all civic-minded people. We feel that we have been dealing with accountability already through various areas of government: district health councils, the provincial government, the federal government. One of our questions is, how much more accountability could we have than what we already have with the community itself? We consult with our community and try to make decisions that reflect our community.

We feel it's clear that our hospital, like other hospitals, has been a leader in being efficient, accountable and proving value for money. I'm told that in Ontario we have the lowest number of acute care beds of any province, our per capita hospital expenditures are the lowest of the provinces, our in-patient utilization is the lowest of the provinces, the length of stay is the most efficient, and use of day surgery is most efficient.

I understand there has been correspondence between the OHA and the minister and there are some potential changes to the draft legislation. The minister is going to review comments and make some suggestions. We would urge that once the proposed changes are documented, we're allowed further consultation. We're very interested to see what the actual wording of the changes is.

We strongly believe that for this legislation to be successful, Bill 8 should have the support from local governance, like our hospital, for it to work. We feel that the local volunteer boards are the ears, the eyes and the hearts of the community and are totally accountable within our community for providing adequate health service.

**1630**

Having said that, we have some specific comments about Bill 8. In the preamble, we feel that the public accountability should be both the government and the health resource providers. It should be clear that the government is equally accountable.

With regard to part I of the act, which is the Ontario Health Quality Council, we strongly suggest that the council have the power to make recommendations to the Legislature. That would enhance the accountability to the public so that the report would be reviewed at the Legislature.

With regard to part II of the act, which is about accessibility, we're concerned that there's a potential to prohibit payments to some of the doctors who work at hospitals. I think some are called hospitalists; they are laboratory physicians; there are other types of doctors who work in hospitals who may be paid directly. We're concerned that the wording may prevent that and that could, in effect, reduce the access to health care.

We also note that Bill 8 doesn't require the province to fund health care at any particularly adequate level. The Canada Health Act has requirements for the provinces to fund health care and our suggestion is that the act should also make it clear that the province is responsible to provide adequate funding for health care.

We have comments on part III, the accountability section. The first is that our hospital has already been performing survey report cards since 1998 and we've also been, as I mentioned, accountable to district health councils and the government and to our community that we consult with. So we feel we already have a level of accountability.

Our CEO and other members of the staff have participated in developing a hospital funding formula. We're supportive of effective and workable multi-year funding and the development of an appropriate performance agreement.

We feel very strongly that in the draft legislation the compliance directives should be deleted. It seems like an extreme, unfettered power that we feel is unwarranted.

In section 19 of the draft legislation, we believe that what should be deleted is the reference to "executive function or position" and "primary and executive functions or positions." Rather than that, we propose that the wording that would be put in is "'health service provider' means any corporation, agency or entity that provides,

directly or indirectly, in whole or in part, provincially funded health resources."

We'd also like to point out that there's no provision set out in the draft legislation that the minister acts in the public interest when implementing performance agreements. We suggest that should be set out clearly, that in the administration of section 20 the minister is governed by the public interest.

With regard to subsection 21(1), we would suggest an amendment. It's basically, and I know you've heard this before, that the accountability agreements must be negotiated, but the amendment would be, "Subject to subsection 21(2), a health resource provider and the minister shall, if requested by the Lieutenant Governor in Council, enter into a negotiated accountability agreement with any one or more health service providers."

We certainly feel very strongly that Bill 8, as it is drafted, undermines the local voluntary governance in our public hospitals. There are two main ways that it does that. First, by directing hospital boards to sign an accountability agreement without negotiations, the government is basically removing the checks and balances in our local community. Secondly, by having the power to make or effect an amendment that affects an employee of the hospital, the government is again usurping the role of the board.

We're concerned that as a result of the wording of Bill 8, our community will lose a say in the service they receive and how the hospitals are managed.

We're worried that sections 21 and 22 negate community input by directing the hospital to sign an agreement that hasn't been negotiated or agreed to but is basically imposed unilaterally. The position of our board is that those agreements must be negotiated.

I'm told that the British Columbia auditor has already rejected the idea of ordering changes to employment agreements, and that this is because they are detrimental to the governance of the association and are ineffective in improving performance.

While it might be unclear under the draft legislation—this may be the same issue I heard someone speaking about just a few minutes ago, but it may be difficult for us to understand whether our CEOs are accountable to our board or whether they are accountable to the ministry, or both. We're concerned that once the board is bypassed in their strategic decision-making, they lose their ability to function as a governing board.

We'd like to point out that under the Public Hospitals Act, the minister already has authority to appoint a supervisor, an inspector or an investigator. This is only done when there are serious financial or operational problems, but that power is already there.

In section 21 of the act, we suggest an amendment to say, "An accountability agreement between the health resource provider and the minister may require that the health service provider enter into an agreement with the chief executive officer concerning his or her performance, in that capacity, on terms to be negotiated between the health service provider and the chief executive officer."

As Bill 8 exists, we feel the question is, who will ultimately direct the CEO? Is it the hospital board or is it going to be the minister? We're concerned and suggest that this is most relevant to a volunteer board of governors. It's going to have a negative effect on the good relationship that we've had in the hospital for many years.

The proposed powers of the minister to materially change a person's terms of employment we call draconian. It's unsatisfactory; it's unacceptable. We want the best people to be running our hospitals. I have to question whether we're going to find the best people who want to take on those jobs when their employment terms can be changed, when there are all these issues about severance clauses and different conduct. People take jobs that are very important and they want some security. They leave other jobs to take them. When we can change their contract on them, they're going to be less likely to want to take those positions on.

Our hospital, I'm glad to say, has thus far always operated in a surplus position despite other funding shortfalls. We recently did a review, and in the last 10 years our base funding has actually gone down by over a per cent and our expenses have increased, but we have managed to keep ourselves in a positive situation.

We have serious concerns about the future of public interest in our community and how it affects the board. What we're worried about is becoming a puppet board. If we can't fulfill our obligations and responsibilities because they're controlled elsewhere, yet we're trying to be held accountable by the community, how can we be? We strongly suggest that any accountability agreement be negotiated, not imposed, and negotiated freely and openly between the parties.

We're also concerned that our relationship with the community is going to be compromised. If the accountability agreement diminishes our authority as a board, I can certainly tell you that would not be well received in our community and it would seriously affect our ability to obtain volunteers and the capital that we have been able to attract over the years. It's likely we would lose out on some of that if we didn't have control lately. As far as the volunteer boards, in my mind, you don't fix what isn't broken. The volunteer boards are working quite well with the communities, finding out what works for the community in terms of health care services and what the needs are. We would like to keep that input local.

I managed to keep within my time, I guess. Are there any questions?

**1640**

**The Chair:** You did very well. We have time for probably one question from each party, starting with Ms Martel. You only have about a minute, unfortunately.

**Ms Martel:** Thank you for being here today. Your page 11 refers to section 27 and the minister's clarification that this applies only to CEOs, which of course is

true. But what is also clear is that the minister still retains the authority to apply a compensation clawback to a CEO or to apply other financial remedies. So I take it that your concern as a board about your role as an employer has not been resolved.

**Mr McQuatty:** Absolutely not. And it's not just an issue for hospitals; we've seen it in other areas. As I say, our CEO has been 37 years, I think, at our hospital. When he leaves and we bring in someone else, we may have to bring them in from somewhere and we may have to make agreements with them so they know they are secure. If they know that they can be turfed on certain terms very easily, they may not be as interested in coming.

**The Chair:** Ms Smith.

**Ms Smith:** Thank you very much for coming. I was unclear through your presentation whether or not you had seen the framework for potential changes to the legislation that the minister presented to this committee last week.

**Mr McQuatty:** We have, yes.

**Ms Smith:** Then I just have one question for you. On page 8 you say, "With respect to subsection 21(1), accountability agreements, we suggest that subsection 21(1) should read as follows: 'Subject to subsection 21(2), a health resource provider and the minister shall, if requested by the Lieutenant Governor in Council ... do either or both of the following," and then you've got "1," and I expect that 2 is paragraph 2 in the act. I'm just wondering by that suggested amendment, are you of the position that hospitals should not be entering into accountability agreements with the Ministry of Health?

**Mr McQuatty:** No, but the accountability agreements have to be freely negotiated.

**Ms Smith:** And if they are negotiated, you're fine? I mean, here you're basically saying that you would only enter into accountability agreements if they were directed by cabinet.

**Mr McQuatty:** Right. I don't think it's our position that we wouldn't otherwise enter into an accountability agreement, but again, it would have to be freely, willingly negotiated.

**The Chair:** Mr Hudak, last question of the day—the week.

**Mr Hudak:** All that pressure, Chair.

**Interjection:** Make it a good one.

**Mr Hudak:** I'll do one of my standards.

Mr McQuatty, thanks very much for being here, and congratulations as well on the great work at War Memorial. I'm the proud representative for the Dunnville area and, as was mentioned, it's consistently one of the top-performing hospitals in the province. So I'm very pleased that you are here today for the presentation.

A bit earlier on, somebody said that this bill is a bit of a work in progress. Well, I can tell you it's the farthest thing from a masterpiece this committee has ever seen. It makes van Gogh look clear. This bill will resemble in no way at the end of the day what it was at first reading. In fact, many of us feel the bill should be scrapped entirely and we should start right from the beginning.

You're absolutely right: You have had a chance to look at the minister's promises in the areas for amendments, but as my colleague Ms Martel pointed out, it still falls short in the concerns you have about the Ministry of Health putting the strings on the local CEO and therefore undermining the board and the volunteer governance that has been a tradition in this province. What would your suggestion be for an amendment to this particular section with respect to accountability agreements and the relationship between the Ministry of Health directly to the CEO?

**Mr McQuatty:** You mean in terms of changing the provisions of the CEO?

**Mr Hudak:** Particularly on the relationship between the CEO and the Ministry of Health, the direct reporting relationship that we believe even the proposed amendments don't clear up.

**Mr McQuatty:** My personal opinion is that it should be between the hospital and the CEO, that the agreements be between the minister and the hospital and then the hospital and the CEO, and the hospital deal directly with the CEO. That's my personal opinion.

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

## ELIZABETH BALANYK

**Ms Elizabeth Balanyk:** May I make a comment from the public?

**The Chair:** It's kind of out of order. How long is this comment?

**Ms Balanyk:** It'll take two minutes.

**The Chair:** OK. Would you come forward so we can hear you? I'm not sure if this is entirely within the rules but you look like you're a sincere person.

**Ms Balanyk:** I'm a very sincere person. Kim knows me well. He's a great guy and he's been trying to help me.

**The Chair:** There you are. You're in.

**Ms Balanyk:** He's been very helpful.

*Interjection.*

**The Chair:** That's right: I've never seen this woman before in my life.

You have a couple of minutes.

**Ms Balanyk:** Thank you. I'm a registered nurse in the city of Niagara Falls and have been so for 35 years.

**The Chair:** Can we have your name, please?

**Ms Balanyk:** My name is Elizabeth Balanyk. I'm really here today to bring a very important issue that's been brought to my attention, and Kim knows about this. It's been brought to my attention that at the Ontario Works offices and social services offices in Niagara Falls and in Ontario they demand a citizen's health card number in order for identification of that person to be approved for any acceptance to any type of assistance they ever offer, which they often quote at $245 a month. Of course, it's not any higher than $520 a month.

I'm here to ask a couple of questions, and I've asked Kim and he's been looking into this, but it really is becoming a great issue. Where did this rule come from that we have to give our health card number to Ontario Works employees, who are not doctors, who are not hospitals, who are not labs, who are not X-rays? I think it's a very dangerous thing to do. So I need to know where it came from and if it's an absolute rule. If in fact it is an absolute rule, it needs to be changed.

As a nurse, and dating a doctor for 10 years, I will tell you health card numbers in the wrong hands are very dangerous. You can lose patient confidentiality. They can take that number and they can charge whatever they want. You get the wrong person and they can start charging—they can send it out to OHIP and make all kinds of money, if they want to. Lucy Magda was in St Catharines, and that's my point, really. So things in the wrong hands are very dangerous.

I've heard a lot of rhetoric here today. I've been fighting a legal battle myself. I've been fighting the Ontario Nurses' Association for 18 years and I've been fighting the Greater Niagara General Hospital. I'm now fighting the region of Niagara, and it all started over a romance. I'm writing a book called Flaws in the Laws. You really will want to read it.

The reason I'm saying all this is because at the end of the day—I've worked in long-term care, I've worked at Upper Canada Lodge and I can tell you the letters that I've received that broke my heart, they were so wonderful.

But to bring something to your attention, at the end of the day it's the patient we really have to worry about. We're all human beings here. We're all getting older. We're all going to end up in one of these homes one day. Believe me, trust me. You're very aware of a lot of the serious problems. However, you may not be very aware of the management—or lack of it—problems. Because of the lack of management, who are there to guide their staff, that is where you get a lot of your problems. So it may be something you should look into, because if you don't, this is what happens, folks. You get judges slamming facts and it costs you money. You get nurses suing over SARS; Doug Elliott suing the three levels of government—federal, provincial, city of Toronto—for $600 million. It costs you money. It costs us money.

**The Chair:** Ms Balanyk, thank you very much. I've extended you more latitude than I thought I was going to. There probably is an answer to your question.

**Ms Balanyk:** I need the answer about the health card number.

**The Chair:** Unfortunately, it won't come from this committee, as much as I wish I knew the answer. I will undertake or Kim or somebody will undertake—your MPP will undertake, I'm sure—to find out who can give you that answer, because there must be an answer out there.

**Ms Balanyk:** If it does exist, please change it, because if you don't change it, you're going to run into a lot of problems. I'm not cattle. I think about what people ask me. Another one is your SIN number too. Why do they need it? It's only for an employer who employs you. They don't employ me.

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

**Ms Balanyk:** Good luck.

**The Chair:** Thank you.

*Interjection.*

**The Chair:** That's our job.

We're going to adjourn until March 9 in Toronto. I just wanted to extend my thanks to staff. It's the first time for many of us. I think staff did a wonderful job, considering probably half of us are rookies. Certainly I'm a rookie Chair. Special thanks to the parliamentary assistant and the opposition critics from both parties. I think you did a wonderful job. Thank you for your very thoughtful consideration. The respect that you showed the public was great during the last two weeks. The civility we displayed to each other I think was wonderful. There were times when there were a few little sparks, but I don't think it was too bad. So my thanks to you all and let's move on. We're adjourning until March 9 in Toronto.

*The committee adjourned at 1652.*

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