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Thursday 19 February 2004

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Jeudi 19 février 2004

Standing committee on justice and social policy

Commitment to the Future of Medicare Act, 2003

Comité permanent de la justice et des affaires sociales

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

Chair: Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

Thursday 19 February 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE ET DES AFFAIRES SOCIALES

Jeudi 19 février 2004

The committee met at 0904 in the Windsor Hilton Hotel, Windsor.

COMMITMENT TO THE FUTURE OF MEDICARE ACT, 2003

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

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

The Chair (Mr Kevin Daniel Flynn): We'll call the meeting to order, ladies and gentlemen. It's a little bit after 9 o'clock, and we should get going.

Welcome to those who have joined the committee. Mr Hudak, Ms Di Cocco, thanks for joining us here.

WINDSOR REGIONAL HOSPITAL

The Chair: Our first presenter this morning is Mr David Musyj, vice-president of corporate services and medical affairs for Windsor Regional Hospital. You've got 30 minutes to make your presentation. You can use that any way you choose. At the end of your presentation, we'll divide the remaining time evenly among the three parties to ask you any questions about your presentation. The floor is yours.

Mr David Musyj: Thank you, and good morning, everybody. My name is David Musyj. The last name is spelt m-u-s-y-j. I'm the vice-president of corporate services and medical affairs at Windsor Regional Hospital, as well as acting in the capacity of its general counsel.

I want to thank the members of the standing committee on justice and social policy for allowing me to make a verbal presentation on Bill 8 today. I'll be addressing two issues identified in Bill 8: the accountability agreements, found in part III of the bill, and physician compensation, found in part II of the bill.

I am somewhat buoyed by the comments of the minister before this very committee on February 16, 2004. However, a dear friend of mine likes to say, "The proof of the pudding is in the eating." I will await the actual amendments.

I can inform you that Windsor Regional Hospital supports and embraces the concept of accountability. The hospital is an active participant in the hospital report series. In addition, over the past two years Windsor Regional Hospital has been involved in the third party review and in an operational review, along with Hôtel-Dieu Grace Hospital, Windsor, which, once it was published, resulted in the appointment of a monitor for both hospitals.

This commitment to accountability has resulted in the creation of the Windsor Hospitals Coordinating Committee between the two hospitals, and the joint appointment of a chief financial officer and an integrated vice-president of clinical services between the two hospitals.

However, the implementation of accountability needs to be done in a proper context, with proper entities and with a mutual understanding and agreement between the parties. Otherwise, one could end up creating accountability objectives that cannot be achieved right from the outset. This is as a result of either the party requesting the objectives not having the authority or ability to ultimately ensure the objectives were achieved, or the party required to achieve the objectives knowing immediately that the objectives are unachievable but not having a say in their creation. Both of these are as a result of the objectives being imposed unilaterally.

Bill 8 states that the minister can require a health service provider or any other prescribed person to enter into an accountability agreement. This possible unilateral implementation will not work and will not achieve what the minister wants, which is accountability.

In order for these accountability agreements to work and achieve the objectives of the minister, he will need to ensure that the corporate entity/person he is creating an accountability for has a voice in creating the agreement and setting the objectives. Both parties need to be clear on what the objectives are, how they will be measured and what result is required to achieve them.

You don't have to look far in order to see how this can be done, and done well. Effective January 1, 2004, the

cancer centres across the province integrated their operations with their host hospitals, Windsor Regional Hospital being one of these. They did so freely by negotiating a cancer program integration agreement, which I will refer to as the CPIA. The parties to the agreement were Cancer Care Ontario and the particular host hospital.

The CPIA states at article 12 that "in order to support the principle of accountability this agreement identifies mechanisms for the hospital to demonstrate performance within the context of a provincial plan." The CPIA then provides that the parties will mutually set volume and quality expectation targets. If a variance occurs between the targets and the actuals, then the parties meet to discuss the variance and the reason for the variance. The parties decide if changes to the targets need to be made. Only then do possible changes occur to funding, program content etc.

As stated previously, the CPIA has been negotiated between the two corporate entities, not the presidents and CEOs of the hospital and Cancer Care Ontario. However, the hospital, for example, then places the burden on its president and CEO to ensure the hospital's operations support the achievement of the CPIA and requires the president and CEO to keep the board apprised of the process. Again, the accountability flows between the hospital and its president and CEO.

The CPIA does not create an ability for Cancer Care Ontario to implement changes to the employment agreement of the hospital's president and CEO. Such a move would violate almost every principle of corporate law regarding the relationship between a corporation, its board of directors and its president and CEO, increasing the likelihood of chaos in a corporate governance process and the creation of a lame-duck board of directors.

0910

This leads me to my last point on this topic. The ability of the minister to unilaterally change terms and conditions of an employment agreement, or any agreement for that matter, as a result of the failure to meet an accountability agreement is not correct. For the reasons outlined above, this is not a workable solution. This would interfere with the proper operation of a corporate entity and again, as I stated, create a lame-duck board of directors.

An alternative to such a power would be a requirement that when creating an accountability agreement the minister attempt to negotiate a provision with the hospital corporation that it must negotiate a clause with its president and CEO that provides some consequences for the achievement, or non-achievement, of these objectives. However, a decision on what form that could take should be left to the body that has the corporate and legal ability to make such a decision: the employer of the president and CEO, the hospital's board of directors.

I can only emphasize the risks cited in the British Columbia Auditor General's 2003 Report on Performance Agreements: "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."

I will now deal with the issue of physician compensation, found in part II of the bill. Windsor Regional Hospital fully supports the concept that physicians should not receive monies in excess of the OHIP fee schedule for the provision of insured services. Windsor Regional Hospital, similar to many other hospitals in the province, did provide payments, ie stipends, to physicians in excess of the fee-for-service billings they were receiving from OHIP.

I can inform you that over the past few years, Windsor Regional Hospital has gradually eliminated these excess payments. In return, in some cases, Windsor Regional Hospital has created what it calls internal AFAs, or alternative funding agreements. The basic tenet of these AFAs is that physicians must assign their OHIP billings directly to the hospital. In return, the physician receives a fixed amount of monies from the hospital. In addition, these internal AFAs require the accountability Bill 8 desires.

Bill 8, as written, would prohibit these internal AFAs. Since they are not approved by the ministry, they would violate section 8 of the bill. In addition, I can inform you that the AFAs approved by the ministry do not contain the accountability that Windsor Regional Hospital's AFAs contain. With all due respect, all the ministry's AFAs do is create a funding mechanism for the assignment of OHIP billings and the payment for physicians.

You are now probably asking, what is so unique about WRH's internal AFAs? Well, they provide for accountability by including, among other things, the following terms:

(1) Specific hours that the physician needs to be present to attend to patient care. Thus, nursing staff and other resources can be coordinated to ensure that the complete medical team is present for the patient's benefit—no need to try to find someone;

(2) A requirement that physicians attend regular staff/management meetings to discuss issues that enhance patient care and administrative functioning of the hospital;

(3) A requirement that physicians are directly involved in, and sometimes lead, ongoing staff and patient education;

(4) A requirement that physicians are cognizant and directly involved in addressing patient satisfaction results and resource utilization;

(5) A requirement that the physicians' performance is reviewed by the hospital on a regular basis.

The internal AFAs at Windsor Regional Hospital have been very successful. They are a great physician recruitment and retention tool.

I can inform you that the hospital has attempted to pursue ministry AFAs for some of its physician groups. However, the ministry only approves a fixed amount per year and there is a waiting list of some 70 applications.

I strongly urge that unless the legislation is changed to permit internal non-ministry-approved AFAs, a process needs to be developed to fast-track approvals for these internal AFAs and allow for a grace period while awaiting processing. However, as previously stated, if the existing ministry AFAs are used, I do not believe the minister will get what he desires, which is accountability.

Those are my submissions. Thank you for your time.

The Chair: Thank you, Mr Musyj. It's about 9:16, so you've used up about 12 minutes. That's left us with 18. Let's start with the PCs. You've got six minutes for questions.

Mr Frank Klees (Oak Ridges): Thank you very much for your presentation this morning. You've addressed a couple of key issues that we've heard repeated a number of times, and you reaffirmed the concern around the issue of accountability. I'd like to deal with that first of all.

The minister admitted in his opening remarks to this committee that he was clearly embarrassed by the flaws in this bill. You've probably read his statement. You've heard that he is prepared to make wholesale changes to this bill. Some of those changes he has undertaken to address the very issues you're referring to. The question really remains as to whether we can rely on his commitment to that. This government has quite a track record of not doing what it said it was going to do, so why we would believe that promise remains to be seen.

Nevertheless, the accountability issue in this bill goes one way only; and that is, what you and your institution can do for the government. There is no reference whatsoever to accountability on the part of the Ministry of Health. I don't know about you, but I've been involved in many circumstances where I've been called to help advocate on behalf of hospitals in my area, where the Ministry of Health has been dragging their feet, where they haven't come forward in a timely way with approvals, sign-offs, if you will, on budgets and so on.

I'd be interested, first of all, in your comment on the issue of the lack of accountability mechanisms here that speak to what the ministry must do and how they can be brought into compliance. Lots is said about what the minister will do to you if you're not complying. Second, do you have some recommendations in terms of how we can build some of that accountability into this process coming from the government to you?

Mr Musyj: As I stated in my presentation, that's the importance of making sure that these accountability agreements are freely negotiated. As I stated, you don't have to look far to see one that is starting to work, and that is the one between Cancer Care Ontario and host hospitals in the province. Dr Alan Hudson, on behalf of Cancer Care Ontario, is the one who pursued this way of integrating cancer centres and their host hospitals, which took effect January 1. Those freely negotiated agreements do have accountabilities cutting across both ways. What we would see is a similar process in developing the accountability agreements that the minister talks about. They would be negotiated between the ministry, the minister and the hospital, and it would be up to the hospital itself, if it achieves certain objectives, to make sure that there are certain commitments made by the ministry in setting those objectives. That's the process we would see taking place to ensure that occurs and that accountabilities flow both ways.

Mr Klees: What about the numerous references in this bill—let's say you did enter into a negotiation and the minister was gratuitous enough to say, "I'll agree that we'll negotiate these things," but the bill refers to the fact that you will be deemed to have agreed to whatever the minister decides. He may call you in and have a nice sit-down and talk about what we should do and negotiate—you might negotiate for six months—but at the end of the day the bill says that whatever the minister says, you will be deemed to have agreed to it. How do you feel about that?

Mr Musyj: That's the point: It needs to be freely negotiated. But there are certain provisions in the Public Hospitals Act currently that give the minister certain other powers. If he or she feels that a hospital is not living up to its obligations in how it is being run, he or she has the ability to appoint inspectors, supervisors etc. So I guess ultimately they already have that power with the final say in things. If they feel that the hospital is being unreasonable in its negotiations of these accountability agreements, they could fall back to what is currently existing in the Public Hospitals Act.

Mr Klees: With one exception, though: The current legislation makes it very clear that whatever decision is made by the minister must be made in the public interest. There is no reference to the public interest anywhere in this legislation. Does that concern you?

Mr Musyj: It would concern us if we entered into good-faith negotiations and continued in negotiation and then something was imposed unilaterally, like you said, that wasn't in the public interest. If that hypothetical occurred, we'd be very concerned.

0920

Mr Klees: I have another question regarding AFAs. How many AFA agreements would you have in your hospital?

Mr Musyj: We have approximately four now. The four of them combined probably cover at least 40 to 50 physicians.

The Chair: Mr Klees, your time has expired.

Ms Shelley Martel (Nickel Belt): Thank you very much for being here this morning. We've been questioning why the minister wants to move with the kind of power that he does through the accountability agreements. There certainly has been the suggestion that if the minister has a concern about what's happening in a hospital now, he can use the Public Hospitals Act in the public interest. He can have an operational review, a capital review, a supervisor, the whole nine yards. Some of our communities have experienced that, and mine is one.

Despite what the minister said earlier this week, we haven't seen the changes yet. There have to be wholesale

changes to this whole section before it might be something people could agree on. There is certainly the reference you made to accountability agreements in your concerns, but there are some others in this section that have really serious, draconian powers given to the minister, and none of us can figure out why that would be done.

For example, over and above the accountability agreements are the compliance directives. Section 22 says:

"(1) The minister may at any time issue a directive compelling a health resource provider or any other prescribed person, agency or entity to take or to refrain from taking any action that is specified in the directive or to comply with one or more of the prescribed compliance measures." That's pretty broad.

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

The termination section:

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

This is the best one:

"Consequences of failure

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

These are broad, sweeping, draconian powers, far beyond what's in the Public Hospitals Act now, allegedly in the public interest. Do you have any idea why the minister might want to have such broad, sweeping, draconian powers? Has your hospital or other hospitals done something to merit this kind of power on the part of the minister now?

Mr Musyj: As I stated, our hospital has been subject to an operational review with the other Windsor hospital. It did not result in the appointment of an inspector or a supervisor. Actually, it resulted in the appointment of a mutually agreeable monitor. The monitor's role is to work with the parties and monitor their progress over restructuring. As of now, we're hopeful. We've been through that process very recently and those were the steps that were taken previously and are still in place under the new government. So we hope that we've done nothing to merit those types of sweeping measures.

Ms Martel: You hope this is it.

Mr Musyj: Yes, that's the point we made. We've done a lot up to this point. We're hopeful that we're on the right track and don't have to meet with something further.

Ms Martel: If you look at the last number of years, where either a supervisor was put in place or an operational review was instituted, in terms of the overall number of hospitals that exist in the province, the numbers were relatively small. I think in only one case was a board removed. So I don't see what the problem is to merit such broad, sweeping, draconian powers. As you say, the proof will be in the pudding, because we haven't seen the changes yet either.

Let me ask just a couple of questions about the AFAs. You certainly intimated that your internal agreements are far superior to the government's. I assume that has to do with the accountability mechanisms, perhaps, which aren't included in the government's. Is that correct?

Mr Musyj: That's the focus. Any of the government's AFAs, from what we've seen and dealt with, clearly have an assignment of OHIP billings in return for a flat fee. What we've put in place in our agreements with our physicians—and again, mutually agreed upon and negotiated with the physicians—are some of the accountabilities I outlined previously. If accountabilities are what you're looking for, our concern is that if this legislation is passed as it is worded on those types of agreements, we would be in violation of the act at that point with these internal AFAs. We would have to stop them, and that would be a grave injustice to the hospital, to the physicians and most importantly to the patients, because our patient satisfaction scores in those areas in which they are in place have gone up.

Physician retention and recruitment has been very solid in those areas. Staff are happier in those areas because the physicians' agreements—and they sign on to them individually and collectively in groups—state that they have to be involved in patient education, they have to be involved in staff education. That's something they don't get paid for through OHIP, but they've agreed, as a part of these internal AFAs, to be a part of that. So we find them very positive, and we want them to continue. We want to find a way for them to continue without being thrown out automatically.

Ms Martel: In fact, it could be a model which the ministry could use if they really wanted to enhance accountability.

Mr Musyj: Yes. It's something to build on, definitely.

Ms Martel: One final question: If nothing changes and under law you are in effect out of compliance, what's going to happen to your recruitment and retention efforts?

Mr Musyj: I would expect the physicians who are part of it would go back to their OHIP fee schedule and be subject to volume variations etc, and we could face difficulties with respect to retaining physicians. Again, they are attracted by these AFAs, they like them, and the ones who have signed have stayed. Before we put them in place, we had problems with retention and recruitment in these areas. That's one of the reasons we put them in place. Some have been around for over a year. We haven't had any physicians leave who are party to them.

The Chair: Ms Smith.

Ms Monique Smith (Nipissing): Thank you, Mr Musyj. We're very happy to have you here today. As you're aware, this government has taken forward Bill 8

after first reading, and it was anticipated that we would be placing amendments to this act after we had our consultation with Ontarians. We are certainly happy that you're here today to give us your input in order that we might improve this legislation.

I'm sure you're aware through your position at the hospital that we've been in discussions with the OHA, the OMA and other stakeholders about various amendments to this legislation, and I hope your association has assured you of some of the language and work that we've been doing over the last few weeks.

As well, you referenced in your introduction that you had seen or at least heard the minister's statement—and if you haven't got a full copy, I'm happy to give you one today—where he outlined some of the changes. One of the most important changes that we are proposing is establishing that the accountability agreements will be between the boards of the hospitals and the ministry, which I think will calm some of your fears about the interference between boards and the CEOs of the hospitals. Certainly we don't intend to affect governance of hospitals in any way. We expect that after accountability agreements are come to between the hospital boards and the ministry, a board would then follow with a performance agreement between its CEO and the board. Is that your understanding? Have you heard that those discussions have been taking place?

Mr Musyj: I've heard they've taken place. The OHA has informed us as late as yesterday that they want to see the amendments as well before they go one way or the other with respect to their support. So they're anticipating or waiting for the amendments, and so are we. So again, as I've stated, the proof of the pudding is in the eating, and we'll see what they said.

I guess ultimately what we're concerned about as well is that there can't also be this final hammer still hanging out there over the presidents and CEOs. That has to be off the table in the sense that if the ministry or the minister enters into an accountability agreement with the hospital, as a part of that they could ask that this be folded into the president's and CEO's employment agreements. But if they don't and they can't negotiate it and it doesn't happen, then that's as far as it goes. There can't be this hammer in the legislation sitting out there saying, "But ultimately we still have the power to do it if the board does not agree to do it." Again, that would create this uncertainty in the corporation.

0930

Ms Smith: Do you agree, generally speaking, with the notion of accountability agreements between the boards and the ministry?

Mr Musyj: Certainly. As I stated, our hospital has gone through hospital report series, third party reviews and operational reviews, and has a monitor in place who's down basically on a monthly if not a weekly basis with our hospital. So we definitely support accountability, but again, it's got to be a two-way street.

Ms Smith: Right. And the monitor you talk about and the interaction you've had with the ministry is as a result of section 9 of the Public Hospitals Act, correct?

Mr Musyj: Arguably, no. There's no such concept in the Public Hospitals Act, this monitor concept. It had to be mutually agreed upon by the parties at the time, and that was clear. The hospital had to sign on the dotted line that it agreed to the appointment of the monitor. But in the legislation of the Public Hospitals Act, if you don't agree to the monitor, the next step probably is a supervisor; although that wasn't threatened, one is led to believe that could possibly occur. In this process, the terms of reference of the monitor and the appointment of the monitor were really freely negotiated between the previous government and the hospitals, and it was up to hospitals to sign off.

Ms Smith: OK. And certainly there's been a lot of work done in this area between your two hospitals. We appreciate that. I have been at a number of meetings where the minister has used Windsor as an example of co-operation and a really good system that seems to be working very well for the community, so we commend you for that.

Mr Musyj: I appreciate that.

Ms Smith: We're looking at possible amendments to the legislation that would allow for a whole process for the implementation of the accountability agreements, and a process as well for directives and orders if there's non-compliance. I was interested, when you were talking about your CPIA, if you could just give me a quick rundown of the process in place for the negotiation of that. Also, if you're unable to reach an agreement, what provisions are there to put an agreement in place?

Mr Musyj: With the CPIA, what happened is that last year the host hospitals and Cancer Care Ontario struck committees to negotiate this cancer program integration agreement. Again, it was freely negotiated amongst the parties and it put in place certain accountabilities, because that was one of the big issues in that agreement too. When the services integrated, Cancer Care Ontario wanted to ensure, when the monies got flowed directly to the hospitals from that point on to operate the cancer centres across the province, that there were certain accountabilities with respect to volumes, with respect to quality etc. So those are outlined; there's a structure for the parties to negotiate what the volumes are, what the quality expectations are. In return, the hospitals were guaranteed that they were going to be provided these monies and these services and this equipment etc, those types of things coming from Cancer Care Ontario.

If those targets are not met—targets have been set by the parties, mutually agreeable targets that are reasonable and rational—the agreement calls for the parties to get back together to look at why the targets were not met. They could be things that are out of the parties' control; for instance, unfortunately we had SARS. Something like that changes everything: Across the province, volumes go down, people don't go to hospitals. That could affect a lot of things. So if something like that occurs, you sit down and discuss it before changes are made, if changes need to be made. It's a freely negotiated, ongoing negotiated, dynamic process.

Ms Smith: Mr Chair, on a point of order: I'd just like to inform my colleagues on the other side, who I know are waiting for the framework on amendments, that we should have that by 1 o'clock this afternoon. I just wanted to assure them that that was on its way.

The Chair: Very good.

Thank you, Mr Musyj, for coming today. We appreciate it.

HEPATITIS C NETWORK OF WINDSOR AND ESSEX COUNTY

The Chair: I now call forward Susan Price, Michelle Graham and Andrea Monkman from the Hepatitis C Network of Windsor and Essex county. Make yourselves comfortable. The same rules apply to you as to the previous delegation: You've got 30 minutes to use any way you see fit; at the end of your presentation, we'll split that time up equally amongst the three parties. This time the questioning will start with the NDP and Ms Martel. Would you each identify yourselves for Hansard, please.

Ms Susan Price: My name is Susan Price. I am chairperson of the Hepatitis C Network of Windsor and Essex county.

Ms Michelle Graham: I'm Michelle Graham. I'm the secretary for the Hepatitis C Network of Windsor and Essex county.

Ms Andrea Monkman: My name is Andrea Monkman, and I am peer support person and co-founder of the Hepatitis C Network of Windsor and Essex county.

Ms Price: I will be delivering our presentation, and Michelle and Andrea are here to help answer any questions.

We'd very much like to thank all of you for coming to Windsor. We would also very much like to thank you for the opportunity to appear before you today. The Hepatitis C Network is very pleased to be a part of this process that attempts to meet Ontario's needs and strive toward accessibility and accountability in health.

Overall, right up front you should know that we're supportive of this government's initiative. We do, however, have some questions and some concerns. Before we get to them, I would like to introduce you to the Hepatitis C Network and give you an overview of the disease and the context in which hepatitis C has unfolded in Ontario, including the government's response to hepatitis C. I'd then like to highlight some of our kudos and concerns regarding Bill 8, including those qualities we feel are important to people affected by hepatitis C.

Because, for the past 15 years or so, they have been listening to and negotiating their welfare with various levels of government, we feel that people affected by hepatitis C are uniquely situated to contribute to any discussion related to the government's role in health care. We'll attempt to bring into our submission their often less-than-positive experiences with health care and the government, whom they trusted to protect them. Their skepticism is justified.

The members of the Hepatitis C Network here before you are representatives of some of the populations most at risk for contracting hepatitis C. We include representatives of the aboriginal community, addictions and corrections. Our representative from the youth community is not able to make it today. The Hepatitis C Network was born of the concern and commitment of two of these groups: St Leonard's House, which is a halfway house for federal offenders, and members of the aboriginal community. We're a grassroots community collaborative that includes agency and consumer representatives. We receive no funding at any level of government. Nevertheless, for the past five years, we have provided services in this community, including care and treatment support, counselling, advocacy, outreach and education. In addition to presenting an annual conference, our outreach has taken us to such diverse locations as daycares and provincial jails.

A little bit about hepatitis C itself: It's a chronic, disabling disease caused by a viral infection that was first discovered in 1989. It spread rapidly through the blood supply. Today, it's estimated that 170 million people world-wide are infected, up to 300,000 of those in Canada. This causes grave concern that our health care system will be overwhelmed. Because most persons with chronic hepatitis C infection have yet to be diagnosed but are likely to come to medical attention in the next 10 years or so, we can expect a fourfold increase in the number of adults diagnosed with hepatitis C infection over the next decade.

For those new to the subject, hepatitis is a medical term that means inflammation of the liver. It causes swelling and scarring of the liver that leads to cirrhosis, which reduces the liver's ability to function. It has an initial phase that's acute. If it goes past six months, the virus is considered chronic. The progression of the disease is slow and unpredictable. As appendix 1 of our written submission indicates, out of 100 people who become infected with hepatitis C, approximately 80% will go into the chronic phase of the disease. Of those, approximately 20 people will develop cirrhosis after 20 years. The chance of developing cirrhosis increases the longer you have the infection. Approximately 5% of the group that develops cirrhosis will experience liver failure or liver cancer.

The extent of the problem in Ontario and in our community: In 2002, the last year for which annual statistics are currently available, Ontario reported 5,280 cases of hepatitis C to Health Canada's infectious disease surveillance program. But because only between one third and two thirds of those currently infected with hepatitis C have been identified, up to 60,000 Ontarians do not know they're infected, are not accessing treatment and are at risk of infecting others.

The local situation: Every couple of days, one of our fellow residents is diagnosed. A recent study funded by Health Canada confirmed the infection rates of Ontario's department of public health, indicating that infection rates in Windsor and Essex county are 19% higher than

the provincial average—5.8 per 10,000 people compared to 4.9 per 10,000 in the province.

Close to 1,800 people in Windsor and Essex county have hepatitis C. We had 163 new cases last year. We had 159 the year before. The number of people in our community at risk is close to 56,000, and includes marginalized populations, including the homeless, youth, mental health people with addictions, particularly those who are intravenous drug users, corrections—in which infection rates can reach 40%—as well as the aboriginal community, which also experiences elevated rates of infection.

0940

Windsorites and Essex county residents diagnosed with hepatitis C and their loved ones can be overwhelmed with this disease. Their search for accurate information and timely care and support is both frustrating and frightening. A family physician is most often the first point of access for people with hepatitis C, but because Windsor remains seriously underserviced both in terms of family physicians and specialists, it may take many months to access appropriate medical care and/or to commence antiviral therapy. We have no hepatologist or liver specialist in Windsor. Because of this, people who require treatment are referred to one of four gastroenterologists or they must travel 200 kilometres to the London health centre. This situation creates disparity in health care. While some of our clients can travel to London to access treatment and support, for others the cost of even one 200-kilometre trip to London is prohibitive.

Ontario's response to hepatitis C over the past five years has been mixed. Initially, Ontario demonstrated leadership in monetary compensation for those who acquired hepatitis C through blood transfusion or products, but the lack of subsequent action related to this disease has produced disparate and fragmented health care and community services that are unresponsive to the needs of all those affected in Ontario.

The government espouses the principle of accountability, and we'll have more to say on that later. For now, suffice to say that people affected by hepatitis C and those who advocate on their behalf are aware that Ontario received 44% of the $300 million the federal government agreed to pay to the provinces as part of the 1998 hepatitis C compensation program. Ontario's share of this money is $132 million. These funds are to go specifically toward providing programs of care and support for those infected with hepatitis C. By this year, Ontario should have received $67.2 million. What has happened to it? Apart from the development of a hepatitis C advisory committee set up by then-Minister of Health Tony Clement to advise the government on hepatitis C, it's anybody's guess.

For all intents and purposes, the hepatitis C advisory committee has been disbanded. They've not met in over a year. Furthermore, members of the advisory committee, along with hepatitis C victims and their advocates, have for the past year repeatedly made requests of this government, including the current Minister of Health, as to the status of the advisory committee and the tens of millions of dollars in the government's care. We haven't received a response. To date, there has been no accounting of these monies.

The government intends to commit to community care and an integrated health care system, but they have not done so yet with regard to hepatitis C. There was to be a comprehensive hepatitis C strategy that includes the support of community-based groups and organizations. Community organizations were promised a role in directing and monitoring this strategy, yet to this day, community groups and individuals continue to struggle to provide supportive services within a vacuum of resources.

The government talks about fiscal responsibility, but we have to question that as well. The hepatitis C epidemic is continuing to spread, and this consumes not only personal financial resources but also those that we all in Ontario share. Some costs to the province include: Every 20 people who die of hepatitis C related liver failure will cost our health care system $1 million a year; every 40 people who require the antiviral treatment will cost our health care system another $1 million per year; every 100 people who need to access provincial disability benefits because of the disease will cost the province close to $1 million a year. Yet Ontario has not initiated a province-wide public awareness campaign to identify those at risk. The result is that from one third to two thirds of those infected will not realize they have the virus until the disease is very advanced. Because of the long incubation period, which can be up to 30 years, many will suffer with undiagnosed symptoms such as fatigue, depression and infections that may be severe enough to affect their work, home life and mental health.

Overall in Ontario, we suffer from a lack of coordinated health care that cuts across the silos of public health, hospitals, clinics, physicians, home care and pharmacare. We're pleased to see that the government intends to address that through integration. However, this lack of integrated strategy really is harmful in terms of hepatitis C. For instance, harm reduction programs directed at high-risk populations do not carry an effective hepatitis C message. Those of us who support high-risk groups are not effectively engaged and supported to focus on hepatitis C prevention. As a result, we can expect at least 2,000 new infections a year over the next five years. Those infected are not diagnosed, and those diagnosed face major barriers in getting access to appropriate treatment and supportive care.

Thank you for your patience while we walked you through the scope of this disease. I'd like to now turn our attention to the legislation before us. I will be speaking to part I of the legislation, the formation of the health council, and part III, which is accountability.

This bill establishes the Ontario Health Quality Council, part of whose responsibility is to report on important health care indicators in an effort to raise the quality of the health care system. We support that initiative as a

commanding first step in addressing some of the ailments of Ontario's health care system. Our concerns surround the composition and representation on that council.

First, subsection 2(3) of the bill says that the council is to be comprised in part of experts in the health system in the areas of patient care, consumer issues and health services provision. Our question is, who are these experts and whom do they represent? For the government to achieve its objective of consumer-centred care, as is stated in the preamble of this bill, the council must openly support the participation of health care consumers in decisions about their own care as well as those related to the responsible use of health care resources. Health care consumers deserve a place at the table. If that's not to be at the table of this particular council, then the council itself must develop some mechanism to allow for the direct involvement of consumers of health care.

The Minister of Health told this committee on Monday that the council does not advance individual stakeholder agendas but allows for the broadest perspective possible to advance the agenda of our most important stakeholders, the 12 million Ontarians who are counting on us all. We appreciate that orientation toward broadness and inclusiveness, but we'd like to point out that community stakeholder groups are those who have risen to fill gaps in health care, providing front-line service to the millions of Ontarians unable to access the service they need from their government. To exclude community stakeholder representatives from this process is to ignore a vast body of acquired knowledge and best practices from which the government could benefit, not to mention alienating the people the government needs to speak to and to whom they are responsible, and whose support is vital to the success of this mandate.

Second, as per subsection 2(4), it is the government's intent that an additional factor to be considered in the composition of the health council is that "regard shall be had to representing the diversity of the population of Ontario and expertise with particular groups." It is an unfortunate reality that regional disparities in health care services exist in our province. The experience of accessing health care services in Windsor and Essex county, for example, is very different and often more difficult than in Toronto or London. To reflect the province as a whole, we feel the health council should include in its diversification regional representation from underserviced areas.

In our opinion, it's important that the health council not become just another advisory body in an already dizzying array of bureaucracy. Its work must remain relevant, not only to government but to the people of Ontario who fund the health care system and are the consumers of its resources.

Third, this government recognizes that access to primary health care is a cornerstone of an effective health system. We support that initiative, but the preamble is short on specifics when it comes to primary health care. Romanow recognizes that there is no single model of primary health care that captures the diversity and needs of situations across Canada, nor is there one, we submit, that would capture the needs of all Ontarians. The Romanow report identifies early detection and action as one of the four essential building blocks that define primary health care. The other three are in our written submission.

As outlined in appendix 3 in our written submission, a Preliminary Strategy to Address Hepatitis C in Ontario, we welcome any initiative toward developing a model of health care that promotes public awareness, early detection and action in preventing the spread of infectious hepatitis C.

Finally, while we support the government's intention to entrench accountability as a central principle in Ontario's health system, we note that as the present legislation reads, accountability appears to be a top-down process defined by matters, according to section 20, that the minister deems "to be appropriate in the circumstances," including shared and clear roles and responsibilities, transparency, fiscal responsibility, value for money, consistency and trust, amongst others. Moreover, accountability is imposed upon health care resource providers and/or any other prescribed person, agency or entity not identified in section 21 through the use of ministerial directives.

Is it the government's intent that accountability be a two-way street? We've had some conversations surrounding this today that I'm glad to see. If so, what proviso does the government intend to enact, if any, to ensure that the government itself is accountable to Ontarians? Again, the Minister of Health said this past Monday to this committee that, "Accountability isn't a burden we place on others. It's a responsibility we all accept and share, and I include this government and my ministry." We're hopeful that he will follow through on those words.

Our experiences, combined with those of victims of hepatitis C and even those of the government's own hepatitis C advisory committee, have shown us that the government is not yet fully committed to accountability. We don't feel we've received value for our money. In fact, we remain unable to extract from the government an answer to the question of where the money went.

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If the government has stringent expectations of accountability on the part of its partners in health care, ought not the people of Ontario have the right to expect their government to meet, if not exceed, those expectations? We don't feel this legislation makes allowances for Ontarians to exercise that right. It does not hold the government accountable for any of the qualities that it puts forth as being appropriate.

The minister has said that this government has a clear plan to transform health care in Ontario. If this is it, it leaves a lot to be desired. If this bill is a component of a larger plan, that needs to be made very clear to Ontarians. Ontarians need to be involved in this process. This process needs to be transparent and open. The government is asking the people of Ontario to trust that it has their best interests at heart, but we don't see that it gives us a reason to trust.

However, through this bill the government is indicating its readiness to come to the table, to collectively share roles and responsibilities with the people who fund this precious resource. We welcome this initiative, and we look forward to the day when we can play a more active role in a participatory process with an open and accountable government.

I've included recommendations in our written submission that I encourage you to read, as well as our preliminary strategy for hepatitis C in Ontario. I won't present them verbally.

Thank you very much, again, for your time.

The Chair: You've used up 16 minutes. That leaves about five minutes for each party. We'll start with Ms Martel from the New Democrats.

Ms Martel: Thank you, to the three of you, for being here this morning, bringing a brief that has a bit of a different perspective than many we've heard. We appreciate that very much.

First of all, I think you've raised very serious concerns with respect to where money has gone, what is happening to money that has, by all accounts, come to Ontario at this point—at least we understand it should have by now—and you don't have an idea of where it went. The second problem seems to be that the advisory council is not even meeting to determine what to do.

I think this committee would make a recommendation or a request to the minister to get an answer about these important questions for you that can be shared with your colleagues across the province. You deserve to have an answer, and it's not acceptable that you haven't yet, through two different governments. I think we can all agree that we will undertake to request that the parliamentary assistant that she get some answers for you that can be shared.

Ms Price: Thank you. We'll look forward to those answers.

Ms Martel: I think, both in terms of the money that has been spent and what is happening to the advisory council—is it going to start operating again? Also, when will a strategy for hepatitis C actually be developed? Who is working on that, who is involved and how can you be a part of it? Those are questions you need some answers to.

Let me just talk about the council for a little bit. What I want to focus on is the point you make, which is, "In our opinion, it is important that the health council not become just another advisory body in an already dizzying array of bureaucracy." I appreciate that you mention that, because the minister and I had an exchange on Monday about this very council. I am concerned that it will become a body, like so many others, that is monitoring and filing reports, and once that's done, the reports sit on the shelf, collect dust and nothing ever happens to address what's in the reports.

I had this exchange with the minister, because he also said that this was one of the accountability mechanisms for the government. You talked about, where is the government's accountability? He said the accountability comes from the council. Well, it doesn't if the council doesn't even have the ability to make recommendations for change based on the reports. The council can't make recommendations about funding, can't make recommendations about change in health policy or in health legislation; the best the council can do is make a recommendation on what it might report on, which is, to my mind, completely unacceptable. They need to be able to do more than that.

Do you want to elaborate on the concern you expressed that this may be something else, just like the others, where very little gets done to actually change and improve health outcomes for Ontarians?

Ms Price: The intent of the council, I think, is good. The intent of the council is to oversee the system, to oversee accountability and to bring forward to the ministry those issues which are important to Ontario. However, like you say, we've seen other advisory bodies, we've seen other councils where nothing happens. A report gets filed and nothing goes forward. We feel that this bill is an attempt to be proactive in changing health care in Ontario, so we're really hoping that it follows through.

I think our primary concern is, where is the consumer's voice in this process? Consumers traditionally have not been given a voice in this process. We have health care experts and stakeholder groups and ministry representatives and everybody else, but our concern is where the consumer's voice is.

Ms Martel: And if they have a voice, what that voice says in terms of what needs to be done. Would you like to expand on that at all?

Ms Graham: What you said is correct. When we brought this up, putting in the idea that we could sit on this hearing today, some of the other members of the network said, "Well, it's just going to be another council that will be formed, and what's the point?" So we had to convince them that at least it's us getting our voice out again. But like Susan said, it's the community representation, and will these councils come to the local communities and sit down with the relevant consumers and hear first-hand what the struggles are that we hear on a daily basis from just the Windsor and Essex county residents who are dealing with this hepatitis C?

The Chair: We'll go on to Ms Di Cocco.

Ms Caroline Di Cocco (Sarnia-Lambton): Thank you for your input. I hear the cynicism, I guess, that comes through in your discussion, and I want to make a very strong point that I think is being lost here: This process of us as a government having a bill go to committee after first reading is quite remarkable. Why are we doing it? Because it's an important process that, as the minister says, welcomes vigorous review of the bill, which is a proposed bill.

Unlike the former administration, where it was a fait accompli when it went to committee, this is about getting input. It's a commitment to a better approach to enacting legislation and enacting law. Therefore it's a tremendously, I would say, positive approach to making laws

for this province because this hasn't had second reading. This input becomes a very dramatic influence, if you want, into the finalization of the bill. I want to make sure that's understood here. We are here to listen to the perspectives so that when we actually finalize this bill, at least it has had thorough scrutiny by the stakeholders, by the public, before it goes to second reading. I have to tell you it's quite a dramatic step, if you take a look at legislatures around the world, parliamentary systems. It truly is about the scrutiny roles that committees have on bills if those bills are shaped by the stakeholders after first reading. I'd like to make sure that point is certainly understood.

Again, I want to say it's very dramatic. I have been on committees for four years, and I have to tell you that the notion of having an amendment to a bill was almost nonexistent. That's not the case now. It's a whole different approach to developing the bill. Thank you very much for your input.

The Chair: Mr Duguid.

Mr Brad Duguid (Scarborough Centre): I took notice of your suggestions and comments with regard to getting representation on the health council from the general public. When you have hearings on bills, when you have deputations on almost anything, you get a lot of participation from stakeholder groups, all of which is welcome but most of whom have their own agendas to bring forward. At the end of the day, for whom are we really doing this? We're doing this to improve the health care system for the general public. I had this discussion with one of my colleagues the other day: Whom can you get for a board like that who actually can represent the general public? Are you aware of advocacy groups out there that don't have their own agendas but are out there, whether it be to look after seniors or look after specific public interest groups?

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Ms Price: Not specifically. I'm quite certain that, province-wide and at every community level, you are going to find people capable of advocating on a number of different levels. We're advocating for people in terms of hepatitis C. If you were to look for a provincial spokesperson for hepatitis C, I would suggest Dr Wong-Rieger, who has been advocating on behalf of this disease for many years, quite loudly and quite vocally. I see some of you nodding your heads, so you're familiar with who she is. But I would hesitate to make recommendations concerning consumer advocates at any other level.

Mr Klees: I do appreciate your submission today. I want to just clarify something for the record. I think Ms Di Cocco has a lapse of memory, but we're going to cut her some slack. This is her first time in government. The fact of the matter is that it's not new to take a bill to the public following first reading. Our government certainly did that, and meaningful amendments were made.

She used the term "dramatic." Let me tell you, for the last four days since we have been travelling the province, the word used to describe this bill hasn't been "dramatic," it's been "shocking," because first of all the minister, in introducing it, embarrassingly had to admit that this bill was seriously flawed. To say the bill is being submitted, maybe for shock value—had the minister read this bill before he actually presented it, he would have withdrawn it before it even came to committee, because the intent here, as you point out and as others have pointed out, is draconian. It's a top-down imposition of ministerial power and authority the likes of which this province has never seen before. That's why doctors, nurses, employer groups, unions, advocates, together, unanimously have condemned this bill. It is a terrible bill.

We hope, with your help in the kind of submission you have made, that the minister will see the wisdom of keeping the preamble of the bill, scrapping the rest of it and getting on with building a piece of legislation that can actually serve you folks and serve the people of this province in a positive way. Thank you for your submission. I think my colleague has some more comments.

Ms Price: Let me just respond to that briefly. In response to both of your comments, I would like to say that we are very new to this process. This is the first time we've been involved in any type of legislative process, so forgive me if we're not professional with it. But we really, truly appreciate the opportunity to bring the consumer perspective to the table.

Mr Tim Hudak (Erie-Lincoln): Thank you very much for the presentation. I had no idea it was your first time. You've done an excellent job and made some very good points for this committee's consideration.

I agree with my colleague Mr Klees's comments. I think the government went to first reading hearings because they realized that they had stumbled tremendously out of the gate. We haven't found anybody who actually likes this bill, except maybe printers, because they're going to have to print off scads of amendments to rewrite this bill from the preamble on.

There's one point I wanted to pursue with you. The one part they boasted about that I think actually falls well short of its hype—in fact, I think the health council could be a sheep in wolf's clothing, to turn the term around. They actually do what the minister tells them to do in reporting, and they report only to the minister. You made an excellent point about reports sitting on the shelf gathering dust.

I have two suggestions for amendments, and I want to know if you would support them. The first is an amendment that would guarantee consumer representation as part of that council, that there be at least one seat, if not more, designated for consumers only. Secondly, would you support an idea to have that council report to the Legislature in general, as opposed to the minister? The Auditor General's report in Ottawa, for example, was given to Parliament as a whole, which has caused greater publicity for what she had found, as opposed to just simply sitting in a minister's office.

Ms Price: Let me start with your second recommendation. I don't feel I have enough experience to recommend that a council report to any particular body of

government, although I would support that it report publicly.

To your first recommendation, I would definitely support that it be enshrined that a consumer representative from some area, be it hepatitis C, be it cancer, be it whatever, be at the table.

The Chair: Thank you for coming today. We certainly did appreciate your input, the comments that were made. You did an excellent job. If that was your first presentation, you've got a lot of good ones ahead of you.

Ms Price: Good. I look forward to being part of it. Thank you.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1132

The Chair: I call forward the Canadian Union of Public Employees, Windsor area office, Geraldine Carey, acting president of local 1132; Ann Huffmon, vice-president of area 1; and Brian Manninger from the CUPE council. Greetings. Make yourselves comfortable. Would you all identify yourselves for Hansard?

You've got 30 minutes. You can use that 30 minutes any way you see fit. At the end of your presentation, the remaining time will be split among the three parties for questions, supposedly, and we'll be starting with the Liberals this time.

The floor is yours.

Ms Geraldine Carey: My name is Geraldine Carey, acting president of CUPE 1132.

Mr Brian Manninger: I'm Brian Manninger. I'm president of the Windsor district CUPE council.

Ms Ann Huffmon: Ann Huffmon, area VP for area 1 of the Ontario Council of Hospitals.

Ms Carey: I'm going to start off the presentation. I'm going to give a brief history of Windsor and our union.

CUPE local 1132 represents RPNs, which is registered practical nurses, certified and non-certified rehabilitation assistants, and operating room technicians at Windsor Regional Hospital. These health care providers are the front-line staff who provide hands-on care.

We bring to this committee the experience of front-line hospital providers and, between myself and Ann, 50 years of experience. 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. We provide the core of Ontario hospital services and are the backbone of hospital infection control.

Windsor Regional Hospital is a result of a merger between Windsor Western Hospital and Metropolitan General Hospital, which occurred about January 1, 1996. The Metropolitan hospital is the acute care sector; the western campus is non-acute.

The other two hospitals in Windsor are the Grace Hospital and Hôtel-Dieu, which are now known as Hôtel-Dieu Grace. The Grace Hospital closed in the early part of 2004.

In 1995, Riverview Hospital, a chronic care hospital which was part of Windsor Western Hospital at the time, was replaced and renamed Malden Park Continuing Care Centre and is classified as a long-term-care facility.

Along with the mergers, there have been program transfers that occurred on or about January 2000 with acute psychiatry and maternal/newborn, NICU and the sexual assault treatment centre. Acute psychiatry was to be transferred to Hôtel-Dieu, and to date is still not at that location. The maternal/newborn, NICU and the sexual assault centre were transferred to Windsor Regional; that was completed at the end of 2003.

During this period of time, CUPE 1132 members as well as other health care providers have gone through numerous layoffs, job losses, early retirements, and being bumped from one unit to another, along with service, program and bed cuts.

To date, CUPE 1132 has had several rounds of layoffs, the first starting in 1997 to the most recent in May 2003, when 100 qualified, experienced and competent registered practical nurses were removed from the acute care sector of the hospital and replaced with registered nurses. These events have created frustration, stress, workload issues and professional dissatisfaction, causing many of our experienced and vital nurses to take early retirement or leave the profession. We cannot afford to lose these nurses.

Implementing Bill 8 as it stands today will cause many more nurses and other health care providers to leave the health care system.

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The Ontario Liberal government introduced Bill 8, the Commitment to the Future of Medicare Act, with great fanfare in November 2003, less than two months after the government was elected. The government introduced this bill by emphasizing its support for principles that this union local and the Ontario public hold very dearly. However, the bill itself raises troubling issues. While the bill does set some worthwhile goals, these are either not achieved or the rights are already largely set out in existing legislation. But most importantly, the bill creates serious problems for the health care industry.

I'm going to hand this over.

Ms Huffmon: As I said, I represent area 1, and I think you should realize that area 1 encompasses Wingham, St Mary's, Clinton, Seaforth, Guelph, Stratford and Windsor, so it is a large area that we represent.

This bill does create some very serious problems within health care. The government said it would "make universal, public medicare the law ... and put an end to the creeping privatization of the system in recent years." This statement was made by Minister Smitherman on introduction of the bill.

Another statement made by Minister Smitherman was, "We are slamming the door shut on two-tier, pay-your-way-to-the-front-of-the-line health care in Ontario. This bill would enshrine into law what we already deeply believe in our hearts, that every member of our society

has an equal right to quality health care based on need, not income."

These certainly are statements that would have helped the Liberal government get elected.

When Minister Smitherman introduced this bill, he referred to the speed with which it was introduced, which causes us some concern, stating that it would help "ensure that new hospitals in Ottawa and Brampton will be publicly owned, publicly controlled and publicly accountable." His reference to the new hospitals is of deep concern to us. The Liberals campaigned against P3 hospitals during the election, and he has now introduced a similar P3 model that will affect Brampton and Ottawa. In these two areas, over $1 billion of health care monies will be turned over to giant for-profit operations. It is really hard to see creeping privatization come to an end when things like this are happening. We have also learned that there are another six private hospitals on the docket that they can investigate for private funding. It raises the question again of how seriously we should take Bill 8 and what is the hidden agenda behind this bill. I have some real concerns about that.

Mr Manninger: Part I of Bill 8, sections 1 to 6, establishes the Ontario Health Quality Council to monitor and report to the public respecting (1) access to publicly funded health services, (2) health human resources in publicly funded health services, (3) consumer and population health status and (4) health service outcomes, and also to support continuous quality improvement.

However, the nine- to 12-person council will not deal with many vital issues. It cannot report on the extent to which the Ontario health care system conforms to the requirements of public administration, comprehensiveness, universality and portability—key provisions of the Canada Health Act—focusing instead on accessibility. Further, the council is not required to report on issues relating to two-tier medicine, extra-billing and user fees, despite the fine sentiments expressed in the preamble to the bill and by the government when it released the bill. The council is also specifically prohibited from making recommendations. In other words, the council only deals with accountability on a narrow range of issues.

Our greatest concerns, however, relate to part III, sections 19 to 32, of the act. Specifically we are concerned about the broad powers of the minister to require accountability agreements or to issue compliance directives. While the government has made much of the accountability set out in the act, it is notable that the accountability in this part of the act is accountability of health care providers to the government, not accountability of the government to the public.

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

Under the provisions, the minister can direct any health resource provider or any person, agency or entity that is prescribed by regulation to enter into accountability agreements with the minister or with the minister and any person, agency or entity.

The term "health resource provider" is broadly defined. Unless the act is clearly and unequivocally amended, a trade union, for example, might well qualify under the broad definition of "health resource provider." Health Minister Smitherman has admitted that the bill needs amendment. We need to see the amendments in full to ensure that our families' futures are safe. We urge the government to bring these forward in full as soon as possible and not wait until March 9.

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

The minister'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 proposed bill even provides that where an order makes a significant change in a person's terms of employment, including a reduction in compensation, the change shall be deemed to have been mutually agreed upon between the person and his or her employer. Is this a democracy or a dictatorship?

Under this bill, as written, 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 subject to an order requiring them to reduce wages or benefits or to eliminate no-contracting-out or successor rights protections contained in collective agreements.

Similarly, the minister's powers under part III could be used to require hospitals to consolidate certain operations and require collective agreements to be modified to facilitate such initiatives; or, regardless of any restructuring, the minister could simply order a reduction in wages and benefits.

Taken together, all of part III can only be viewed as an attempt to bestow upon the minister and the government virtually unlimited authority to unilaterally order and direct fundamental changes to the health care system and to do so in a top-down, dictatorial manner, without any traditional procedural safeguards or substantive limitations. This is reminiscent of the omnibus Bill 26 legislation introduced by the previous Conservative government when it was elected in 1995.

We also note that health care privatization has been persistently criticized for reducing public accountability for a vital public service. Commercial confidentiality radically reduces the public's ability to find out how their dollars are being used. If the government intends to use this section of the act to attempt to counter this criticism while intensifying privatization, it should say so clearly now. To do otherwise would be to mislead the public about the government's intentions, particularly given how the government has introduced this bill.

We might add that the need for commercial confidentiality in the for-profit sector will largely frustrate any such attempt to impose accountability to the public on for-profit corporations. Commercial competition limits the ability of for-profit corporations to openly reveal their secrets, as doing so would reveal any advantages they have over their competitors.

Finally, we note that 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 minister 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.

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 compensation. Our livelihoods, our homes and our retirements are on the line. So we take threats to our collective agreements very seriously, and we hope this committee will too.

We have recently lived through, and are still recovering from, the massive hospital restructuring under the previous Conservative government. In our view, the massive restructuring did very little or nothing to improve the hospital system. It did seriously disrupt the lives of tens of thousands of hospital workers. Constant change and restructuring do not serve the hospital system or its employees well.

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 directive, a much worse possibility. We cannot understand why the Liberal government would choose to proceed in such a high-handed and brinksman-like manner. It raises great dangers for a health care system that has been under great stress for a number of years. We had hoped this would be understood by the new government.

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We note that British Columbia has also recently introduced agreements between the government and health care authorities that are similar to the accountability agreements proposed in Bill 8. Media reports indicate that the so-called BC performance agreements have connected the incomes of CEOs to the implementation of cutbacks in health care. We view this form of restructuring with alarm. We believe that hospitals and hospital managers must first and foremost consider the health care needs of the public at the hospital they serve. There should be no wedge driven between the hospital management and the community. This committee must consider this development seriously.

The community has gone through restructuring and layoffs. It is time to re-engineer our health care system and examine if our system provides the program or services to Ontarians and ensure that there is appropriate funding. It is time to examine if we have enough nurses to care for the ill, and housekeepers, dietary providers, lab technicians, etc. It is time to enhance our health care system, not dismantle it.

We support many of the principles that the government focused on when it released this bill. Universal public medicare is Canada's most cherished social program. It helps define us as Canadians. We are not sure why the government chooses to introduce a bill that gives such sweeping power to the Minister of Health and Long-Term Care. However, legislation does not turn on the intent of the legislators. Its power rises 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 with part III:

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

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

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

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

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

We also believe that the government should reconsider the powers the bill may give to the Minister of Health and Long-Term Care to reorganize and restructure health care. The hospital system has already undergone extensive reorganization over the last 10 years. Allowing the minister to unilaterally impose more is a recipe for strife and chaos that may well push hospital employees still dealing with the previous round of restructuring to the brink.

On behalf of CUPE, the Ontario Council of Hospital Unions and Local 1132, thank you.

The Chair: Thank you. I do appreciate you submission. You used up about 18 minutes. That leaves us 12 minutes to split among the three parties, starting with the Liberals for four minutes.

Mr Duguid: Thank you very much for your submission. It was very detailed. I appreciate that you got through it in pretty good time. When I looked at it, I thought you were going to use the whole 30 minutes.

You talked about stress—your members being in a stressful situation. I think we all recognize that being the case. I have a sister who's a nurse at North York General Hospital in Toronto. She was on the SARS unit, so she knows and has told me that not only the RNs but many of your members operating right now are still in a bit of a burnout situation from that crisis.

You also mentioned that your members are very concerned about the accountability agreements and the impact they may or may not have on collective bargaining agreements. I'm just going to read a letter that was sent to your president, Sid Ryan, just to give you some assurance. This is a letter from the minister. Perhaps I can get your comments on it. I'd be interested to know whether the conversations Mr Ryan had with our minister in January were brought to your attention. The letter from the minister reads:

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

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

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

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

In that letter, it's pretty clear that Mr Ryan was advised of this back on January 13. I just want to ensure that you've been informed that in fact the minister has made that commitment.

Mr Manninger: Yes, we are well aware of the letter that the minister sent to Brother Ryan. In the letter he states a lot of good things. What we need to do is see those things in amendments before this committee. At that time, we will accept the letter at face value, when they are here.

Mr Duguid: I recognize that, and I guess what I would ask from you, given the stressful situation that your members are in, is that, when you get those amendments, would you endeavour to make sure that your members are made aware that in fact there was and is no intention to impact on the collective agreements?

Mr Manninger: Once we see the amendments to the bill and once they prove satisfactory to us, we'll by all means communicate this to our membership across the province.

Mr Duguid: We'd appreciate it if you did, because we recognize the stressful situation they're operating within now. I think the last thing we want to do is have information not clarified for them when there's nothing that they should be stressed out about on this particular thing.

Is my time up?

The Chair: You've got about 30 seconds.

Mr Duguid: The second thing is, you talk about the draconian impact of the bill in terms of the accountability agreements when you are not able to get an agreement from a hospital board. You're aware that under the Public Hospitals Act the province has the ability to step in at any time and take control of a board in a hospital. Given that, do you recognize that what's being attempted here is, when we do have a rogue board or a board that doesn't want to implement an accountability agreement, to find a process where we can work with that board and ensure that they do in fact comply?

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

Ms Huffmon: We are aware the government does have those rights, but our concern is that when they're trying to balance budgets they always start with the lowest worker first and work their way up, and then they are rewarded for balancing their budgets. That is one of our greatest concerns. It has to be across the board, I guess would be the appropriate way of saying it. I'm very new at this myself, so I'm hoping I'm getting this right. The front-line worker has to be protected. There's no protection for them within this bill.

The Chair: I think that makes it very clear. You've run out of time, but I think you've summarized well.

Mr Klees: Thank you very much for your presentation. I might say to you that I share your cynicism, along with every other Ontarian. Whether it's this minister or the Premier, having made many, many promises that they haven't kept so far, why should you or Mr Ryan believe them now? You have a right to see these things in writing. That was precisely the point we made in committee in Sudbury when we had a similar discussion. We gave the Liberal members of the committee an opportunity to demonstrate their commitment to the very things that Mr Duguid is saying. At that time, I moved a motion that this committee in fact support the very specific amendments that you're proposing to put some teeth into the promises. Do you know what happened there? We voted for it, Ms Martel voted for it, and every single member of the Liberals sitting on this committee voted against it.

1030

I'm going to give them one more chance here. I'm going to move a motion now that this committee support specific amendments that guarantee that collective agreements will not be opened, that will guarantee all the things you rightfully request for front-line, health care workers in this province. You may observe that. We will be very interested to see whether the Liberal members of this committee perhaps have changed their minds. Perhaps today they'll agree to vote in favour of this amendment.

Chair, I would like to read into the record this motion, with your permission.

The Chair: Submit it in writing and then we'll get it copied.

Mr Klees: Yes, I will.

I move that the committee support incorporating the following amendments into the bill:

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

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

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

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

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 enforceability of a collective agreement, (2) purport 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 or (4) directly or indirectly interfere with the ability of parties to a collective agreement to comply with the terms and conditions of a collective agreement;

And that these amendments be incorporated into the appropriate sections of the proposed Bill 8;

And that they be given every consideration during clause-by-clause.

The Chair: If you would submit that in writing—it sounds like it's the same motion that was passed before. We're going to confirm that.

Mr Klees: No, it's not.

The Chair: OK. We'll just confirm that. If it's not the same motion, then it will be in order. If it's the same motion, of course it would be out of order.

Mr Klees: I made sure that it's not.

Mr Hudak: Mr Chair, is there debate on the motion?

The Chair: There will be debate once we see if the motion is in order. The clerk is going to take a look at the written copy.

I was going to suggest that we move on with your time perhaps, Ms Martel. Before it's copied, we want to confirm it's a motion that's in order.

Ms Martel: Do you want me to start or wait?

The Chair: I think you should start.

Ms Martel: Thank you to the three of you for being here. You must be as intrigued as I am with the Conservative members' new-found respect and concern for trade union members and trade unions. It's the most amazing conversion on the road to Damascus. They haven't even slagged union bosses once during these hearings, so it's a quite amazing change. I wish I had seen some of that concern during the eight years they were in government. I bet you feel the same as I do.

Let's get to the heart of this. I want to ask questions in two areas: one, the compliance directives and what they mean; and second, privatization.

You heard the letter from Mr Ryan. You note that you didn't hear anything about compliance directives. In fact, in the section on compliance directives the minister could, by the back door, order amalgamation of food services, for example, or contracting out of food services, or contracting out of laundry services. That would have an impact, not particularly on your members in this local but probably on CUPE members and others right across the province. How do you feel about a letter, when we haven't seen the amendments yet, that doesn't say anything about compliance directives and what can be done by the back door through that mechanism?

Mr Manninger: I think we stated that already, but the fact is that the letter is a piece of paper with a lot of good intentions on it. We need the amendments. The amendments need to deal with everything that we asked for in our presentation. Until we see such, we have to fight this bill.

Ms Martel: You need to be looking not only at the sections around collective agreements, but particularly at the compliance directives to see what, if any, changes are there.

Let me talk about privatization. The front of the bill talks in glowing terms about medicare. Who wouldn't support the preamble? Everybody would, except there's a huge gap between the government's talk about two-tier medicare—which is cheap, frankly, given what they're already doing—and actually having details in the bill which would stop the P3 hospitals or stop the private MRIs or stop competitive bidding in home care, none of which appears in this bill, which is very strange.

You hit the nail on the head when you talked about commercial competition limiting the ability to get accountability. We were in Ottawa yesterday and moved a motion asking for the P3 deal at the Royal Ottawa to be released publicly, because the Minister of Health had announced that it would be before the end of December, and it hasn't. One of the Liberal members, Mr Levac, cited commercial confidentiality as the reason why that particular deal shouldn't be released and the details shouldn't be released, because it might force the company to flee. I would like the private consortium to flee, because I want public hospitals built with public money, financed publicly and publicly administered, publicly delivered. I don't want the private sector to be anywhere near hospital building in this province.

Does it surprise you, given what happened in Ottawa yesterday and given the fact that there are no details in this bill whatsoever to stop P3s or to stop the private MRIs—do you really believe that the government is interested at all in stopping the further creeping privatization in Ontario?

Ms Huffmon: It doesn't surprise me at all. I also believe that part of this bill, the introduction of it—through research I've done, I also believe that it is opening the door for P3 hospitals. I think the accountability and the compliance will help dictate what is going on with the private organizations so the government can step up and say, "We do have a bill to protect you, so we can

make sure that these for-profit hospitals are really doing what we want them to do. You're going to have to pay, but we're pretty sure that we're going to make sure that they do what we want."

I think this bill has a secret agenda of paving the way for the P3s, which I don't support at all.

Ms Martel: There's no doubt that people are going to pay; they're going to pay more, because it costs the private sector more than the government to borrow money for financing. The private sector is not going to do this for free; they're going to want a 10%, 15% or 20% profit. So when hospitals have to find money in their operating budgets to pay the Liberal mortgage versus the Conservative lease, we're all going to pay more. That's money that should be going into patient care, not into profits for the for-profit corporations.

Are you cynical at all when you hear the nice words from the minister that say, "We support medicare; we're going to stop two-tier, creeping privatization," and then you look at the details and there's nothing there? In fact, the Liberals are continuing down the road started by the Conservatives with respect to privatization of health care. Does that make you cynical at all, especially given the promises they made during the election about these matters?

1040

Mr Manninger: We're totally cynical. They campaigned on P3 hospitals and that they'd do away with them. They have done nothing yet, to our knowledge, to move away from P3s. So the cynicism is there.

"Private" means "profit." We're in a non-profit sector. We provide it at cost, and to take it private is going to cost more money—no question about it. P3 hospitals are not a good thing. Anything P3 is not a good thing. It costs more.

The Chair: Thank you for the delegation. We certainly appreciate it.

We did have a delegation scheduled for 10:30 from the Ontario Medical Association. Just out of interest, are there people here yet from the Windsor and District Labour Council? OK, good. At some point we may be moving you up a little earlier than 11 o'clock. Is that fine with you? Is everybody's here who needs to be here?

Interjection: Yes.

The Chair: We're going to deal with this issue, then we'll move right on to you.

It would be far preferable if the mover of the motion was in the room. Mr Hudak, I'm going to rule this out of order on two points. If you'd like to defend those two points, that would be fine. If you'd like to take a second to bring Mr Klees in, I'd accept that too.

Mr Hudak: Chair, my colleague is just responding to a media request about the motion in particular. I know that he and probably the media would like to be here to see the vote. If we have a couple of minutes to wait for Mr Klees to return—

The Chair: Well, I don't think the committee waits for the media. If you'd like to bring him in, I'll wait a few seconds. If not—

Mr Hudak: On a point of order—

The Chair: If it's a real point of order, Mr Hudak.

Mr Hudak: You're going after my point of order before I even start speaking about it. The motion has just been brought forward to us for consideration. I anticipate that you'll be ruling momentarily on whether this is in order or not. I believe Mr Klees did indicate that this motion is different from a motion that the committee may have considered before. I wasn't there in Sudbury. My point of order about the motion being in order—I wasn't there in—

The Chair: I haven't ruled it out of order yet. I don't know what your point of order is; I'm waiting to hear it, and I don't hear it. If you'd like to bring Mr Klees in the room right now as I rule on it, that would be fine. That's what I'm saying. I don't think it's the role of the committee to wait for the media to finish an interview.

Mr Hudak: Fair enough. I appreciate that you want to have Mr Klees in the room to hear your ruling on the motion, but my concern is that this motion is different from the motion that the committee has considered before.

The Chair: Why don't I just rule on it, then, and we can deal with that?

On two points the clerk has advised me that this motion would be out of order. The first one is that even though some of the wording may be a little different, the motion is substantially the same motion that was moved in a previous meeting and was defeated. Also, by moving this motion, it would be, in effect, asking the committee to move to clause-by-clause, which it planned to do on March 9 and 10. If it was the wish of the committee to move to clause-by-clause at this time, certainly we could deal with the amendment. That is my ruling.

Sorry, Mr Klees, I've just ruled your motion out of order on two points. I can briefly summarize them. It didn't take me long. One is that, even though the wording may be a little different from the motion that was previously dealt with and lost, the substance of the motion is really the same. The other point is that by moving this motion at this point in time, which is something I'll honestly say from the chair that I don't understand why we allowed the other day, is that you would, in effect, be asking the committee to move to clause-by-clause at this point in time, which it has scheduled and agreed to do on March 9 and 10. That's the ruling of the Chair. If you would like to appeal that ruling, then we can certainly put it to a vote, but there's no debate on the ruling of the Chair.

Mr Klees: What I would ask is that you allow me some clarification. The wording, I thought, was very clear, and that is not that I move the amendment. Would you read back to me, please, for the benefit of all, precisely what my wording was in the introduction.

The Chair: What I have before us is: "Move that the committee support incorporating the following amendments to the bill."

Mr Klees: So my wording was very carefully chosen. I'm not debating the Chair's ruling.

The Chair: I made the ruling. The ruling can be appealed. I'm giving Mr Klees some latitude to explain what he was attempting to do. The ruling does not change. The motion is out of order, unless the majority of the committee decides that it is in order.

Mr Klees: That would be my next request, and that is that while technically—and I certainly would never dream of challenging the Chair in his wisdom, but what I would do is appeal to the rest of this committee for the benefit of demonstrating to the people who are here their willingness to put on the record support for incorporating very specific wording that this committee unanimously, notwithstanding the technicality involved, agrees to have a vote on this motion.

The Chair: Thank you, Mr Klees. So you aren't appealing the Chair's ruling?

Mr Klees: No, I'm asking for unanimous consent of the committee, and the parliamentary assistant refuses to grant that.

The Chair: OK. The motion is dealt with. Thank you for your patience.

WINDSOR AND DISTRICT LABOUR COUNCIL

The Chair: We're moving on to the Windsor and District Labour Council. We have, as I understand it, at least two people, and perhaps three: Gary Parent, president, and Peter Pellerito, political education chair. Please come forward and make yourselves comfortable. Pour yourselves some water, if you wish. You've got 30 minutes to use any way you like. At the end of your presentation, the time that is left over will be split among the three parties, starting with the Progressive Conservatives.

Mr Gary Parent: Thank you very much, Mr Chair. I can't help but say at the outset that I never thought that in the city of Windsor we'd be supporting a Conservative motion, but it certainly sounded like one we could support, but only in Windsor could that happen.

My name is Gary Parent. I'm the president of the Windsor District Labour Council. With me is Peter Pellerito, who's the chairperson of the political education committee of the council. What I would do is ask Peter to start our presentation.

Mr Peter Pellerito: Just before I start the presentation, I can't help but make a couple of comments.

First off, I've been on the board of directors of the Windsor Regional Hospital for nine years, and I am a sitting member of one of the committees of the hospital right now as well. I guess that's kind of a plum for me to stay involved with the hospital here in Windsor.

One of the comments I want to make, and I'm sure Brother Parent will touch on this, is that we have been consulted to death when it comes to health care in this community—from about 1992, if I'm not mistaken. Gary will probably touch on the Win-Win report and a whole bunch of other consultation processes that have taken place in health care.

I just want to make the comment that in the nine years I've been on the board of directors of the Windsor Regional Hospital, I can tell you that we've been told Windsor does one hell of a job by three governments, but when it comes to doing some of the things we propose in Windsor, none of you has listened to us.

The other point I want to make is on this cynicism thing. It's very difficult: With all the consultation processes that have taken place over the last 10 or 12 years, nobody has listened to us. I'm hoping this committee will go away and actually listen to what the people in this community are saying. Let me start the presentation.

1050

On behalf of over 42,000 members of the Windsor and District Labour Council, we want to thank the committee for the opportunity to speak to you today on our health care system here in the province of Ontario.

I also want to make the point that we didn't take any specific area in the bill, because we've taken a brush and sort of touched on all the aspects of health care.

As we look at the preamble of Bill 8, the fundamental Canadian values which make up the five principles of medicare—administration, comprehensiveness, universality, portability and accessibility—seem to be there, but the actual legislation doesn't provide any significant new initiatives with respect to these principles.

A number of people have already mentioned the Romanow report. We don't know what people are waiting for to implement some of those recommendations. We fail to see anything that would absolutely deter support of a two-tier medical system, extra billing, user fees.

The closure of two acute care hospitals here in Windsor and Essex county has created longer waiting lists for services that were promised to be improved. In turn, this has made queue-jumping attractive to those who have the ability to pay.

There seems to be a new section in Bill 8 that is supposed to limit the ability of individuals to jump the queue. It seems to state that an insured person cannot pay or confer a benefit in order to receive a preference in having access to insured services, nor can a practitioner charge or accept money for granting such preference.

The problem we see with this is that it prevents queue-jumping from occurring with insured services only. However, with more and more delisting of services, this provision would not be effective, as queue-jumping could occur within the ever-increasing delisted services. The major threat, in our opinion, is the shift from public to private health care services, which must be stopped and reversed.

Let me make another comment here. We're talking about MRIs and CAT scans and things of that nature. It's interesting that money was made available by the previous government, and it hasn't been stopped yet by this government, so private enterprise can come in, put their MRI clinics into service and then take money out of the public system. To me, it doesn't make sense. In this community, we know what the waiting list is. Our

hospitals have asked for another MRI, but because of our population, we can't get another MRI. We're trying to find an avenue through Cancer Care Ontario and our cancer centre to get another MRI, which I think is ridiculous, because we have the waiting list. We have doctors asking for these tests, and yet our waiting lists are longer.

The new government in our province campaigned against privatization of health care, yet we see them looking at going even further than the Conservative government they defeated with public-private partnerships, or P3s, and even now they are looking at privatizing more than just the three already talked about.

The thing that amazes us is the fact that this government is even looking at this model when it has been estimated that such private models can be expected to cost at least 10% more than their 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, we already see private stand-alone clinics such as MRIs and CTs operating outside the public medicare system and draining money from it through third party billings: WSIB and insurance. The reason we feel this is happening is the government's lack of front-line staff funding for these services so they can be a revenue-generating source for the hospitals. We might also add that this further enables queue-jumping for so-called medically unnecessary services.

Block fees: We've also seen in our community many family physicians charging patients annual or block fees for a range of services, even though this has not been regulated.

The proposal in Bill 8 specifies that the government, not the physician, will determine whether and under which circumstances block fees can be charged, but our feeling is that they should be banned altogether. These fees have caused unnecessary anxiety to our retirees and their spouses, who, as we are well aware, are in much more need of medical attention in their twilight years.

Just before Gary starts, in my retirement now I've taken on the job of taking care of my parents. Just to give you an example of what is happening, my dad has been going through some pretty tough situations right now, and to top everything off, he's had a bout with the gout. Last week, just to show you how crazy this is, the nurse first calls home and tells me the problem that my dad has, but in order for her to get the prescription, my dad needs to pay another $25 so that the doctor can write the prescription, and again, any follow-up—there won't be any more fees—for a $12 prescription. I think that's disgusting.

My dad is on a fixed income. He retired over 20 years ago—he's going to be 86 in May. Now he has to pay—you know, it was only $12.45, but if he had to get that prescription again, he would have to pay the doctor another $25. The other reason we paid for the prescription was because it wasn't covered under the government's plan. So those are some of the things that are happening in this community.

Mr Parent: Thanks very much, Peter. I just want to expand a little bit, because on my way to the hearings today, CBC had the president of the Essex County Medical Society on. Of course, one of the things the physicians obviously are against is the whole question of getting—leading the whole question of block fees. He used the analysis—and I think this is something the committee will probably hear this afternoon when they make their presentation. I believe he said they used to receive 90% funding from OHIP for their fees for services. They now receive 60%. So the only way they say they can make up the 30% or 40%, depending on what type of math you want to use—he was using 40%; I don't know, it must be the new math to get to 90%. But anyway, he's saying at that particular point in time that's the only way they can keep their heads above water. That is one of the pressures that is leading family physicians to abort their particular practices at a more regular rate.

I guess all I say to this committee is that it should be looking at the payment to physicians so they wouldn't have to cause undue hardships to people they want to extend care to at a rate that these block fees are talking about. I deal with our retirees—and we have over 5,000 retirees in my local union alone,—and I can tell you that one of the contentious issues they have is the whole question of paying this annual fee to a doctor. If you don't pay it, you pay the price of waiting longer in their waiting rooms while other people, who paid the block fee or annual fee, get moved up. That's something I think the committee should be looking at as well.

Accountability agreements and compliance directives: I would like to take a closer look at Bill 8, part III, sections 19 to 32, which cover the powers of the Minister of Health to compel persons to enter into accountability agreements or compliance directives. Our area of concern is that we feel the provisions have been drafted in such a way as to give the minister unprecedented power to require individuals and organizations to comply with whatever the minister desires, potentially including the overriding of collective agreements and other negotiated agreements. In our opinion, this constitutes a fundamental affront to the people's rights in a democratic society. Thus, Mr Klees—you weren't here at the beginning—it is very unusual that this labour council would support a Conservative motion, but we certainly support it today.

We want to be clear that we are opposed to the sweeping powers Bill 8 seems to be giving to the minister, as they appear to be too broad and too open-ended. As we have stated before, the labour community is much in favour of a high quality health care system which would include value for monies paid into the system. But to give these wide-ranging powers to one person would, in our opinion, leave the door too wide open to possible further privatization in the name of being fiscally responsible.

I want to just digress for a minute because Peter alluded to the Win-Win report. This community was a

pilot in the early 1990s in relationship to trying to change the way health care is being delivered in this province. We were—and I say this very seriously—the sacrificial lamb. This community banded together. We had over 4,000 volunteers who came together. I think Ms Martel will remember that particular time, because they were in government at the time. This was something that was looked at even before we went forward with it; we as a community had started a process that now jumped into Win-Win. Hundreds of volunteer hours went into trying to put a plan together that saw that we were going to reduce our five acute care hospitals to three. The savings from those two other acute care hospitals were going to be reinvested into this community in community-based services.

1100

Unfortunately, in 1995, with the election of the Conservative government, we saw that report sit on a shelf. But the continuation of the dismantling of the two acute care hospitals continued. At the same time, those savings did not get reinvested into this community, thus, as we've stated in our brief, causing the unduly long delays we're experiencing day in and day out. I know that when you were in government, the area members—Dwight Duncan and Sandra Pupatello and others from the NDP—were constantly badgering the government of the day that what was happening in our province had a relationship to some of the changes in policy that were made.

Some of the further things that I'll talk about in our brief again extended to this. One of them—I'll digress again and read it as I continue. Our long-term-care facility: For 25 years this community fought to change Riverview chronic care hospital into Malden Park long-term-care facility, and we did that; we raised the money. Finally, the government at that time, the NDP government, said they were going to do that. In that change, there was a commitment on funding, I believe $290 per patient, whatever it was. But in 1995, what did we see happen? It was just a drastic cut in that per diem and costs committed to this community. What have we seen as a result? We've seen patients suffer and families being destroyed as a result of these particular cuts for the ever-rising elder population we have in this community. Quite frankly, we don't have a commitment from this government, nor does it show in this particular bill, that those types of changes are going to be reversed.

Long-term care and children's mental health care: We would be remiss if we didn't raise with the committee other issues that concern us here in Windsor and Essex county, such as the need for additional long-term-care beds. We have seen the closure of one of our oldest, well-respected homes, Villa Maria, because of underfunding from the province.

As a community, we fought very hard for many years, as I stated, to replace Riverview chronic care hospital with the new Malden Park long-term-care facility in the early 1990s. This facility was left vulnerable, as the appropriate funding promised by the government was taken away. In our opinion, this is nothing more than an act of treason on the part of any government, after this community worked so hard to raise monies to meet the growing needs within our community.

As well, something has to be done on behalf of our children, who still have to sit on long waiting lists before their mental health care needs are met. It is absolutely criminal that in 2004 this would still be allowed to happen.

Conclusion: It is our hope that this bill will explicitly prohibit a two-tier health care system.

We would hope that accessibility will be strengthened, not weakened, especially for those communities that are currently underserviced as well as those communities that are geographically remote. You're sitting in one of the most underserviced communities in this province, that being Windsor, and Sudbury being another one in the north.

We would further hope that portability be included, as Ontario currently is not covering services for people from other provinces.

We demand that you live up to pre-election promise and put a stop to the current P3 hospitals being eyed for privatization as well as any others that have been talked about in the media over the last several months that the present Liberal government is looking at. Privatization of our hospitals in any form was rejected by the voters of Ontario, and to betray this faith will lead to voters saying, "Same old, same old, no matter who is in office."

The government has a chance to make a difference by ensuring that our health care system remains publicly funded and administered, universally accessible, portable and comprehensive.

We want to thank you on behalf of the total labour movement for the chance and opportunity to speak to this committee. Your task is great, but let me tell you, the people in this province deserve and want a publicly administered, universally accessible health care system, one that we have always been promoted for around the world. We're slowly but surely slipping into a private, two-tier health care system. We have to put a stop to it. This committee has in its mandate and in its charge to try and prevent that. It's not there in the current Bill 8.

As to the amendments, obviously the proof will be in the pudding, as has been said by many around this table. I did hear the minister the night of his presentation to the committee in Toronto. Yes, it sounded great, but we have to see what these amendments are. We have to see not only the amendments but the regulations that are going to govern this bill. Sometimes the regulations are worse than what is in the bill. I don't know if it's allowed, but maybe consultations should take place on the regulatory part of it so that public input is received. What may work in Toronto—guess what?—doesn't work in Windsor, doesn't work in Chatham, doesn't work in Sarnia.

God almighty, we have to have a universal health care system in this province that's going to be the model for everybody across this country. We have a population that's willing to pay the price for it if it's through taxation, but we can't do it when they continually see their

taxes going up and their services going down. You can't have it both ways. We need to have a health care system that's going to be for everybody in this province, not just a few who have the money to pay for extra services.

Thank you very much for your time.

The Chair: Thank you, Mr Parent and Mr Pellerito. We've got about four minutes left for each party to ask questions, starting with the PCs.

Mr Hudak: Thank you, gentlemen, for your presentation and the passion behind the points you brought forward. I think you're right. I think you have good reason to be cynical about what the true intentions behind this bill were from the outset. While we may have a bit of an apology letter, if you will, from Minister Smitherman to Sid Ryan, which was discussed in earlier presentations, that writing may be in the very same penmanship their platform was. You mentioned a couple of things. They had said they were going to get rid of the P3 hospitals, and there was a very clear debate in the election campaign. We as Conservatives had brought that idea forward, made the points again. Shelley Martel and the NDP were against it, and Dalton McGuinty and the Liberals were against the P3s. But now, after the election campaign, they've gone ahead with them in Dalton McGuinty's own area and they're looking at six others that we were told about earlier today. So I think you have great cause for concern, and that's why my colleague brought forward the motion to try to get the committee—and it should be the committee that tells the minister what's going to be in the bill, not the other way around. They have a chance to actually make amendments like those that have been brought forward today. So we've heard a lot of lip service but very little action.

Points were brought up a bit earlier—I think you gentlemen were both in the room—with respect to the quality council and whether it's actually going to have some teeth or are just do the minister's bidding and have some report that's finished sit on the shelf. What do you feel about ensuring that there's consumer representation on that panel as well, as opposed to the discretion of cabinet only?

Mr Parent: I absolutely, unilaterally agree that there should be consumer representation on that particular council. There should also be front-line staff. When you call health care experts, who are those experts? I feel, quite frankly, that it's the front-line staff. They're the people who deal, day in and day out, with the whole question of health care service delivery. They're the ones who can't make the calls to the patients because of understaffing. They're the ones who know first hand. Don't listen to the experts who may be sitting in an office somewhere trying to influence decisions being made in health care. If this committee and this government are interested in hearing at first hand what the concerns are and what the needs are in a particular health care setting, then it should be from the front-line staff somehow being represented on that council.

Mr Hudak: And as you both mentioned, there's a great deal left to the regulatory process. Regulations are simply brought forward by the Minister of Health to cabinet and they're filed and they become empowered, become the law of the land, if you will. You made the suggestion that the regulations to major parts of this bill should go back to committee or for some sort of public input. That will give a chance for the government side and maybe the parliamentary assistant to respond to that request. Because this bill is going to be changed substantially from when it was introduced—a lot is going to be left in the regulations—that certainly seems like a very reasonable proposal that we would support. I would be curious if the government would respond favourably to hearings on the regulations as well.

Mr Parent: We'd be interested to hear that as well.

The Chair: You still have about a minute left, if you've got—

Mr Hudak: Yes, I've got another question on the health council as well. There are two types of reporting mechanisms of bodies. They can go to the minister, in which case the minister would receive the report, sort of put his or her own spin on it and then could put it out publicly or not. There are others that report to the assembly as a whole. The auditor, for example, does that, and we've seen what's happened in Ottawa as a result of the auditor's public report through Parliament. Do you like the suggestion that the health quality council should report to the Legislature publicly as opposed to simply going through the Minister of Health of the time?

Mr Parent: Listening to the conversation and your point this morning, I'd have no problem with that. In fact, I think it should be part and parcel. I think the Legislature should have responsibility over it, not just the minister himself or herself. It should be the responsibility of the Legislature in total.

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The Chair: Ms Martel?

Ms Martel: Thank you, Chair. Thank you, Gary and Peter, for being here this morning. I appreciate it very much. With respect to public consultation on the regs, it's interesting that this is not a proposal that's in the current bill. We just finished dealing with amendments to the health care bill, Bill 31, last Monday and the bill specifically states that there will be a public consultation process on the regulations. It was also out just for first reading, so I'm not sure why the government didn't include a similar provision for this bill, which is also out for first reading. It's an amendment that will now have to be brought forward.

I want to go to your conclusion. At the top you said, "It is your hope that this bill would explicitly prohibit a two-tier health care system." Well, it was my hope too. It was especially my hope when I read the preamble and heard all the glowing words about saving medicare and our system of publicly funded health care services and we're going to prohibit two-tier medicine, and then I look at the contents of the bill and see that there's nothing to be found. If it were a priority for the government to prohibit two-tier medicine, then that would have been in this bill on the first round, at first reading—if it were a

priority. I don't think it is a priority, and I think that's why it doesn't appear. I would bet my bottom dollar that it's not going to appear in the amendments that come forward.

Let's just contrast what the preamble says and what's not in the bill. If you look at our system of publicly funded health services, P3 hospitals, which the Liberals promised to cancel, have now become P3 hospitals under the Liberals. I like to refer to it as a Conservative lease now being replaced by a Liberal mortgage. The same problem occurs; that is, public money that should be going into increasing front-line services is going to be money that goes into the profits of the private consortiums that are building these privately financed hospitals. What do you think of a preamble that says, "We recognize our system of publicly funded health services," when you know the Liberals are going forward with private financing, and money that should go into those publicly funded services is going into the pockets of some of the consortium members?

Mr Parent: Obviously, I think that's misleading the people of Ontario. Even during their campaign they campaigned very hard, and the voters, as we say in our brief, voted against that type of health care you're talking about. Somehow, the Liberals were saying at the time that they were going to prohibit it. I think that has to be lived up to. There's no way we should have our publicly funded money going into making someone rich.

Again, in our brief we alluded to it. You look at other jurisdictions that have experienced the whole question of these P3 models and they haven't worked. In fact, the proof is in the pudding there that the actual cost increased as a result of going to these types of models.

So why would the Liberal government even entertain any thought process of doing it and not go in, as their pre-election campaigning said they were going to, and stop the three that were already on the radar screen by the previous government to go into that type of partnership, put a stop to it immediately and not look at six or seven more, whatever it is, to continue that thrust? At the same time they're saying they're against the two-tier privatization of the system in Ontario. They're speaking out of both sides of their mouths, in our opinion.

Ms Martel: If you look at the private MRIs, there was a great report done out of Alberta looking at the private MRIs there, which also clearly showed how much more they cost in relation to the MRIs and CAT scans that were operating in the publicly funded, publicly administered hospital system. Again, the Liberals said they were going to shut down these clinics, and they are not shut down. I heard the minister say on Monday, "We're not going to shut them down now; we can't at this point because people need the service." Maybe they should do what they promised, which was to move that technology into publicly funded hospitals so that people could get the service there. Again public money is going into the profits of the operators of the for-profit MRI clinics. What does that do when you have an alleged shortage of funds for health care? Does that make any sense?

Mr Parent: Not any sense at all. We in this community fought and campaigned very hard and rigorously to have our first MRI put into our Hôtel-Dieu Grace Hospital site, only to find out that it went there, but the problem was that the government of the day did not have the funding to keep it on a 24-hour basis to meet the needs of this community. Remember, we only had the one particular MRI, which was absolutely ludicrous. So here at 4 o'clock, 5 o'clock or 6 o'clock, that MRI would shut down because they had no funding for the actual staff to provide the programming.

I've said it publicly before and I'll continue to say it: They had a Together in Caring Campaign on this whole question of turning our hospitals from five acute to three acute. I said at that time, as labour council president, "We're not going to be there. We're not there until we get a commitment out of the government." Any government that sits in the province of Ontario has to commit that the proper funding will be there. It does no good to have nice entrances, it does no good to have shiny walls if you don't have the money to provide the programs for the services that meet the needs in this community. I'm telling you that that's what we don't have. We don't have the money to provide the services, to provide the front-line staff to meet the needs in this community. That's what's so wrong about some of the decisions that have been made on our health care system in our community. I think this community deserves an absolute, unequivocal apology from the government, all governments, both past and current, on what they did to this community. I think it was a tragedy; I think what they've done was terrible. Even the funding formula—

The Chair: Mr Parent, you're a little over your time. Thank you.

Mr Parent: —is not being properly administered in this community. We're underfunded, and someone has to look at it.

The Chair: Thank you. We still have some more questions. You'll have time to continue, just with somebody else.

Ms Di Cocco, from the government side.

Ms Di Cocco: Thank you for your presentation, both of you; they were both very passionate. You obviously have had a great deal of experience in the health care field.

First of all, I can't agree with you more that we should not be using public dollars to line anybody's pockets. I can say this—now, I know there is this constant rhetoric that we are for private hospitals. We are not. I can assure you that we're committed to a health care system that's publicly owned, that's publicly controlled and that's publicly funded. I don't know how much more clearly we can relay that. I know there are a lot of other agendas out there that try to suggest that's not the case. I would not be serving as a representative from my area if I didn't believe that was the case. That's what we believe in. We have heard even the economic argument that, no, it isn't cost-effective to have privatization in many cases. It isn't effective.

By the way, there are definitely tremendous challenges. I heard Mr Pellerito, I believe, saying, "We've been consulted to death." This bill, the intent of it, is so we can reaffirm our commitment to medicare. It is also about dealing with accountability, because yes, there is a funding issue that's there, but it's also the accountability mechanism that we have to look at, how the money is being spent. That's very important as well, as you know; I don't have to tell you that.

I heard Mr Pellerito talk about his dad, and I understand when we personally face challenges in the health care system. As government, all we want to do is to make it better. This process, the process of really listening—this is a bill that's been brought forward at first reading so we can hear the experts or people who are out there say, "Look, this is what's really gone wrong here. This is what's not working. This is what we'd like to see changed."

I can say to you that when it comes to the concern you have about regulations, which was my concern when I was in opposition, a huge concern, in the amendments we're going to be bringing forward there are going to be a lot fewer regulations we're going to be dealing with, and the minister is going to consider some of those regulations for public hearings.

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Our intent is to deal with the tremendous structural deficit we have in this province, that you've both described better than I could, a structural deficit over many, many years of taking out and taking out, and things don't work the way they should be working.

What we want to do with this bill, in getting input at first reading, is get the best possible legislation so the concerns raised by the interpretations—this is only a proposed bill—that you have provided, how you see it, will better help the government to draft a bill that is there to serve the public or that is in the public interest.

Mr Parent: I guess I have one question that I'd like to put to you.

The Chair: It'll have to be in about 10 seconds.

Mr Parent: What changed from pre-election to now on the P3s? Why is this government persisting in going forward on the P3s now and not—

Ms Di Cocco: But we're not.

Ms Martel: Private financing.

Ms Di Cocco: But it's publicly owned. It's the ownership; it's publicly owned.

Interjections.

The Chair: Order.

Ms Di Cocco: It's publicly owned, publicly run.

Interjections.

The Chair: Order.

Ms Di Cocco: You have a vested—

The Chair: Order. You've been so good everywhere else. Just in Windsor everybody starts acting out. What is it? Thank you very much for coming today. You've caused a little excitement, and maybe that's good for us.

Mr Pellerito: We've done a lot in this community. That's why you ought to be listening to us.

The Chair: We are. We will be.

JAN KEMPE

The Chair: Could I call forward Jan Kempe. Mr Kempe, make yourself comfortable. I understand you're speaking on your own behalf today, is that right?

Dr Jan Kempe: I am indeed. I'm speaking on my own behalf, on my patients' behalf and on behalf of the chiropractors.

The Chair: So it's Dr Jan Kempe then.

Dr Kempe: I'm Jan Kempe, chiropractor. Dr Jan Kempe.

The Chair: Very good. You've got 30 minutes. You can use that any way you like. At the end of your presentation, we'll split the remaining time up among the three parties. The floor is yours.

Dr Kempe: My name is Jan Kempe. I'm a practising chiropractor in the city of Windsor for some 38 years. I'm pleased to make this submission in support of Bill 8, the Commitment to the Future of Medicare Act, at least insofar as I understand it. I understand that Bill 8 is intended to demonstrate Ontario's commitment to medicare, which in Ontario is the OHIP system.

When I began my practice in 1966, it was a rare month when I received a referral from a physician. It was unusual for a person to attend a chiropractor. Some 3% did, at most, in any given year. Now 12% to 14% of Ontarians visit a chiropractor every year, and some 40% have in the last five years. The reason is that many physicians now refer patients to chiropractors. Over 85% of my practice is based on direct referral by the medical professions. They do so because chiropractic care is safe care, it is effective care and it's inexpensive care. All of those clients referred by their physicians, family doctors and specialists present with musculoskeletal pain; many are elderly. Chiropractors share in the care of these clients in collaboration with their physicians. This is coordination of care, and this is good medicine.

Coordinated, collaborative care is good health care for patients. Whether we speak of the unfortunate individual who can't stand erect because of back pain or who suffers excruciating headaches due to some neck dysfunction following trauma, in any event, the intervention of a well-trained professional is paramount. The alternative is long waits for specialists, unwarranted tests and unneeded medication.

Good health care is appropriate intervention by appropriate professionals. This allows a physician to focus on those patients who need her expertise and allows me to focus on those who need my expertise. In this age of shortages, it would indeed seem appropriate to have the physicians focus on the things they know best.

As a senior practitioner of chiropractic, I feel I'm well past the point where I should have to justify the efficacy of my care. I think the WSIB's new evidence-based program of care for back pain provides for the treatment of patients in the manner in which chiropractors, including myself, have been practising for years, that being early return to activities, spinal manipulation, exercises and education.

I provide timely, cost-effective interventions. In my absence or in the absence of others like me, who takes the time to explain, counsel and demonstrate? Who is better trained to prescribe the exercises and the needed lifestyle changes? Who is better placed to restore function to a joint? No one duplicates the services I provide.

As noted earlier, I treat many elderly. Most present with few things other than pain syndromes, and for them, health care is musculoskeletal care. Withdrawal of funded services would lead to lack of mobility, loss of independence, increased use of pain medication and increased discomfort. Support in the form of effective chiropractic care is their path to independence and comfort. This act ignores that type of health care.

Many individuals cannot access chiropractic care because of lack of funding. There are few alternatives. I can tell you unequivocally that cost is the major barrier to appropriate musculoskeletal care that my patients face in this community. There is limited OHIP funding, which amounts to about 30% of a visit. Back in 1970, when OHIP started, it was 80% to 85% of a visit.

I understand this act does not prohibit copayment, because with only partial payment, this is not understood to be extra-billing. However, in the absence of funding, which this act facilitates, those individuals who can't afford appropriate musculoskeletal care will seek an option which costs them nothing but which costs the province much more. They may attend a clinic, visit the ER or take medication paid for by the Ontario drug benefit program, or there may simply be lost productivity as they heal more slowly or incompletely.

I refer specifically to section 10. In this country, the third most frequent reason for attending a health practitioner is musculoskeletal pain. Nevertheless, conspicuous by their absence in section 10 of the bill, which establishes that OHIP fees will be reached by agreement with associations, is any mention of those professions most closely associated with the treatment of musculoskeletal pain, specifically chiropractors and physiotherapists.

Although the act provides for other associations, it is apparent that the absence of specific mention of chiropractic and similar professions is an indication of this government's lack of commitment to that component of the Ontario health care system. I'll leave the other professions to speak for themselves.

Section 10 refers only to physicians, dentists and optometrists. It specifically ignores those most qualified to treat the fully one third of patients who present with pain syndromes: chiropractors and other similar practitioners.

I agree that medicare must be preserved and that the future can only be assured with perfect planning, but that planning should include the other health professions like chiropractic, which provides effective, evidence-based care, which are good value, specifically low-cost, have a large impact on patients' speedy return to normal activities, which are valued by patients and which are not just add-on costs but which take pressure off other parts of the system.

With respect to accountability, this act purports to increase accountability by requiring anyone receiving funding to enter into an accountability agreement. In the light of only partial funding, I've long been accountable to those who matter most, and those are my patients. Chiropractors, like other publicly funded health service providers, have always been accountable. Greater accountability should be welcomed by everyone, and I and other chiropractors don't fear it. The colleges already have standards of practice and peer review programs which maintain high professional standards, and I'm ready to be held accountable not only for my patient outcomes but also for the value received for the OHIP dollar.

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With respect to accessibility, this act has specific provisions for eliminating barriers to access, including financial barriers, specifically the elimination of extra-billing, direct billing and block fees. I reiterate that one of the barriers my patients face is the barrier that exists because of costs, and there are no alternatives. MSK care is not very noticeable; it's dramatic to no one but the individual who is returned to mobility, function and work. Nevertheless, there remain many individuals who can't access chiropractors and physiotherapists and their services because of lack of funding. This act ignores the fact and enables its perpetuation.

I'd submit that the future of medicare in this province requires a careful look at the big picture. Making the best use of human and other resources we have is paramount.

I conclude by saying that this act as written, particularly section 10, which talks about medical, dental and optometric services, continues to perpetuate the dismissal of other valuable services, including chiropractors, nurse practitioners, pharmacists and physiotherapists. It perpetuates the concept of funding silos and the dampening effect on efforts to save costs by providing the most appropriate and cost-effective care. It impedes our ability to utilize the most effective human resources in specific instances. It continues to rely on the medical practitioner to the exclusion of all others, despite, in this city, shrinking manpower, expensive tests and long waits. I consider chiropractic an integral part of our health care system, and I would ask you to look carefully at section 10.

Thank you very much. I'd be happy to answer any questions.

The Vice-Chair (Mr Jim Brownell): Thank you, Dr Kempe. We have about 21 minutes, so we'll split that: seven minutes each. From the opposition side, Ms Martel.

Ms Martel: Thank you for coming here today. Some of your colleagues came to see us in Sudbury, which is my hometown, and raised similar concerns.

One of the suggestions I made with respect to section 10 was that we could do one of two things: either delete from this section any reference to any associations so no one is excluded, or add all the regulated health professions and list them in that particular section, so it

would be clear that the government may enter into agreements with all the regulated health professions, because all, in some way, receive some funding. For some it's partial—and I appreciate that in your case—and for others it's a fuller amount.

I'm not sure what the government will come back with in terms of a change to that section. I'm not interested in a bill that would exclude any of the regulated health professions or undermine or lessen the contribution they have to make to the health care system, so whichever of those two options works is an option I'm interested in. But as it appears now, it certainly gives everybody the impression that chiropractors are excluded, dental hygienists are excluded and all the other broad categories of health care providers regulated under RHPA are also excluded. That can't stand the way it is.

I hope it will give you some comfort that in fact there was a recognition in Sudbury that this section cannot stand the way it currently stands. It would leave everybody with the impression that the government doesn't want to negotiate with you or doesn't appreciate the skills and competence that chiropractors can bring to the health care system. I hope that will give you some comfort.

Dr Kempe: It gives me some comfort. I would fear that if you don't mention all the professions, it would then leave the door open to negotiate with none of the professions or whichever professions the government in power at that time would choose. Certainly I'd much prefer that they list the regulated health professions.

Ms Martel: So the 21 or 22 are listed in part I, and then, in part II, the associations are listed as well, because we'd have to do it in both sections. I appreciate that recommendation.

In light of that, and maybe it's because of what currently appears in section 10, on page 4, in the top paragraph, you said, "However, in the absence of all funding, which this act facilitates, those individuals who can't afford appropriate MSK care will seek an option which costs them nothing but which costs the province much more." Was that a reference to seeing that you were not included and assuming there were not going to be any more funding negotiations between yourself and the government?

Dr Kempe: If we're not included, the option is there not to negotiate with us at all or to drop it out or to terminate funding for us and the physios and any other musculoskeletal care professionals and leave them with nothing.

Ms Martel: That's a legitimate concern if you look at the current wording of the bill. That's exactly the inference you could draw. But none of us is going to have that happen. I don't disagree that the current funding you're receiving is much different from the 1970s; it's much less, and that does put additional burdens on people who may not be able to afford their copayment. But I don't think any of us had the impression from the minister that what he was talking about was eliminating any portion of funding at all to chiropractors or to the other regulated health professions. I don't think that's where he was going, and none of us would support that.

The Chair: We'll move to the government side.

Ms Smith: I'd like to thank you very much for coming to speak to us this morning. It's important that we get input from the various groups and stakeholders and individual practitioners, and we really appreciate your participation in this process. My colleague will speak a bit more about the process, but I just wanted to address a couple of your concerns, specifically with respect to section 10.

Section 10 of this bill was drafted as it was set out in the health care accountability act, which was passed in 1986. It's an exact duplication of that provision, which is what you and other regulated health professionals have been living under. So there was no intention of leaving out specific health care providers; it was just a tracking of the language that previously existed.

Subsection (3) of that particular section allows the minister to enter into agreements under subsection (1) with specified groups or organizations other than the associations mentioned in subsection (2). It does allow the minister to continue, as he or she has in the past, to enter into agreements with regulated health professionals.

I don't think you should take this as any kind of slight. It was a tracking of previous language. It is not in any way an indication from this government that we do not intend to continue, as governments have in the past, to deal with all regulated health professionals, including chiropractors. I hope that goes some way to calm your fears.

It may be as a result of Ms Martel and I spending too much time together this past week that we both underlined the exact same sentence on page 4, the top paragraph. She addressed it, and I think I have as well, in just outlining to you where section 10 came from and the fact that subsection (3) does allow for agreements.

As to the accountability agreements, which you seem concerned about, the minister stated in his opening statement on Monday that the accountability agreements we foresee through this legislation will be between hospitals, CCACs, long-term-care facilities and other independent health institutions, and not between particular physicians or health practitioners and the government. That might be what you were referencing on the bottom of page 5 and the top of page 6. That is not the intent of this legislation, and the amendments we bring forward will address that particular concern.

I think at this time I'll let my colleague, Ms Di Cocco, have a few more comments and questions.

Ms Di Cocco: Thank you very much. The intent of this committee in having this bill here at first reading is that it's a proposed bill, and your input, sir, is very important. You make a really good remark in your submission about the big picture, that "making the best use of human and other resources we have is paramount." I think that's the crux of the matter. Many times in this huge monolith of health care—you provide examples of how in your profession you provide a good service for the dollars spent and the accountability mechanisms you have. For us to have an official submission from you

provides the government with on-the-ground input, some of your opinions. Again, I thank you for that. If you could even make any other comments in regard to the accountability mechanism, it's a huge financial consideration in this province and it seems the accountability mechanisms are truly important. You've outlined how you've met those obligations in your profession, so if you have anything else to say about that, I'd be glad to hear it.

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Dr Kempe: Are you asking me to comment on accountability as it refers to practitioners?

Ms Di Cocco: In a large context.

Dr Kempe: Are you asking about corporations and hospitals and things like that?

Ms Di Cocco: And practitioners, if that's your—

Dr Kempe: As a professional, I'm more comfortable speaking about practitioners. As an individual, I suppose I could address anything.

Certainly all practitioners who bill OHIP have multiple accountability measures to which they have to adhere. That includes reviews by OHIP and audits. There are letters sent to my patients. Every couple of years, patients start calling, saying, "I got this letter from OHIP about whether or not I was really in your office." I say, "Well, tell them." So there's that type of thing. There's the chiropractic review committee, and there's the CCO. As practitioners, we feel there's a whole bunch of loops we have to jump through. Certainly, I don't know of anybody who's ripping off the system or billing in instances when services are not provided.

Ms Di Cocco: When it comes to this process of actually asking for input before the bill is at second reading—this is first reading, meaning that the whole process is about modifying this bill so we can catch issues that are out there that we want to modify and draft a better bill—do you have any comments about that process?

Dr Kempe: I can't fault the process. I have concerns about section 10, and the reason I'm concerned is that this profession and a number of ancillary professions including the physiotherapists, I know for sure, and I believe optometrists and one other group, reached agreements with the government before the last election. Those agreements have disappeared somewhere. The current government is not aware of the agreements, and that scares us. It scares the physios, and it scares a number of other professions.

The Chair: We'll go to the official opposition.

Mr Hudak: Thank you for your presentation. It sounds like you've reached a sympathetic ear with all three parties with respect to section 10. I understand the Minister of Health is delivering amendments at one o'clock or so today. Hopefully that will be included in those amendments and we can clear up any kind of misunderstanding about the government's intentions. We look forward to those amendments.

I have a couple of questions for you. You mentioned that about 30% is funded through OHIP and the rest is through either the insurance company or the individual's pocket and that sort of thing. How do you set the total fee?

Dr Kempe: That's an individual thing. It's illegal to collaborate on setting fees.

Mr Hudak: So it's set by the market; it's not set by the government or any institution?

Dr Kempe: Yes, it's set by market. The members of the CAW in this particular locale are very lucky in that their union probably looks after them much better than most unions. The people in Windsor do a little better with respect to funding than most other people in Ontario, but the 40% to 50% who don't have extended health care either don't come or come for the 15 visits that OHIP partially funds, or we're just nice people and treat them for free.

Mr Hudak: Is there any reason for concern, if accountability agreements are put upon chiropractors and such, that you'll lose the ability to set the fee without getting subsequent government funding to close that gap?

Dr Kempe: I always have fear when it comes to government funding. As far as accountability is concerned, if the accountability is linked to fee-for-service, then I would have some concerns. But as I stated, I'm not afraid to be accountable as far as value for service provided is concerned in my practice or in any other matter as far as accountability is concerned.

Mr Hudak: Maybe you could describe a bit the mechanisms that currently exist for your profession through the college of chiropractors for ensuring you do have accountability in training standards.

Dr Kempe: There are a number of mechanisms. There's a long-standing one that if you use radiographic examinations or take X-rays in your office, then every so often, about once a year, you have to send in copies of your X-rays and your X-ray reports to see that they meet quality standards. As it is now, one fifth of all chiropractors—so all chiropractors at least every five years—receive an audit in their offices by someone appointed by the CCO who reviews all the files and makes sure the practitioner is keeping proper documentation and that there are indications for the continuation of care and people are not being brought in just to generate finances.

Mr Hudak: The last question I have, and I think it's important, is with respect to the point you made in a general sense about how the fees are and that the fees have not changed in some time. Were any commitments made to you by the government, either when they were campaigning or in opposition, as to how they were going to address particular issues of importance to chiropractors?

Dr Kempe: I'm not aware that there were agreements between any party and ourselves during the campaign.

Mr Hudak: No campaign promises or commitments, either locally or provincially?

Dr Kempe: I'm not aware of any.

Interjection: Nice try.

Mr Hudak: It's always worth fishing. It's worth asking. We believe you should keep your campaign pro-

mises. If you say something during the campaign, you should keep it, and these guys don't. I thought I'd see if there was one here that I could throw back at them, but I'll have to keep looking.

Dr Kempe: If I had something on them, I certainly would have brought it up.

Mr Hudak: There you go. Good for you. Thank you, Dr Kempe.

The Chair: On that note, thank you for coming forward today. We appreciate it.

TEEN HEALTH CENTRE

The Chair: I call forward the Teen Health Centre, represented by Sheila Gordon, who is the executive director, and Dean P. La Bute, president, board of directors.

You have 30 minutes to use as you see fit. Any time remaining at the end of the presentation will be split among the three parties, and this time the party that will go first is the Liberals. The floor is yours.

Mr Dean La Bute: Thank you. My name is Dean P. La Bute. I'm president of the board of directors of the Teen Health Centre. I'm accompanied today by Sheila Gordon, our executive director. Ms Gordon will make the formal presentation of the position of the Teen Health Centre as it applies to Bill 8.

I would like to say as an opening comment that you will find we have documented in our submission that the model of the community health centre has its basis founded in the 20th century. You will find, as ratified by the government of Ontario in this report released at the end of June 2001, the Romanow commission report of 2002 and the position taken by Anne McLellan, the former federal Minister of Health, that the CHC model is the model for the 21st century for the delivery of primary health care in Ontario.

You will find that we have documented it is effective, efficient and equitable in the distribution and delivery of community primary health care services to all citizens. It has that potential. We will call upon you, the government, and the opposition members to recognize this established and documented fact and look favourably on the model we are presenting to you today for reaffirmation and confirmation that this is the way to go in the 21st century for the delivery of primary health care in Ontario.

At this time, I'd like to call upon Ms Gordon to formally present our report. Following the presentation, we'll be more than happy to answer any questions you may have.

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Ms Sheila Gordon: Let me start by giving you some insight into how the community health centre model actually fits with the provisions in Bill 8, the Commitment to the Future of Medicare Act, and also the recommendations, as Dean has pointed out, of the Romanow commission.

Community health centres are models of primary care, with multiple support services in place to ensure that consumers receive the care they need, when they need it and where they need it. We believe that the government should continue to invest in primary health care and that community health centres are natural and worthy candidates for that investment. By investing in community health centres, the government will improve the province's health system and begin to deliver in a significant way on its commitment to expand primary health care across the province.

Community health centres have been in the forefront of primary health care for over 30 years. We support the government's commitment to the principles of accountability and accessibility, and we encourage this government to implement their plans for primary health care renewal across the province.

First, just a little bit about who we are in Windsor. Windsor and Essex county currently has two community health centres. One is the Sandwich Community Health Centre, which serves the geographic population on the west end of Windsor. Dean and I represent the Teen Health Centre, and we serve youth from the ages of 12 to 24 across Windsor and Essex county. We also serve the homeless population of all ages in the downtown Windsor core.

Today in Ontario there are 65 centres, of which 55 are community health centres and 10 are aboriginal health access centres. All these centres are community-based, non-profit organizations that provide high-quality, cost-effective primary health care services. But our centres don't stop there. I think one of the prime pieces that fits so well with primary health care is the focus we have on health promotion and illness prevention. As you know, prevention is going to save the government dollars in the health care system down the road.

In June 2001, the Ministry of Health and Long-Term Centre completed a strategic review of community health centre programs. The key findings showed that:

(1) We exhibit desired primary care reform features.

(2) We are accountable through community governance, service agreements with the ministry and accreditation.

(3) We deliver on ministry goals and strategies.

(4) We have a strategic role to play in primary health care, particularly with serving populations that face access barriers to the system. Certainly, community health centres are one way to meet the need of underserved areas such as Windsor, which is significantly underserved.

In his 2002 report, Mr Romanow identified that the community health centre model of primary care was found to be an effective, efficient and equitable form. As Dean has already said, Anne McLellan has acknowledged our model as an effective one for primary health care delivery.

The Teen Health Centre applauds the approach the government is taking toward managing the health care system. We support the call for accountability agreements between the ministry and health resource providers. We also applaud the establishment of the Ontario

Health Quality Council to provide advice to government on health system outcomes and access to health services. It's important to measure what is happening in the health care system, and these two avenues will hopefully do that.

In order to achieve these outcomes, we need the support of shifting health resources to communities to deliver services closer to home. Spearheaded by local need and governed by local boards, health centres are quintessentially creatures of their communities. Primary health care is our number one priority and remains a top issue for the majority of people across the province.

Currently, the Teen Health Centre serves over 17,000 active clients through Windsor and Essex county. We have eight satellite offices throughout the county, with our main office in Windsor. In our last fiscal year, we had over 21,500 visits to the centre, to see physicians, nurses, dietitians, psychologists, social workers and counsellors. We also go into the community, primarily schools, and do health promotion activities and prevention services. Last year we saw over 5,500 youth through that method.

As you know, Windsor and Essex county is one of the most underserved areas in Ontario for family doctors. Many of the clients who use our services do not have family doctors and would rely, if it weren't for the services we provided, on walk-in clinics for health care. Some of our clients have a family physician but choose to use the Teen Health Centre because of the confidentiality and non-judgmental way in which we serve our clients.

We've recently received increased funding to provide an additional nurse practitioner. Those services are a cost-effective way to provide health care for our youth and homeless population. We certainly applaud the government for that as a step in the right direction.

Our medical department sees a large number of teens for sexual health reasons, yet the percentage of teen parents in Windsor is 26% higher than the provincial average, according to the health unit's health profile technical report of 2000. Increasing funding in our medical, counselling and health promotion areas will help us to reduce this number to at least the provincial average. This one area alone will help the provincial government reduce costs to health care and to the welfare system as well. Additional funding would allow us to serve 200 new clients a month, as well as providing our existing clients with increased access to physician, nursing and dietitian and counselling services.

Our current waiting lists for counselling services are approximately eight to 12 weeks. For a teen who has made the decision to stop using drugs and alcohol and turn their life around, this waiting period is far too long. For a client who is depressed, an eight-week waiting period can result in hospitalization.

The demand for Teen Health Centre staff to do presentations in high schools and elementary schools far exceeds our ability to provide this service. We need additional health promotion staff to meet those demands and allow our clinical staff to remain in the centre to serve clients.

The committee may not be aware, but the salary budget lines of community health centres were frozen for over 10 years. Recently, the ministry reviewed and approved new salary scales for physicians, nurses and all the other staff we have, and it was measured in today's environment against other health care providers. The funding for the scales, however, was only provided at 60% of the ministry recommended rate because of funding shortfalls. We're not here to complain that we received increases; we're very grateful for that. However, it becomes a recruitment and retention issue when we're competing with other areas of the province or within the city. To compete with a hospital to try to hire a nurse practitioner—they're offering the top of the range, which is higher than the amount of our funding. So we're hoping that we can, through wise investment, help solve that problem.

The proposal submitted to the Ontario government by the Association of Ontario Health Centres in 2002 can provide assistance to the government in managing the health system and to patients who are trying to gain better care and better access. People go to hospital emergency rooms not because they want to but because they have no alternative; they cannot gain access to their family doctor because it's an after-hours time or the clinic has been closed. By funding our proposal, our community health centres are in a position to provide 24-hour access, seven days a week. So we can provide a natural alternative to hospital emergency rooms, which should improve patient flow in ERs and make sure hospital capacity is maintained for true emergencies.

One of the things we do at the Teen Health Centre is stay open until 8 o'clock two nights a week so that our clients can come after school or after their jobs and still have health care access to their primary health care provider. A number of other community health centres across the province are open three or four nights a week providing the same types of service, which again fits into the access issue addressed in Bill 8.

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Our wellness approach also encourages people to take better care of themselves, which in turn may prevent illness and result in fewer emergency room visits. Health promotion activities should be looked at as an investment in the future and a cost reduction down the road. The government is certainly correct; we would agree with their approach in expanding primary health care teams or groups across the province, but we would also urge you to consider that one size does not fit all, nor does one model, so we should look at a variety of models. We're not here today to say that the family physician should be outlawed. You shouldn't consider that; certainly, the system requires that. But you should consider an expansion of what we do.

We have a proven, cost-effective, measurable model that treats all of the individual's primary health needs. We also serve the hard-to-reach population groups that

can potentially drain hospital resources if care is not provided ahead of time or on time. The strategic review the ministry did notes that community health centres are one way to meet the needs of underserviced areas, and certainly in Windsor, the Sandwich Community Health Centre has been outstanding in that area, but they have a closed practice because they cannot take on any more clients with the number of practitioners they have.

We have a wellness philosophy and approach about making people well so they don't need to rely strictly on a treatment regime. We know this is a priority for the government, and we think we are an effective and successful strategy to achieve this goal.

In summary, the key points that I think community health centres can offer, and do offer currently, are that we feature a multidisciplinary team, we provide 24-hour access to coordinated services and our model of care is built on a broad understanding of the determinants of health. All providers in our system promote illness prevention and health promotion. Our centres have invested heavily in information technology and we can measure what we do and what we achieve. We have a high level of patient satisfaction. Our centres are community-based and reflect the health and service needs of the communities. We are accountable. We enter into service agreements with the ministry on an annual basis. We are governed and managed by local board members. We submit to an outside review through an independent accreditation process.

What we hope to accomplish is to reaffirm our presence and worth in today's health care system. Key health directions the government has identified as priorities are areas in which we have a proven track record of accomplishment. We support the direction taken in Bill 8 for access and accountability to all Ontarians. We know that investing in community health centres like the Teen Health Centre will result in an improved community health care system.

Those are my comments, if you have questions.

The Chair: Thank you, Ms Gordon and Mr La Bute. You've left us about 15 minutes, which would be five minutes for each of the parties. We'll start with the government side. I've got Mr Duguid and Mr Brownell.

Mr Duguid: I'll try to be as quick as I can to leave some time for Mr Brownell. I think, frankly, we couldn't agree more with a lot of what you've said in your presentation. It is an excellent presentation and, frankly, I'm going to keep it aside as we're going through our changes to the health care system. It's something to refer back to.

Mr La Bute in particular talked about the community health centres as being the future of our health care system, and again, I couldn't agree more with that. I think the government and all members around this table agree with that. It's a question of how you can move to that model from the very institutionalized model we have now.

You talked a little bit about shifting resources. My question to you—and it may be an unfair question because it's a difficult one—is how the heck do we do that? We've known for 20 years that community-based health care is the superior model, but shifting those resources has been the difficulty. We've closed the beds in some cases, but we haven't got the resources out into the community to accommodate those changes. Do you have any comments on that?

Mr La Bute: I do have several comments. One, we have to renew our relationship with the federal government and have the federal government step up to the table and meet its obligations under its commitment to the future of medicare in this country. Through a collaboration between the provinces and the federal government, we would bring into the system the necessary funding to fund the system now and for the foreseeable future.

Separate and apart from that, I have been involved and have been in communication with many members of all three parties over the years and am of the understanding that there's considerable money in the system. It's the allocation of that money within the system, possibly the approach of an audit of the system—it's a systemic problem across the system that you are dealing with. It may be that we have enough money in the system and that it's the reallocation of those funds, with emphasis being placed upon prevention and primary health care, so the funds that are necessary for acute care will be there, and the beds in the hospitals will be available and not taken up by others.

Mr Duguid: My second question is, and I'm going to make it as brief as I can to try to save time, you serve the homeless population here in the Windsor area. One of the problems I've seen in urban areas has been that hospitals, in particular for the mentally ill but not just for the mentally ill, will provide a treatment or a service, but pretty soon they're out the door and back in the street, where there really is no opportunity to convalesce at all, in particular if it's a surgery or something like that, or even in the case of a mental illness. They'll get them back on their meds and within a few days they're back out on the street again, only to maybe have to be taken back to the hospital a week or two later. After a while, I think the social workers just grow tired of that circle of non-treatment and stop doing it.

Do you have any comments as to how community health centres might be able to contribute to helping us resolve that difficulty?

Ms Gordon: The system we have in place in Windsor is that we have a nurse practitioner who is located actually at the Salvation Army, and they have hostel and crash beds for homeless people. So she's there a couple of times a week and can do that sort of follow-up from an acute care incident and monitor meds or help them, work with them to ensure that they're staying on medication or following the protocols.

Again, we could absolutely use another full-time nurse practitioner in that system, because we move her between about four different satellites. The homeless population is not a population to whom you can say, "I'm here.

Everybody come and see me." You have to go to where they congregate and where they feel safe and comfortable, and trust in that population is a big issue. It's a difficult population to put in a healthy situation, just because of the nature of the lifestyle and the extreme poverty. But definitely having a nurse practitioner available to them where they reside or where they go for the warm lunch has been very beneficial.

Mr Duguid: Thank you. I hope there's time for Mr Brownell.

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh): It's more of a comment, but I might have a question.

I just want to say how exciting it is to have you here at the table and to hear community health centres being part of the talk that we're into now, part of the dialogue. I believe that is Minister Smitherman's big interest, to have this as part of primary care.

Before I ever got into this—I'm one of the rookies—in 2003, it was exciting to see when the leader of the official opposition came to my riding on two occasions to see how a francophone health care centre was working in my constituency, where we have a large francophone population. It is the minister's wish, and he's very keen on this, to have it as part of primary care delivery.

This morning we've had a few comments about Windsor being part of underserviced areas, and I think it's very important to have these centres in these underserviced areas. So it's really exciting to see you here. I wanted to say that as somebody who has been very much a part of health care centre work in my community. Thank you for being here.

The Chair: Let's go now to the official opposition.

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Mr Hudak: Thank you both for your presentation, certainly the ideas you bring forward in terms of reinforcing the multidisciplinary approaches to health care and community-based health care.

There's a question I had for you. One thing we haven't talked too much about yet today are the privacy issues inherent in Bill 8, very serious privacy issues. In fact, I think the reaction was so strong initially when the bill was introduced, it provoked the minister to bring forward Bill 31 to deal with access to personal health care information. Particularly in the teen health centre, you would deal with some very sensitive issues, with STDs, teen pregnancy and things like that that parents may even not know about in some circumstances.

Maybe just for the committee's records, could you describe some of the sensitivities that any good government policy would have around personal health care information? Under what circumstances would it be appropriate for that information to go to the Ministry of Health or the minister himself or the health quality council, all of which are allowed in certain circumstances under different provisions of this bill?

Ms Gordon: I just returned from meetings in Ottawa, where all the executive directors of community health centres were meeting with the ministry. In primary care alignment, the biggest issue, particularly for youth centres and those centres that serve a homeless population, is the issue of enrolment that the ministry is taking us to. We've identified clearly to them that there are clients we have who would be unenrollable in that alignment issue that the government is looking at.

For example, if we had a 22-year-old who wanted to come and we would enrol her as a client with us, that information would forward to the Ministry of Health. She would make that choice. I say "she," because 80% of our clients are female. We might have a 16-year-old who's at the teen health centre for birth control and doesn't want her parents to know. If that information moved forward and the parents had enrolled that 16-year-old with another health care provider, our main concern is that that information would get back to the family doctor whom the whole family sees and some confidentiality may be breached.

That is an issue. We're working with the ministry to look at ways in which we can avoid that. Clearly, at our centre, our staff is unanimous in saying, "We won't enrol them, because we cannot risk that a confidentiality would be breached." We wouldn't have anybody coming to our centre if that got out on the street. They come to us because of confidentiality.

Mr La Bute: That's a bedrock policy within our organization and throughout the association. Confidentiality, as documented in our submission, and a non-judgmental approach to dealing with our clients is paramount to the success and credibility of our organization.

Mr Hudak: I appreciate the point. I'd push it a bit farther, because I think it is very important. We want to make sure that, through the amendment process, Bill 31, which will have some rules in place in terms of disclosure of information—to whom and what types of information, and when you anonymize the information, for example—would take precedence over anything in this bill. In fact, we're going to make sure that aspects of this bill that could compel information to go to the health minister would only occur in the most limited of circumstances, subject to good privacy practices.

For the benefit of the committee, are there good principles of privacy practice that you could recommend to us or sources for those privacy policies, in terms of what type of information should be allowed to go forward, whether it's to parents, to the minister, to the Ministry of Health, that sort of thing?

Ms Gordon: Currently, with the system we're under, on a regular basis we do send in to the ministry a listing of the services we've provided and data about the individual. Rather than using an OHIP number, a health card number, we use an identifier that's a made-up computer number, so there's no way to link the information. Clearly the ministry needs information about the type of services—if we're going to measure outcomes, they need to know what we're doing—but we need to do it in a way that's confidential so you can't link that information with a specific person.

Just going back to what I said before, the ministry appears to be open to our not enrolling clients for con-

fidentiality issues. There are also issues around enrolment for people with serious mental illnesses, homeless people or people in poverty who have been subject to terrorism or persecution in their home country.

Ms Martel: I want to thank the two of you for being here. I want to preface my questions by saying I'm a huge fan of CCA—CHCs. Not CCACs; I'm not a fan of those. I'm a huge fan of CHCs.

Mr La Bute: There's a big difference, Ms Martel.

Ms Martel: You've got that right, in terms of elected boards versus non-elected boards and a whole bunch of other things.

I'm pleased I was part of a government that was probably responsible for 21 of those 55 that are established now, and all the 10 aboriginal community health centres, which were established under the aboriginal wellness and healing policy. So I support a full extension and was glad we got a francophone community health centre in our own community through that period of time.

The bill says in the preamble, "Recognize that access to primary health care is a cornerstone of an effective health system." Without raining on anybody's parade, where does the bill commit to establishing new CHCs in Ontario? It's great that the preamble has that as a policy statement, but the bill is silent on when the government's going to move on this important matter.

Mr La Bute: By incorporating that in the bill, we'd be restricting its application. Now it's wide open, and it's open for the opposition parties and the government to work in collaboration to see to it that that is carried out. We're concerned about the issue of accessibility and accountability, and we've documented how we address those issues.

Please keep in mind, ladies and gentlemen, that Canada is unique in the world; 34% of our population is baby boomers. The first wave of baby boomers turned 55 in 2001. As we move along that continuum of life, we want to be able to have accessible primary health care to meet our needs. We have been privileged in this country, we in particular as baby boomers. We've always had our way, and we continue to expect to have our way. If the government of the day doesn't provide it, then maybe a new government will.

Ms Martel: My concern is that if it was a priority to move on this—and I think it should be, because Romanow was very clear that we needed to move on primary care reform—then somewhere in this bill, which talks about medicare and which was introduced on the first anniversary of the release of Romanow, you'd think there would be some acknowledgement of the government's commitment to move and that there would be some provisions somewhere in here that said, "We are going to recognize CHCs as an appropriate model, as one of perhaps several models, and we are going to move on this." My concern is that we're moving forward with a bill that talks about medicare but there's nothing in it that enhances the services people need. I'm not sure when we're going to see that.

Mr La Bute: Ms Martel, once again, you're quite apprised of the political process. When you go through the committee readings and the line-by-line review, that's when the public has spoken; the government will listen, and the opposition parties are obligated to see to it that the government reflects in its legislation the wishes of the people who elected the government of the day.

Ms Martel: And we hope we will see some amendments that speak specifically to CHCs. It would be very important.

Let me ask you what your budget is. You have a full CHC, so is your operating budget in the order of $3 million to $4 million?

Ms Gordon: Our budget from the ministry is about $2 million, and then we have other funding sources, so our total budget is around $3 million.

Ms Martel: Operating. Let me ask you this, because there was certainly a suggestion raised of, where is the money going to come from? The dilemma I see is that primary care reform has focused in the last couple of years almost entirely on family health networks. I've had some serious concerns about the family health network strategy, because I don't think it incorporates the many health care providers who should be brought into the health care system in order to use their scope of practice and their expertise to provide care. I think some of that money that has been sitting in the Ontario Family Health Network unspent could easily be diverted to support new community health centres. I look forward to the Minister of Health making that statement in a public way so CHCs would know, then, that there is going to be some funding for them and some way to access some of this money.

My concern also, though, has to do with what I think the Liberal promise was with respect to primary care. They talked about family health teams. If I remember the commitment clearly—and someone will correct me if I'm wrong—it was $150 million for 150 new family health teams, which would be about $1 million per family health team. That's not going to buy us a community health centre, is it?

Ms Gordon: Probably not, at a million dollars per team. I guess it's just how you would take the money and divide it up. But certainly there are smaller centres. We are considered to be in the larger group. We sort of categorize ourselves into small and large, so we would be considered larger.

But you're right. It depends on the population you want to serve, your location, and really it comes down to the staffing issue, because that's the largest component of the budget. You're going to have two or three doctors, and then you get into on-call issues and those sorts of things. You need a minimum number of doctors and nurse practitioners to cover on-call and provide the primary care services. You need the support services, the counselling, to go with that, because the doctor then is not going to spend physician time doing counselling. The doctor can do the medical assessment, decision-making, treatment plan, and then refer them on to a counsellor, but if they can't see the counsellor for 12 weeks and it's a drug addiction issue, they are going to spend physician time doing drug addiction counselling.

The Chair: Mr La Bute and Ms Gordon, as our last delegation of the morning, thank you for coming. We certainly welcomed your input.

Ms Smith: Chair, I'd like to inform the committee that I will now be filing with the Chair a memo from the Minister of Health and Long-Term Care, George Smitherman, that includes an outline of the proposed amendments that we intend to table during clause-by-clause. I have copies for everyone. I just want to remind my colleagues that this is a framework; it doesn't address every clause in the bill. It does address some of the issues and concerns that we've been hearing about this week. We continue to look forward to working with you on this living document. We look forward to the next four and a half days of hearings. We expect to hear much more discussion. These are provided for the benefit of the committee at the request of the opposition members, and we continue to look forward to discussing specific clause-by-clause language on March 9. I will present this to the Chair.

The Chair: And you have a copy for everybody?

Ms Smith: I do.

The Chair: Wonderful. Thank you.

Mr Klees: Chair, if I could speak to this, it's my recollection, and I may be wrong here, that when the minister undertook to distribute this, there were presenters at that meeting who also asked that they be included in that distribution. I was just wondering if that—

The Chair: We can research that. If that obligation was made, I'm sure it will be kept.

A little bit of housekeeping. Checkout is 12:30 if you haven't checked out. Lunch for the committee members and staff is in the Windsor Room. If the subcommittee members could just stay behind for a very short period of time, we have a brief issue to discuss. The room will not be locked, but there will be somebody here at all times.

The committee recessed from 1224 to 1334.

ONTARIO ASSOCIATION OF SOCIAL WORKERS, SOUTHWESTERN BRANCH

The Chair: Can we come back to order. Our next delegation this afternoon is from the Ontario Association of Social Workers, Southwestern branch. The person who will be addressing us today is Mary Kaye Lucier. Ms Lucier, if you would come forward, have a seat at the end of the table and make yourself comfortable, I'll briefly explain the rules to you. You've got 30 minutes. You can use that 30 minutes any way you see fit. At the conclusion of your presentation we'll be asking the three parties to ask questions of you from the government side, the official opposition and the third party in rotation. Other than that, it's 1:36 and the floor is yours.

Ms Mary Kaye Lucier: I'd like to thank the standing committee for coming to Windsor and hearing all of our input. I hope you enjoy your stay here, with that beautiful view out there as well.

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-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 vulnerable, disadvantaged populations and taking positions on important issues. Today's brief is prepared by the chair of the southwestern branch, encompassing Chatham-Kent and Windsor-Essex.

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, to create a health quality council to monitor and provide accountability, and to prohibit two-tier health care. As it stands, the bill does not further the implementation of the principles of the Canada Health Act, nor does it provide improved democracy, transparency or accountability. It does not prohibit the further erosion of the scope of medicare or 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 Windsor-Essex and Chatham-Kent of how the current medicare system is failing persons with a mental illness specifically, and the need for improved and enhanced services for mental health through this legislation.

(1) Rebuild a commitment to the universality, comprehensiveness and accountability of medicare.

The population of Windsor-Essex and Chatham-Kent resembles that of the provincial average regarding demographics. However, a distinct trend is evident in that the geographical location houses a greater population of young people in Windsor-Essex and a greater population of seniors in Chatham-Kent compared to the provincial average. In addition, Windsor-Essex has experienced a growth in population between 1996 and 2001. Overall, the projected increase in population is well above the provincial average, especially for adults.

The percentage of poor children living in female, lone-parent families in Windsor has risen by 89% since 1996. There are 75,975 immigrants in Windsor, an increase of over 10,000 between 1996 and 2001. Future projections speculate that if the economic climate remains steady in this area, the numbers will again increase. The number of immigrant youth residing in Windsor is 4,390, representing 11% of the youth population.

The citizens of Windsor-Essex and Chatham-Kent are suffering the effects of our debilitated health system

compared to the rest of the province. For those with a mental illness, these realities are life-threatening.

Most of the Windsor-Essex and Chatham-Kent mental health care system has not seen new money come in since 1989. It has been seriously eroded by years of cuts. The practice of delisting has caused pressure on agencies to find ways to assist clients who are the most needy in accessing required services. For Windsor-Essex and Chatham-Kent, a designated underserviced area, this has meant increased waiting lists for children's mental health and adults diagnosed with a mental illness.

Suicide and suicide attempts can be seen as indicators of mental health. The suicide rate for the Windsor-Essex and Chatham-Kent community is higher than the provincial average, and more so for males than females, a trend that has steadily increased since 1991. Standardized rates for hospitalization for mental illness are also higher in this area than the provincial rate, for both males and females.

Weight can also be an indicator of health. More residents in Windsor-Essex and Chatham-Kent are overweight than the provincial average, and less have an acceptable weight or are underweight when compared to the provincial average. Anorexia nervosa remains the number one killer of adolescent girls in North America, and obesity is threatening our children under the age of 10. Despite being the first treatment centre location for eating disorders in the province, Windsor-Essex and Chatham-Kent is grossly underfunded for those services in comparison to the rest of the population on a per capita basis. Windsor-Essex and Chatham-Kent residents demand their fair share of the funding regarding services for mental health.

1340

(2) Prohibit two-tier medicine and extra-billing.

Fundamental to the universality of the public health system are 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 care system. For-profit health corporations see user fees, service charges and two-tier access as a potential new revenue stream. They are pursuing these in a much more aggressive way than their non-profit and public service counterparts ever contemplated. In addition, the delisting of services has allowed the growth of two-tier access for uninsured services.

Non-profit agencies have suffered increased costs for administering services such as travel, phone, rent, office supplies and communication technology. Without an increase to the agencies providing the programs and services, cuts to these services have been made. One of the more highly publicized issues is in the children's mental health system, where there are up to 1,000 on waiting lists. For adult mental health services, hundreds and hundreds are on waiting lists throughout the entire system.

Although non-profit mental health services and programs do not charge user fees, clients with a mental illness are affected by this practice when other medical facilities such as labs and for-profit care facilities charge for delivery, notes, forms, scans etc. These costs are prohibitive, especially for those who are debilitated by their illness and unable to sustain gainful employment. Given the current cost and accessibility to publicly funded physiotherapy and rehabilitation services, persons with a mental illness end up going without service. For Windsor-Essex and Chatham-Kent residents, about 19% of the general population indicated an unmet need for medical service, well above the provincial average at 12%. Persons with a mental illness are often residents of long-term-care facilities. The practice of user fees is common among for-profit establishments, causing this population to further miss out on required medical treatments.

(3) Create a health quality council to report on compliance with the principles of the Canada Health Act.

The OASW strongly supports the installation of the democratic process in determining the membership of the council. The council should be representative of the population it serves: the citizens of Ontario. Either by appointment or election, the members of the council should be patients, advocates, experts and workers in the field. We oppose appointments made by the government. No person having a financial interest in for-profit health care corporations should be allowed to sit on the council.

A required role of the council should be to investigate how the health system conforms with the principles of comprehensiveness and universality, as well as accessibility. It should have the power to make recommendations regarding these issues and should be required to conduct its operations in a completely transparent manner.

(4) Prohibit block fees and charges that create a barrier to access.

We oppose block fees, and we believe that Bill 8 should simply ban the practice. They violate the principles of the Canada Health Act and create a barrier to accessibility.

Bill 8 brings the regulation of block fees under the control of the government. We support and applaud the prohibition against physicians and other practitioners opting out of OHIP. Moreover, it allows the bills' regulations, which are unspecified, to determine whether and how block fees can be charged. However, we are concerned that the wording of the bill allows this protection to be reversed in the regulations to the bill, thereby providing less protection than we already have in Ontario law. Government should not allow physicians to extra-bill by regulation.

Physicians across the province are charging patients for uninsured services by use of a block fee in which they set out a specified price to cover all services provided during a year. This is unnecessary, as physicians can charge on an item-by-item basis for those uninsured services. These services might include telephone advice, telephone prescriptions, medical assessments, notes and other professional consultations. Some of these services have been delisted and some were never listed.

To date, the regulation of this practice, such as it is, has been governed by the college of physicians' policies.

However, getting information on what charges are allowed and at what levels and whether a physician can force patients to pay block fees is very difficult. We have been unable to get from the college a list of the services for which physicians can charge. We can get the list from the Ontario Medical Association if we pay a fee of more than $100.

Technically, the college requires that physicians allow patients to make the decision about whether or not they will pay block fees and cannot refuse a patient who will not pay in this manner. Patients, especially those with a mental illness, are unlikely to make complaints or know how they can make complaints if compelled by their physicians to pay the fees or if they are being charged inappropriately. In the context of a severe shortage of doctors, a system that allows block fees is open to abuse, and patients have few choices to leave a physician, since they cannot find another one.

Further, the preamble of the bill sets out a commitment to primary care. This section of the bill should address the transition to a team-based, salaried, reformed primary care model such as that used in community health centres.

(5) Ensure Public Accountability, Democratic Control and Transparency.

Part III of Bill 8 sets out far-reaching powers of the minister to order individuals and organizations to comply with seemingly unfettered ministerial initiatives. Under these provisions, the minister can direct any health resource provider, person, agency or entity to enter the accountability agreements ordered by the minister to those under his direction.

There is little limitation on who might be required to enter into such an agreement. There is limited guidance in the legislation regarding what might comprise an accountability agreement, and the minister can vary, terminate or issue a new agreement at will.

The bill specifically refers to value-for-money and fiscal responsibility, as well as transparency, quality improvement, and public reporting on the list of matters this section covers. However, it can cover any other matter using personal discretion.

Further, the bill allows the minister to enforce compliance according to consequences that are left to unspecified regulations. The bill provides that ministerial orders can cover reduction or variation in a person's term of employment, including compensation, and where this is contrary to his or her contract, the bill determines that such change will be deemed to have been mutually agreed upon.

This section allows the minister to order fundamental changes in the health system with little, if any, public consultation, procedural safeguards, transparency or other checks and balances.

We believe the health system should be accountable to the people of the province and not to the minister in a top-down fashion. We insist that the minister be accountable for the health system and for democratic control and diverse representation on boards and governing bodies. We insist on mechanisms for public access to financial information about the health system, whistle-blowing protection for health care workers and public consultation prior to any changes in the health system. The bill must outline in detail the accountability process for providing stable, multi-year funding prior to the end of the fiscal year.

(6) Stop privatization and ensure democratic public/non-profit delivery of services.

The threat to the future of 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 for whom a veil of commercial secrecy obscures public scrutiny over profit-taking and misuse of public funds. Providing a public service and maximizing profits is a breeding ground for fraud and outrageous salaries, legal fees and higher borrowing costs, which all drive up the cost of health care.

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The Canada Health Act calls for the public administration of the health system, recognizing the inherent threat posed by private insurance corporations. Private hospitals, long-term-care facilities, labs and home care corporations are a serious threat to the future of Ontario's health care system. Additionally, it is a common practice of OHIP to send patients needing mental health care to the United States for specialized drug, alcohol and eating disorder treatment. For eating disorders, a three-month stay at a treatment centre in the US for one person represents a cost to Canadian taxpayers of over $500,000. This could fund an entire year of service for 300 patients in Windsor-Essex county and Chatham-Kent.

Privatization cannot meet the needs of people who are disadvantaged in any way: visible minorities, single-parent families, low-income earners and students. There are over 5,000 visible minorities in Windsor, representing 14% of the youth population. Seventy percent of the female sole-support families use food banks and often go hungry, and 57% had gone hungry within the past 30 days of a recent survey on hunger.

With the fact that the number of immigrants in urban Ontario has increased by an average of 13% since 1997 and the fact that English-as-a-second-language programs have declined by 23% in that same period, a diverse population of linguistically, socio-economically, racially and ethnically disadvantaged students are attending our schools, further limiting their opportunity to understand and afford services available to them.

There are more children living in low-income, single-parent households and a higher number of new immigrants and foreign-born in Windsor to date. This is an increase of 19% since 1996. Among the many factors that put students at risk are aboriginal status, recent immigration status, mobility, physical or mental disability, low family income, low parental education, single-parent status, health issues and inadequate nutrition. Most of Ontario's urban areas have a higher proportion of children who have those risk factors. Privatization excludes our most vulnerable citizens.

The current government ran on a platform of stopping the Americanization of our health care system. The pre-election promise was very clear that they opposed sweeping privatization and were committed to rebuilding medicare. We expect this government to roll back privatization and prohibit future for-profit control of our health care institutions. P3 hospitals must be banned, and services provided through private clinics must be returned to hospitals and non-profit agencies.

The Chair: Thank you very much. The time is 1:55 and you started at about 1:35, so you've used about 20 minutes. Why don't we each take four minutes, starting with the official opposition.

Mr Klees: Thank you for your presentation. I'd like to get your thoughts with regard to the composition of this health quality council. You make the point that you oppose appointments made by government and that there should be a democratic process in determining the membership of the council. Could you share with us how you envision that, how that process would work at a practical level?

Ms Lucier: I think there could be a call for nominations. There could be a nominating committee that would call for nominations, and people would submit their applications.

Mr Klees: So this would be a public call for nominations, open to anyone; anyone could nominate a specific person. Would the Ministry of Health have administrative responsibility for receiving these nominations, or do you see an independent body doing that? Do you trust the Ministry of Health to do this?

Ms Lucier: I think it could be done within the Ministry of Health, and there could be criteria about the nominations. Nominations should be accepted based on the interest of the person: for example, as I said, consumers of the health care system and workers in the field, experts, citizens of the community. But I do believe that piece of it could be managed within the ministry.

Mr Klees: Do you have in mind any specific group that would be excluded from being nominated to participate in this group?

Ms Lucier: As I said in the report, anyone who was on a board or working for a for-profit health organization.

Mr Klees: What about someone who is on a board of, say, a hospital? These are typically volunteers who have many years of experience in the health care field and often have been on the front line of recognizing what is wrong with the system. Do you think they should be excluded as well?

Ms Lucier: No. I think they do have valuable experience to bring to the council.

Mr Klees: OK. With regard specifically to the block fees that you refer to—you oppose block fees. There are obviously two sides to this issue. We've had representations from physicians who put forward their side, saying, "Look, OHIP only covers a certain number of charges, yet we are also subjected to a number of other requirements from our patients," whether that be answering phone inquiries, doing medicals for employment purposes—a range of things that physicians are asked to do. As busy as they are, their point is, "We can't afford not to charge for these things, or we simply have to say we can't do them." Your response to that would be what?

The Chair: A really brief response.

Mr Klees: Are you suggesting perhaps that all those services provided by a physician, should be covered under the OHIP fee schedule?

Ms Lucier: We were also recommending that a health care community practice be adopted, as opposed to the individual physician, so there could be a cut in the costs that way also—shared expenses.

Mr Klees: So you envision, then, that in these group practices, all services a physician offers would be covered off by whatever they're being paid under that arrangement.

The Chair: Ms Martel.

Ms Martel: Thank you for being here today. We've heard from three social workers now in three different communities, but each one has brought some of the local concerns forward, which has been most useful in this case, because it does involve mental health.

You've also brought forward some general concerns, and may I just say that I appreciate that you continue to talk about why we need to get away from two-tier private health care because, as far as I'm concerned, that's money that should be going into patient care, and money that ends up in somebody's pocket in terms of a profit. So we really do need to get away from the P3 hospitals and from private MRIs and CAT scans. Frankly, we should also be ending the competitive bidding in home care, which does the same thing and diverts money away from home care patients.

I want to just ask some general questions in terms of the information you provided. On the back, you talked about the common practice of OHIP to send patients needing mental health help to the United States. Because you have such a serious problem in Windsor, do you have some information locally about how many people might actually be accessing acute—I'm assuming that's what it is—mental health care services across the border somewhere else?

Ms Lucier: I can only speak from the eating disorder perspective, because my employment is with a bulimia-anorexia nervosa association. We have a treatment centre here in Windsor. At one time before we had our funding, there was a significant number going over to the United States, but because we exist here, that's been curbed in Windsor-Essex. The figure I gave you came from the Soo, which is a northern community. I understand that in the other underserviced areas there are a number, but I don't have a number.

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Ms Martel: Does your eating disorders clinic serve adults or children?

Ms Lucier: Both.

Ms Martel: Both. You're lucky in that regard. At home we've been desperately trying to get a children's

service for a long time, to no avail, unfortunately. How many patients do you—

Ms Lucier: We see about 300 a year.

Ms Martel: What's the breakdown between adults and children? Do you know that?

Ms Lucier: There are about 95 adolescents and the rest adults. Adolescents would be 12 to 15.

Ms Martel: You were talking about delisting of services and said that "clients with a mental illness are affected by this practice" of charging user fees "when other medical facilities such as labs and for-profit facilities charge for delivery notes, forms, scans etc." Can you give the committee some example of what's happening? Are you talking about your own clients? You talked about mental illness, so you might be splitting that.

Ms Lucier: Well, our clients are struggling with the mental illness of eating disorders. In our centre, it's very common that they would turn toward us because they view us as their lifeline of support for them, and they cannot afford travel back and forth to the medical facility to get any of the blood work they need done. If we require corresponding blood work as it relates to starvation or other medical tests, doctors are routinely charging to read our referral form and routinely charging to provide any written feedback on how the patient is doing, which is crucial to our treatment planning. So they're looking to us to fund them, because many of them are unemployed because of their illness and they can't afford it. We haven't had an increase to service in a number of years, so we're looking to other fundraising sources and scrambling, which takes time and effort away from patient care.

Ms Martel: Let me just be clear: Your agency does not have family doctors per se; you have a number of clinicians who work—

Ms Lucier: We have a family physician who is a consultant and gives us two hours a week to look at our clinical diagnoses and recommend medical treatment based on what we present.

Ms Martel: So for anything over and above that, patients have to go back to their own family doctors, and it's at that point where charges may or may not be applied to get that work done?

Ms Lucier: Exactly.

Ms Martel: I'm going to assume that most of your clients, your adult population, would be on a fixed income.

Ms Lucier: Yes. But some of the teenagers, 16 to 19, don't want their family members to know, and they're not working at all, so they can't afford to pay for it.

The Chair: Ms Di Cocco, then Ms Smith.

Ms Di Cocco: Thank you, Ms Lucier. You make a compelling presentation in regard to not only your profession but also about some of the needs that are there. It's important for me to reiterate this process we're applying. As you know, this proposed legislation is here after first reading, which doesn't happen too often, meaning that we're shaping it, in many respects, through input such as what you've provided. We feel it's a better approach in ending up with a final product. So the suggestions you've provided with regard to consultation and/or makeup of the health council are valid. I guess what I want to say is how important it is, in this process of getting to a final product of legislation, that we incorporate the suggestions, that it isn't a fait accompli. I want to assure you of that, because otherwise we would be here after second reading. The modus operandi of the past has been that it was a fait accompli and therefore there were just the semantics of being in front of a committee. Thank you very much for your compelling discussion.

Ms Smith: I too want to thank you for coming and for preparing this brief for us and bringing to light a few things, some of which we've heard from your co-workers, the social workers, but it's nice to hear the specifics from your area. I was happy to hear your discussion with Mr Klees about your suggestions for the makeup of the council. That was one of the questions I was going to raise.

I just wanted to quell some of your fears on the accountability and democratic control portion of your presentation, where you raised some concerns about the legislation, as it's now drafted, with respect to unfettered ministerial initiatives and whom the accountability agreements will apply to.

The minister made a statement on Monday wherein he set out some of the amendments to this legislation that he sees coming forth in clause-by-clause, one of which would be to specify that the accountability agreements will apply to hospitals, CCACs, LTCs and independent health facilities. That narrows it, so I hope your concerns are somewhat lessened. As well, we will be setting out in the amendments, procedures for how these agreements will be entered into as well as procedures around the issuance of compliance orders and compliance directives, which I think will go a long way to calm your fears on that particular as well.

You talked about also wanting to see "public access to financial information about the health system, whistle-blowing protection for health care workers and for public consultation." In fact, this hearing, as Ms Di Cocco pointed out, is a good example of a first step in public consultations on changes to health care. Certainly our government is committed to that.

Also, public access to financial information: One of the functions of the council will be to provide information back to the public on how our health system is faring and what we're doing, and that's really one of the major focuses for the council. That will be a big, positive increase in information for the public.

Whistle-blowing protection: There is some in this legislation, and we intend to toughen that up a little bit in the amendments to make sure that people feel comfortable coming forward and reporting misuses of our health dollars.

I just want to thank you again for coming. I'll give you a copy of the minister's statement as well.

The Chair: Ms Lucier, your time is up. Thank you very much for coming today.

HÔTEL-DIEU GRACE HOSPITAL

The Chair: I call forward the representatives from Hôtel-Dieu Grace Hospital at this time. As I understand it, this afternoon we have with us Ken Deane, the president and CEO; Gerry Trottier, former chair; and Mary Fox, the vice-chair. Come forward and make yourselves comfortable. There's some water over there, if you'd like some. There will be the same rules as everybody else. You get 30 minutes. You can use that any way you choose. If at the end of your presentation there is time remaining, it will be split among the three parties in the order of the third party, the NDP, first, then the government side and the official opposition.

Ms Mary Fox: Perhaps I will start. As you can probably gather, being the only female here, I'm Mary Fox. To my immediate right is the president and our chief executive officer of Hôtel-Dieu Grace Hospital, Ken Deane, and immediately to his right is our past chair, Mr Gerry Trottier.

Firstly, let me thank you for the opportunity of letting Hôtel-Dieu Grace be here today to present some brief comments and recommendations regarding Bill 8.

At the outset, I want to say that Hôtel-Dieu Grace Hospital supports the need to have greater accountability in the system and, secondly, that we welcome greater clarity regarding the relationship between government as the funder and the hospital as the provider.

We do have some concerns regarding Bill 8, and I want to identify and highlight four general concerns and will be more specific in our presentation.

Firstly, we're not convinced that the case has been made out for this bill in its current form.

Secondly, we do not believe that the bill will yield the anticipated changes. In effect, it could have unintended negative consequences.

Thirdly, the bill potentially erodes local voluntary governance.

Lastly, the bill does not adequately recognize the circumstances that affect financial performance of hospitals.

I'll make seven points with respect to the view on Bill 8 from the board perspective. A pillar of our hospital system in Ontario is community involvement through voluntary local governance. The effect of Bill 8 is to decrease accountability to local communities by fundamentally undermining the role of voluntary local governance of public hospitals in communities across this province. This, in our respectful view, will irrevocably alter the relationship of hospitals to their communities.

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Our second point is that the accountability provisions of Bill 8 do not sufficiently recognize the interdependent nature of the relationship between health care providers and government, one that historically has been characterized by trust, mutual respect and collaboration and that should continue to be so characterized.

Thirdly, directing hospitals to sign agreements undermines the collaborative approach adopted by both government and hospitals to develop a multi-year funding framework and performance agreements for hospitals. Imposing agreements on a hospital undermines the role of the board in ensuring that the necessary health care services are provided to the community.

Fourthly, the compliance directives in Bill 8 are inappropriate in the context of a negotiated agreement. This appears to be an intrusion upon the role of the community and the hospital board and has the very real potential for undermining voluntary governance in local communities.

Fifthly, the provisions that allow the minister to make an order that may result in a material change in a person's employment, such as the one who is sitting immediately to the right of me, including a reduction in pay or change in benefits, are inconsistent with common law. Under the Public Hospitals Act, the terms of employment of the chief executive officer are for the board to determine and modify as the board deems appropriate.

Hôtel-Dieu Grace Hospital is a denominational hospital. Catholic health services strive to provide the highest quality care with respect and compassion to all in need, regardless of religion, socio-economic status or culture. We collaborate in open partnerships with other members of Ontario's health care system, and we are dedicated to voluntary community governance to ensure accountability to the government and to those we serve in the community. Catholic facilities reflect a proven, community-based, voluntary approach to governance.

My last point is this: In Windsor, Hôtel-Dieu Grace Hospital and Windsor Regional Hospital are committed to integration, and we have instituted a number of changes aimed at strengthening the level of that interdependence and interconnectedness. As an example, integration has been advanced by establishing shared vice-president positions between the two organizations and, additionally, there has been pursuit in the integration of medical staff. In fact, the Minister of Health, the Honourable George Smitherman, stated in his address to the 2003 Ontario Hospital Association convention, "In Windsor we are seeing an inspiring example of two hospitals putting their competitive past behind them and working together to enhance the delivery of care and to bring their deficits under control. And the big winners are, of course, the people of Windsor."

From the board's perspective, we see Bill 8 as undermining some of these initiatives.

Putting forward the view from administration will be Mr Ken Deane.

Mr Ken Deane: Thank you. I'm pleased to be here as well to present on Bill 8.

Many hospitals incur operating deficits due to patient demand or because the funding announcement was too late to achieve the necessary savings in the fiscal year or costs exceeded funding and the ministry precluded service reductions that would allow hospitals to balance budgets. In fact, some of the most efficient hospitals in Ontario are running deficits.

To put that in context, it is now February 19, and the new fiscal year commences in about six weeks. At this

point, the hospital sector does not know its funding increase for fiscal 2005 or the salary increases that will be negotiated. However, given the arbitration award for OPSEU, we're anticipating salary increases of about 3.5% to 5%. The directive from the ministry each year is to achieve a balanced budget, and we certainly emphasize that within our organizations and support the need for fiscal stewardship. However, service reductions have not been allowed as a means to balance budgets. The expectation is that hospitals can achieve efficiency improvements to make up the gap between funding and expenses.

Over the past 12 months, as part of an organizational turnaround at Hôtel-Dieu Grace Hospital, we've moved aggressively to improve operational and clinical efficiencies as part of an organizational turnaround, with the result that, first, we are operating with 100 less full-time-equivalent staff this year than last, and 70% of our cost centres are operating in the top quartile; the remaining 30% that aren't are not because of safety or patient-risk-related reasons, and we're quite comfortable with their level of efficiency. Our focus is on the continuous operational improvement of our organization. However, hospitals can reach the point of diminishing returns and can increase risk by increasingly pushing the efficiency part.

This year, for example, we are expecting to break even, excluding one-time restructuring costs. This compares to operating losses of $4.6 million in 2003 and $15 million in 2002. Notwithstanding this change in performance, our fiscal 2005 forecast is an operating loss of $7.7 million based on assumed increases due to negotiated settlements, benefit cost increases, utilities and drug cost increases. The significant cost of drugs is reflective of the significant role that drug therapy plays in hospitals and the increasing costs related to new technology within pharmaceuticals. The forecast shortfall of $7.7 million translates into an operating funding requirement of 6.4%. Given that the new fiscal year starts in six weeks, if funding does not cover the expected cost increases, we would be unable to achieve a balanced budget in this year because of notice periods that require up to six months. So we could not achieve a balanced, break-even position this year if funding doesn't match expense increases.

End-of-year deficit funding has been identified as a major problem within the health sector. The stated policy has been that hospital budgets are fixed, but in practice hospitals are told not to cut services in order to break even. Deficit funding invariably followed as a year-end adjustment, recognizing the patient demand in communities.

There is an inherent conflict due to the fact that hospitals are funded on a fixed or global basis and physicians are funded on a volume basis through fee for service. That creates an inherent conflict in hospital operations.

Our area is considered by the Ministry of Health as an underserviced area for family physicians and specialists. Consequently, we spend approximately $1 million per year for hospitalists to provide care to unattached patients and for internal medicine specialists to provide on-call coverage in our hospital. Under Bill 8, this would not be allowed, resulting in major problems in the provision of medical care, such as delays in tests and treatment, increasing lengths of stay, increasing waits in emergency departments and physician and staff burnout.

In addition to the integration that has occurred within the city of Windsor, it's important to acknowledge what's going on in our geographic area. There are three hospitals in Essex county: the Leamington hospital and the two Windsor hospitals. The three hospitals are working together to take an overall approach within our geographic area. For example, we're recruiting a regional chief information officer to facilitate the development of a region-wide information systems plan. So we are very supportive of integration and are moving in that direction.

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Mr Gerry Trottier: The Hôtel-Dieu Grace Hospital board and administration have a set of seven recommendations for the committee's consideration.

The first recommendation is that Bill 8 be considered to be amended in the following ways:

—to enhance the accountability of providers and government to the citizens of Ontario in a manner that is consistent with the collaborative nature of health care, as Ms Fox just mentioned;

—to provide for the negotiation of accountability agreements rather than the direction that such a paper be signed; in fact, a directive to sign a piece of paper is antithetical to it being an agreement. It must be by consensus.

—to delete the requirement for compliance directives, which fundamentally alters the nature of governance of public hospitals in Ontario as it is today;

—to provide for multi-year agreements so that financial planning and the achievement of clear objectives is known and can be assessed over a period of more than one fiscal year; and finally

—to amend Bill 8 by deleting the provision that would allow the minister to make an order resulting in a material change in a person's employment, which also removes any opportunity for the individual or an institution to have recourse to any remedy at law that it might otherwise have.

Our second recommendation is that the ministry update the Public Hospitals Act. If significant changes to governance of hospitals in Ontario is to be undertaken, it should be looked at in a global way.

Our third recommendation is that the ministry and the Ontario Hospital Association work together to promote and facilitate standardization across the hospital sector, including standards for information systems, data quality, safety, the provincial drug formulary and non-core services. This standardization will permit a greater ability to assess performance, which is an inherent component of accountability.

Fourth, we recommend that the government establish arbitration guidelines for collective agreements and/or establish the principle that arbitration awards or negotiated settlements will be funded. As Mr Deane pointed

out, it is very difficult for hospitals to adjust in a period of six weeks in order to be able to assume and deal with external expense factors beyond our control.

Our fifth recommendation is that the ministry advance performance agreements that also incorporate the responsibilities and deliverables of government and recognize the uncontrollable factors that influence hospital operations, including decisions of other ministries. Members of the committee can well imagine the effect on hospitals of the deregulation of utility rates, a very significant element of our expenses on an annual basis.

Our sixth recommendation is that the ministry implement service-based funding and provide a transition process for hospitals. In this way, communities will know what the anticipated level of service is.

Our seventh recommendation is that the ministry establish an arm's-length commission to establish the price per unit of service and review requests for deficit funding. In that way, public hospitals and boards may know what the expected cost is of delivery of a known volume of service which is approved for a geographic area.

We thank you for this opportunity to speak with you today, and we'd be delighted to answer your questions.

The Chair: Thank you. You've used up about 18 minutes of your time, which leaves you with 12 minutes for questions. We'll start with Ms Martel.

Ms Martel: Thank you for being here today. We appreciate your participation.

I'm going to go to the section "View from the Board," because there are a number of concerns outlined in there, concerns we've heard before. They were concerns I had hoped would be addressed by the minister in terms of amendments which were going to come forward.

We received earlier today, and you wouldn't have known this because we just got this, an indication from him of where some changes would be made. I'm looking at the sections around the accountability agreements and note that in the changes that came to us I would have hoped that somewhere it would have said that these were going to be negotiated. I don't see the word "negotiated" anywhere yet in the changes that are before me.

I see some other things that continue to concern me. Let me deal with section 22. You've said that the compliance directives in the bill are inappropriate in the context of a negotiated agreement, and I agree with that. The proposal doesn't seem to make much change in this regard. We don't have the exact language, but the proposed thoughts leading to the language say the following: "Include notice and other due process provisions, including time frames for notice, to address development of accountability agreements, issuance of compliance directives and orders (eg, discussion process, meetings, exchange of documents/information, representations that the minister has to consider before issuing a compliance directive or an order.)"

So I don't hear much in the way of negotiation there. I hear the minister having to review some information and have a timetable before he goes and does what perhaps he wanted to in the first place. I want to know if you think that is going to address your concerns.

Ms Fox: I can answer that, and I can say definitely no. I would view those submissions as simply nothing more than perfunctory. The word "directive" or the word "order" is mandatory. To put some salutary language into it that suggests there would be some ability to put forward resistance statements, co-operative efforts into reaching a collaborative agreement, frankly does not seem to be the effect of the intended amendment. I would underscore it as simply being nothing more than a perfunctory attempt at it.

Ms Martel: OK. Let me give you the next one, because you talked about common law with respect to allowing a minister to make an order that might result in a material change in a person's employment, that that would be inconsistent with the common law because this is the role of the board in relation to the CEO. The language that we have been given says in that section, "Include range of remedies directly in legislation that could be issued in a compliance directive or an order to address non-compliance (eg, audit, budget review etc). CEO compensation clawback or any other financial remedies to be applied to a CEO as a last resort only after all due process has been exhausted and in exceptional circumstances." My read is that there is still an opportunity for the minister to do the CEO clawback. It says, "exceptional circumstances." I don't know what that'll end up being, but it still sounds to me that that would be contrary to common law, because you are the employer, not the minister.

Ms Fox: There is no question about it. The CEO is employed on a contractual basis by the board. He serves at the will of the board, if you will, and to the extent that his services are not as directed by the board or satisfactory to the board, it is the board, on behalf of the community, that makes a determination as to what transpires. The minister's comments cause me concern and, I hasten to add, will cause our board significant concern, because although there is some suggestion at some more modest language, ultimately words such as "directive," "order" and "clawback," albeit under exceptional circumstances, provide the ability for the minister to in essence step into the shoes of the board, to assume the role of the board for governance. In effect, what it really does is do away with the need for boards to do their job.

The Chair: We go on to the government side.

Ms Smith: Thank you for coming today to present us with your views on this bill. As you know, we are coming to you after first reading of this bill, which is unusually early in the process, and we are looking for feedback and input. We appreciate your coming today to do this. As well, as I'm sure you're aware, there have been discussions ongoing with the OHA and other stakeholder groups leading up to these hearings.

The minister, in his statement on Monday, did make a number of statements regarding some of your concerns. I'm not sure if you've seen his address, but I would like to bring a couple of those comments to your attention.

First, of course, he did state that the accountability agreements, as I'm sure you're aware, are expected to be between the boards of the hospitals and the ministry, and not between the CEO and the ministry. Is that your understanding through your discussions with the OHA?

Mr Deane: Yes.

Ms Smith: I understand further that that would not affect governance per se, so when you speak about the Catholic health services that you strive to provide in your community, I don't think those will be affected in any way by the implementation of accountability agreements. Is that your understanding?

Mr Trottier: If the accountability agreement is negotiated in the true sense, then that will go a long way toward addressing our concern, but if we are directed to sign a piece of paper, that is no agreement.

Ms Smith: Right. The minister in his statement on Monday said, "Bill 8 is a big step toward greater accountability in the system. It creates a framework that allows the minister to establish negotiated accountability agreements with publicly funded health resource providers. The health care providers we intend to designate in the bill are hospitals, community care access centres, long-term-care facilities and independent health facilities." So I think he has indicated in effect that these will be negotiated.

I'm just a little curious about the tone of your presentation. Are you against accountability agreements?

Mr Trottier: As they're described in this current bill, yes.

Ms Smith: Are you against any accountability agreements?

Mr Trottier: Oh, no, not at all. In fact, we welcome them, because then it will clearly define the parameters of the relationship between the hospital as the provider and the ministry as the funder, and it will clearly define for the public in a transparent way how both of us are accountable.

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Ms Smith: I think that's the intention of this act, to implement these types of agreements so there is transparency and the public is aware of where their funds are being spent in health care.

Mr Trottier: Then what I would recommend to the committee is to seriously consider amendments, first of all, to section 21, which states, "A health resource provider, and any other prescribed person," which can include a CEO, "... shall, when directed by the minister ... enter into an accountability agreement," which does not describe a negotiation process.

Ms Smith: If I could just comment on that, I think the minister did address the tone of the legislation in his opening remarks on Monday as well. I think he did say that there will be changes to that as well.

Mr Trottier: And we look forward to seeing the language that implements that. I would also point out section 24, which states, "The minister may at any time terminate an accountability agreement or a compliance directive, and may at any time vary a compliance directive or issue a new compliance directive." That has the effect of overriding an accountability agreement, in my view.

The Chair: Mr Klees.

Mr Klees: Thank you very much for your presentation. I'm wondering, based on the exercise we've engaged in with stakeholders from across the province over the last four days, what you folks have done to deserve this bill. On the one hand, you quoted the minister complimenting you on the good work that you've done. By the way, hospitals right across this province have worked very co-operatively under some pretty strict obligations as well, under other acts in this province, to become efficient and to do the right thing.

The minister admitted on Monday that this bill is seriously flawed. However, surely the minister read this bill before it was introduced, and surely the minister, who is fairly intelligent, would have drawn the same conclusions that you did about the punitive actions, the draconian measures, the undermining that it does of a volunteer board, the encroachment, the reaching into agreements of all types, whether that be a CEO's employment contract or other contracts. Why, in your opinion, did the minister feel it important enough to bring a bill like this forward? What has this sector done to deserve this?

Mr Trottier: I can't answer that question. However, I do share your concern that the way the bill is currently worded, including certain punitive measures, will act as a disincentive for persons of good faith and talented people in the community to first of all be voluntary board members, with fines of up to $50,000 in the event that you inadvertently have an assigned billing for otherwise insured services. That's a very serious concern for me as a board member, to be subject to that kind of potential punitive provision. But more important, I think it acts as a significant suppressive factor in excellent people, such as Mr Kenneth Deane, sitting next to me, wanting to be hospital CEOs, particularly with respect to sections 27 and 28, which are—I would share, in those particular elements, your view that they are draconian, that a CEO's salary be clawed back in situations where the CEO may not have responsibility.

Mr Klees: By the way, with regard to that, when it was pointed out in these committee hearings that section 27 is in fact draconian, has serious repercussions to the sector, the minister undertook to provide clarification. Here is what his clarification is relative to section 27: This "would only apply to CEOs (not trade unions or other employees)." So once again I say, Mr Deane, you're not at all comforted by this clarification, are you? I would certainly have questions, if I were you, notwithstanding the fact that not only does the minister reserve the right to get into your contract, but he also is saying that when he does, you will be deemed to have agreed to that, and you have no recourse. How does it feel to be such a special class of person in the province of Ontario?

Mr Deane: I've always considered my position to be special.

Mr Klees: Not many people will want to join you after this.

The Chair: On that note—

Mr Deane: We're done?

The Chair: We are done. Do you have something to say very briefly?

Mr Deane: I just wanted to make a brief comment. When the question was asked about whether we support accountability agreements—we do. In fact, our board has supported my involvement in the joint policy and planning committee, where I serve on the operations steering committee, the multi-year funding executive committee, and I chair the hospital funding formula committee. So we are, as an organization, committed to accountability and want to advance accountability relationships within Ontario.

The Chair: Point well made and taken. Thank you for coming today.

WINDSOR AND AREA HEALTH COALITION

The Chair: If I can now call forward the representatives from the Windsor and Area Health Coalition. I understand that we have Mike Longmoore, who is the chair; Rob McGuffin; and Darlene Prouse, who is the vice president of the Canadian Auto Workers local 2458. Be seated. There's some fresh water there if you need some. You have 30 minutes, like all the other delegations, to use as you wish. Should you have any time left over during that period, we'll use that time up with questions from the three parties, starting this time around with the government party, the Liberals. The floor is yours.

Mr Rob McGuffin: Good afternoon. On behalf of the Windsor health coalition, I'd like to welcome the committee to Windsor, and I'd like to thank you all for this opportunity to speak to you.

Bill 8, the Commitment to the Future of Medicare Act, was introduced as a 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, the bill does not further the implementation of the principles of the CHA; does not provide improved democracy, transparency and accountability; and does not prohibit the further erosion of the scope of medicare and the increasing problems of privatization and profit-taking of the two-tiering for those services that have been delisted. We must rebuild a commitment to universality, comprehensiveness and accessibility of medicare.

Over the last decade, $100 million in OHIP services have been delisted. Homemaking and home support services have been virtually eliminated across the province, lowering caseloads from 2002 to 2003 by approximately by 115,000 people, often the frail and elderly. Drug costs are prohibitively high and inaccessible for a growing number of Ontarians. Bill 8 incorporates the principles of the Canada Health Act in its preamble, but provides no concrete initiatives, either to ensure access to these services that have been cut or to implement the sentiments outlined in the CHA.

As noted in the preamble to the bill, home care and pharmacare are key components of rebuilding an accessible, comprehensive, universal public health care system. So too are homemaking and support services, access to primary care, access to drugs and assistive devices, and comprehensive OHIP lists covering these services that people need. The intent of the Canada Health Act was to ensure that Canadians have access to a comprehensive range of medically necessary health services. Real, concrete steps are needed to fulfill this vision.

We must prohibit two-tier medicine and extra-billing. Fundamental to the universality of the public health system are 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. For-profit health corporations see user fees, service charges and two-tier access as potential new revenue streams and are pursuing these in a much more aggressive way than their non-profit and public counterparts ever contemplated.

Private MRI/CT clinics are allowed to provide scans to those who pay out of pocket for so-called medically unnecessary scans. Therefore, those with the least medical need can jump the queue. In addition, the opening of private MRI/CT clinics has resulted in technicians leaving publicly funded hospitals to reap bonuses offered by the private clinics, putting even more strain on the overburdened public system. This was the case in Windsor this past summer, as a technician left a local hospital to go to a private MRI clinic, lured by a $10,000 signing bonus.

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Bill 8 must be changed to stop the two-tiering for so-called medically unnecessary scans that is allowed in the private MRI clinics. There is no public interest justification, either in providing scans to people who don't need them, and incidentally exposing them to radiation in the process, or in shuffling the queue to allow those with no medical need to get service before those with medical need.

Bill 8 must also anticipate and prohibit increases in fees and charges levied by the for-profit corporations in search of a new revenue stream as they take over more health facilities. The government campaigned against P3 hospitals and private clinics. They should fulfill their campaign promises and stop and reverse these privatizations. In addition, as the scope of medicare has been reduced due to delisting and underfunding, the bill should protect against two-tiering for all the services that have been delisted and any further erosions of this sort.

We must create a health quality council to report on compliance with the principles of the CHA. Given the CHA principles enshrined in the preamble to this bill, it is surprising that the health quality council outlined in part I does not ensure reporting on the extent to which the health system conforms with those principles. Further, it is not required to report on issues relating to two-tier medicine, extra-billing and user fees.

No person who has a financial interest in for-profit health care corporations should be allowed to sit on the council. Rather than an appointed body, this council should be composed of a democratically selected group appointed by all parties that represent patients, advocates and workers, as well as the so-called experts. The council should include representatives from diverse groups as well as from geographically remote areas and equality-seeking groups.

The council should be required to investigate how the health system conforms with the principles of comprehensiveness and universality, as well as accessibility. It should be required to report on two-tier access, user fees, service charges and extra-billing. Further, this democratically represented council should have the power to make recommendations regarding these issues and should be required to conduct its operations in a completely transparent manner. We must stop privatization and ensure democratic, public, non-profit delivery of service.

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 for which the veil of commercial secrecy obscures public scrutiny over profit-taking and misuse of public funds.

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

The Canada Health Act calls for public administration of the health system, recognizing the inherent threat posed by private insurance corporations. Similarly, private hospital corporations, private long-term-care corporations, private labs and private home care corporations are a serious threat to the future sustainability of 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: They opposed creeping privatization and committed to rebuilding medicare. Any legislation purporting to show this government's commitment to the future of medicare must include concrete initiatives to roll back privatization and prohibit future for-profit control of our health care institutions. P3 hospitals must be banned. The private diagnostic clinics must be returned to non-profit hospitals. The tide of privatization sweeping 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.

Ms Darlene Prouse: I'm Darlene Prouse, vice-president of the CAW, local 2458. I thank you for allowing me to speak. First of all, I would like to acknowledge the commitment from Health Minister George Smitherman to correct Bill 8's flaws. His statement that the bill does not affect the current collective agreement offers little relief to health care workers, as many agreements expire this year. The provincial Liberals' response to the Romanow report, in the first draft, requires tightening of the language and further clarification of the intent of the language.

The assurance that the bill, in its original content, has been misinterpreted by the public and not intended as such is reassuring as we await the amendments. As representative for one of the unions representing many of the health care facilities in Windsor and area, I feel I must voice my concerns regarding the accountability portion of this document. Of concern, of course, is the protection of current and future collective agreements. Any suggestion of opening these agreements with the intent of reducing compensation or benefits is not an appropriate solution to the financial recovery of our health care system. This bill should not be a deterrent to the current and future collective bargaining processes. If the intent is not to interfere in these processes, the wording needs to be clarified within the amendments. This issue is also problematic if the intent of opening the collective agreements is cost-saving for health care and opens the doors for contracting out of services, P3s and privatizing.

There also is no restriction on the scope of compliance directions and accountability agreements. Of concern as well is social accountability, or accountability to the public. This will not be assured with the current bill, as accountability falls under the CEOs and hospital boards, reporting their accountability to the Minister of Health only. This needs to be adjusted further for the public's ability to be informed as a whole. Any fundamental changes in the health system without public consultation could prove to be detrimental and not as productive as the intent was meant to be.

Absent from this bill is whistle-blower protection. I would suggest at this that time this language would be welcomed as the federal government is entering into similar protections for public servants. A health care worker who cannot complain or report employers against wrongdoings is denying public consultation and the right to speak out. Whistle-blower protection would also ensure accountability from the bottom up.

I eagerly anticipate reviewing the planned amendments to Bill 8 and sincerely hope that the wording and intent become clear and reach approval from all. Bill 8 should provide the public with advancement to the Romanow recommendations, and the health quality council should become the public guardian that Romanow expected the national health council to become.

Mr Mike Longmoore: I guess we're done.

The Chair: Very good. That took you just 10 minutes, and leaves us with about 21 minutes. That's seven minutes per party. We'll start with the government side.

Ms Smith: I thank the three of you for coming today and presenting to us. As you probably heard in the previous presentation, we are very happy to be bringing this bill forward after first reading, which is unusual, looking for public input into the amendments that we hope to make. As you know, I'm sure, the minister made a statement on Monday in which he highlighted some of the proposed amendment areas that we are looking at. Certainly there are a number of things that we will be tightening up and changing, going forward. We appreciate your input into that.

Let me just quickly address your concern about P3 hospitals; you raised a concern about the two hospitals that are referred to as P3 hospitals. I just want to quote from a statement the minister made in the Legislature on November 27, that our new government has acted quickly to ensure that new hospitals in Brampton and Ottawa are "publicly owned, publicly controlled and publicly accountable."

There has been some talk as well that another six or seven hospitals are being looked at for similar financing. I just wanted to assure you that no decisions have been made with respect to those facilities. Certainly, we're working with the infrastructure ministry to find financing arrangements that will continue to ensure that all of our hospitals in Ontario are publicly controlled, publicly owned and publicly governed and accountable.

I then want to go on to address a couple of your concerns with respect to this bill. You made a suggestion at one point that collective agreements could be opened by this legislation and that there could be an intent to interfere with collective agreements. The minister has made it perfectly clear, and we have made it perfectly clear at least 15 times in the last three days and will continue to do so, that this legislation does not apply to collective agreements and will not affect collective agreements. It does not apply to unions. You have the minister's assurance and you have this committee's assurance that we will be bringing forward specific amendments to the legislation on that point.

1450

You spoke about accountability and the need to make it public. There is a provision in the legislation to allow for the posting of accountability agreements between hospital boards and the ministry, so those agreements could be made public and will be made public. I believe it's the intention that they will be made public, so that those members of the community will know what accountability agreement has been signed between their hospital and the ministry.

I think you're aware, but I'll just repeat it for the sake of repeating myself yet again, that the intention is that the legislation will be amended to provide for accountability agreements between boards and the ministry. Then the boards would enter into performance agreements with their CEOs. There was some concern that the ministry was usurping the authority of boards, but that is in no way the case. The boards will continue to be boards specific to those institutions. We're not in any way trying to affect the governance of those institutions.

You did raise a concern as well about whistle-blower protection. I just wanted to note that in subsection 14(7) there is whistle-blower protection, in the second part of this legislation, to enable health care workers to ensure that health service accessibility is provided. We will be expanding that to explicitly prohibit disciplining or penalizing whistle-blowers. So that assurance is there as well.

I was interested in discussing with you a little bit and asking you a question, if I still have time. I know I'm steamrolling through. Am I OK, Chair?

The Chair: I think you still have about two minutes.

Ms Smith: OK. I'm getting down to a very quick pace these days.

You spoke a bit about your concerns about the health quality council and the membership on that council. You talked a bit about the reporting function, but you also talked about the membership, and you thought it should be democratically selected and appointed by all parties. I wonder if you could expand on that for me a bit, about basically what you mean by "democratically selected and appointed by all parties." What parties would you be referring to?

Mr McGuffin: The parties in government.

Ms Smith: OK. One of the things that we foresee including in the amendments is precluding stakeholder groups from having a seat at the table. So for the large stakeholder groups that exist to represent certain interests in health care, we were looking at precluding their executive from holding a position, but that wouldn't preclude a member like a doctor, as opposed to the head of the OMA. A doctor would still have a role, or a health care provider of any kind, as well as consumers. I think we also want to see regional representation. Are there any other specifics you would like to see included on that council?

Mr McGuffin: Basically what I stated.

Ms Smith: That's kind of what you were looking at?

Mr McGuffin: Yes.

Mr Longmoore: Could I respond on the P3 hospitals? What we understand is that the main difference between the P3 hospitals of Harris and the public hospitals of Mr McGuinty is that one is a leaseback and the McGuinty proposal is a mortgage. Many of the elements of the P3 hospitals are in place: the operating budgets, privatization of finance, of services, of the land deals. I just wanted to quote John Baird, who is a former cabinet minister in the Conservative government:

"Dalton's tie might be red, but his whole suit is blue. I'm just happy to see our plan go forward.... Despite the Orwellian doublespeak ... it looks pretty identical to the deal that Ernie Eves" came forward with.

What's a public hospital? Until now, the hospitals have been built with capital grants from the government, with additional fundraising in the community. We raised $21 million in Windsor. The hospital is owned publicly; it's paid for publicly through capital grants, not out of the operating budgets. It is operated as a public service, not as a commercial entity. We've seen in the United States,

with the Hospital Corporation of America, where the corporation had to agree not to offer the executives incentive bonuses as part of the billion-dollar settlement for fraud.

The Chair: Thank you, Mr Longmoore. Your time has expired.

Ms Smith: If I could just respond.

Mr Longmoore: Could I just finish?

The Chair: No.

Mr Longmoore: I just have three more lines.

The Chair: Somebody else will be asking you a question, and certainly you can use your time.

Mr Longmoore: OK, you'll let me finish?

The Chair: I'm sure you'll get your chance.

Ms Smith: You'll have a chance to talk to the authors of private hospitals right there. Feel free to address Mr Klees.

Interjection.

Mr Klees: Absolutely, they're the same.

The Chair: I had extended your time by a minute just to let you go at that point.

Mr Klees, the floor is yours.

Mr Klees: I want to thank you for your clarity on the issue of the P3. The fact is that I will take issue with you. We don't agree. We're not on the same page on that, because I happen to believe that there is a role for the private sector. Having said that, though, what you're addressing, I think, is something along the lines of a credibility gap that exists between what the Liberals were saying when they were on the campaign trail and when no doubt many of your supporters helped get these folks over here elected—you believed them, didn't you? You believed that they were going to shut them down and that they were going to ensure that hospitals would be publicly funded.

Mr Longmoore: The people of Brantford did; they believed.

Mr Klees: They believed, yes. How do they feel now?

Mr Longmoore: Who's the MPP for Brantford? Ask that person, I guess.

Mr Klees: I'll tell you what we've been hearing across the province as we've been travelling. It didn't matter if it was Sudbury or Ottawa. It doesn't matter where we are. People are very, very disheartened because they see one more broken promise here in this bill—actually, many broken promises. It has been referred to as a dramatic bill. It's actually a very scary bill to most people in the province, when they see what is here.

Let me give you an example of what they're trying to hide. We were in Ottawa yesterday. Of course, the parliamentary assistant was defending the fact that it is not a P3 hospital that is going in there. So a motion was made. Ms Martel made the motion, asking the Liberal government to table the contract. Mr McGuinty ran on the platform of being open, an open government. A very quick way for people to determine whether this is a P3 or not is to see the contents of the contract. Surely, if it's a publicly funded hospital, then the public should have access to the agreement. Would you agree?

Mr Longmoore: I agree.

Mr Klees: Well, do you know what happened? Every single Liberal member on this committee voted against doing that. Can you possibly imagine why? I think you'll draw your own conclusions. We on this side actually can't believe for a minute what Minister Smitherman is telling us he'll do by way of fixing this, because we have seen very little evidence that they will do what they say they're going to do. So our caution to you—and by the way, I moved a motion that incorporated specific wording to protect collective agreements. In fact, it was wording lifted right out of presentations made by the CUPE local in Sudbury. It was voted against—by whom?—by every single Liberal member of this committee. I tried to table that same motion today, thinking that there might have been a change of heart, but it was ruled out of order.

So, folks, beware. There's something at work here. We're not sure what, but we do know this: It's not going to be in the public interest. It concerns us gravely.

I'm going to give you the rest of my time to read the rest of your lines.

Mr Longmoore: Thank you, Mr Klees. Welcome back to Essex county.

Mr Klees: Thank you.

Mr Longmoore: There is no for-profit consortium in charge of great sections of the hospital. We do have Tim Hortons doughnuts, which is a wonderful health message to send to the people of our community. There have been attempts to diminish this by privatizing some services such as laundries, food—the wonderful food that comes in frozen from London. In some cases, they have succeeded; in others, privatization of services has been stopped. We have actively fought to keep all hospital services non-profit. In no case has the privatization of the hospital services been as deep or as broad as is now being proposed.

Look across the United States. Forget David Osborne, the new guru of the Liberal Party. Look at the United States, at what has happened, the mess of the private hospital system. We don't need that. It's coming. It's coming to this country. Once we open the hospitals up, they're all coming over. Great-West Life is already in the United States. They'll come back and they'll be competing to carve up the hospital industry, and we will have lost what you allegedly are trying to enshrine in this document, Bill 8.

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The Chair: Ms Martel.

Ms Martel: Thank you for your comments. It will be no surprise to anybody that I'm going to focus on the P3 hospitals as well, which I've tried to do during the course of these hearings. Thank you very much for raising what Mr Baird said, because, actually, that was going to be the first thing I did, just to make it very clear. Let's be clear, Mr Baird was in cabinet essentially from 1999 on—I can't remember if he was in before that—and was at the table when the P3 model was being developed. So he very clearly understands what's going on here and where the government was heading. So if Mr Baird comes

forward and says in Ottawa, as he did on the day Mr McGuinty tried to pretend this was something different, that this is exactly the same, then I think Mr Baird is exactly right: It is exactly the same.

What's interesting about the announcement made by Mr Smitherman on the 27th was that he didn't say anything about publicly financed hospitals, and I didn't hear Ms Di Cocco talk about that in terms of her commitment. That's critical in this issue: publicly financed.

What the Liberals are involved in now, which is exactly what the Tories were involved in, is private financing of these hospitals, which breaks with tradition in Ontario, where the public and public dollars financed hospital renovation, hospital construction. Why? Because public dollars are dollars that are well spent. There is not a profit motive, and there are also no additional costs with respect to borrowing. Government gets the lowest borrowing rate. So as the private sector finances this, we, through the mortgage, pay a higher cost for interest.

We also pay a higher cost for the mortgage, because the private sector isn't doing this out of the goodness of its heart. The private sector is in this game to make a buck; maybe it's 15%, maybe it's 20%, but that's an additional cost that gets added on to the mortgage. In this case, the mortgage is going to be paid for out of the operating budget of the hospital. Taxpayers' dollars that should be in the operating budget to go into patient services instead get diverted to paying a profit to the consortiums that are doing this construction. That's what I find so offensive about these deals, and that's what I find offensive when I listen to the Liberals talking about how this has changed, because it hasn't. The private sector is at the table, and the private sector is going to benefit by getting public money that should be going into patient care and patient services.

The Liberals should be living up to their election promises, because Mr McGuinty was very, very clear: He was going to cancel P3 hospitals. And here we are, moving down the same road as the Conservatives before us. He was also very clear that he was going to stop the private MRI and CAT scan clinics and put that technology back into the public system, and that hasn't been done either.

It's interesting that it was a member from this community, Ms Pupatello, who talked about poaching and why the private clinics were so bad, because people were going to be poached out of the public system. That's exactly what has happened, and those things are still operating.

When you look in the preamble, there's also a reference to home care and a commitment to home care, but this government is also not doing anything about ending competitive bidding in home care, ending the privatization in home care so that money could go into patient services instead of profits.

So I appreciate that you talked about privatization today and reminded the Liberals about their promises, because I think people voted for change. It's clear to me there's a different government and people haven't seen any change.

There's a real contradiction—that's the politest term I can use—between the preamble, which talks in glowing terms about support for medicare and publicly funded services, and what is actually happening. There's a huge disconnect, there's a huge gap. I'd just like the Liberals to live up to their election promises in this regard. I think the public would be much better served if they actually did that.

Mr McGuffin: Absolutely.

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

CHATHAM-KENT LABOUR COUNCIL

The Chair: Now if we can move on to the Chatham-Kent Labour Council, represented today by Bill Steep, who is the vice-president. I understand you'll be joined by Gary Watson, the treasurer—moral support in the back, perhaps.

Mr Bill Steep: That's what I was looking for.

The Chair: You've got 30 minutes, Mr Steep. You can use that any way you like. At the end of your presentation, we'll use the remaining time to ask you questions, and we'll share that time evenly. The floor is yours.

Mr Steep: I won't be 30 minutes.

The Chatham-Kent Labour Council represents 10,000 people in this community in various occupations. We have long been involved in the economic and social issues of our community, such as health care, and welcome the opportunity to speak to you today.

Bill 8, the Commitment to the Future of Medicare Act, introduced by the newly elected Ontario Liberal government last November 27, 2003, aims to establish an Ontario Health Quality Council, replace the existing Health Care Accessibility Act with somewhat modified provisions and provide for accountability in the health services sector.

We have serious concerns with this bill as it is currently drafted and intend to proceed through its major sections to point out its weaknesses and offer our views for change.

The preamble to Bill 8 recognizes that our system of publicly funded health care services reflects fundamental Canadian values and that its preservation is essential for the health of Ontarians now and in the future. It confirms an enduring commitment to the five principles of medicare: administration, comprehensiveness, universality, portability and accessibility, as currently codified in the Canada Health Act.

Unfortunately, there is little actual legislation that provides any significant new initiative of 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 which directly addresses either of these concerns.

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

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

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

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

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Should the council have representative and inclusive criteria and elections for its makeup, there is a further issue that should be dealt with. While the council is required to deliver a report on the health care system on an annual basis to the public and to the minister, it is specifically prohibited from making recommendations as to the future course of action to be undertaken. A good deal of the value of such council is thereby thwarted by its inability to make recommendations.

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

Opting out and extra-billing: 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 section of the bill, subsection 9(4), contains language that may well open up the possibility of the government itself, through regulation, allowing extra-billing and opting out.

We support a ban on extra-billing and opting out and the act should specify such.

I personally don't have any examples of extra-billing in our community. I think we're probably lucky in that regard.

Queue-jumping: Here Bill 8 proposes a new section, 15, to limit the ability of individuals to jump the queue. An insured person cannot pay or confer a benefit in order to receive a preference in having access to insured services, nor can a practitioner charge or accept money for granting any such preference. In other words, a person cannot be charged money to receive a particular test or procedure in advance of another 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, which 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 privatization of health care and should follow through on their commitment to the people of Ontario. Currently, the most insidious form of this privatization is what is termed public-private partnerships, or P3s. The P3 projects of the previous Conservative government, 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 their public sector equivalents. So, in addition to the evidence from other such experiments in Britain and Australia that suggest 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 P3 organizations.

Already, private stand-alone clinics such as MRIs and CTs operate outside the public medicare system and drain money from it through third party billings, such as WSIB, third party insurance, and thereby deprive hospitals of lucrative revenue. Further, such private clinics poach scarce reserves of skilled staff from the public system. They further enable queue-jumping for so-called medically unnecessary services.

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 monies out of patient care and into ballooning administrative costs, and this

despite sending labour costs—people's living standards—into a nose-dive. Ontario's home care system is rife with duplication, inability to utilize staff efficiently, 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 block fee. Typically, such services include telephone advice, renewal of prescriptions by telephone, completion of various forms etc. Such block fees have to date been largely unregulated, although there are certain 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 which circumstances, block fees can be charged. It is our view that block fees should be banned. Block fees are but another mechanism to erode the publicly funded health care system and should not be allowed in regulations or anywhere else.

Ontarians are already confronted with a reduced scope of services covered by public medicare, and as the burden is shifted to individuals, the unpopularity of such fees will increase. In addition, to allow fees in regulations will make their usage widespread, thereby negatively impacting labour management negotiations by adding an additional cost factor.

Accountability agreements and compliance directives: The most important, controversial and potentially dangerous sections of Bill 8 are contained in part III, sections 19 to 32. They cover the powers of the Minister of Health to compel persons to enter into accountability agreements or compliance directives. These provisions have been drafted in such a broad manner as to give the minister unprecedented power to require individuals and organizations to comply with whatever the minister desires, potentially including the overriding of legal collective agreements and other negotiated agreements. This constitutes a fundamental affront to the people's rights in a democratic society.

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

Not only is there little limitation on the minister's power 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 subsection 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 ill-defined accountability agreements. Indeed, throughout the bill, the powers granted to the minister are too broad, too open-ended. It is often unclear as to specifically what the directives are about, what their content is and to whom they will be directed. As a person proceeds through the bill, he or she 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 for-profit sector. As a representative of the labour council, we are committed to public medicare and are opposed to such language if it is meant to advance a privatization agenda.

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The sweeping powers of the minister and breadth of the directives is further revealed in sections 26, 27 and 28 of the bill. 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, and increased community control and 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 have a directive 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 and wrong-headed? Why should the vast majority of Ontarians who value public medicare 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 Conservatives' 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 medicare system supposedly designed for them. Unfortunately, we are left with little alternative but to call for a complete withdrawal of this section of the bill.

In conclusion, one might have hoped this bill would explicitly prohibit two-tiering and so-called medically unnecessary procedures. Accessibility should have been strengthened and assured with specific attention paid to marginalized and equity-seeking communities and those in communities that are geographically remote. There would have been some recognition that for-profit provision is a giant step back from accessibility, as can be clearly seen in the American context, where millions of people have no medical coverage whatsoever and millions more are inadequately covered.

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

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

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

Let us be clear: Moving to sell assets, such as TVOntario and the liquor board, won't solve the problem of a structural deficit, but more revenue will. It is a one-shot deal postponing the problem until next year.

Privatization, in the form of P3 hospitals or whatever, is not reinventing government. It's a path rejected by the voters of Ontario, and all the evidence from other jurisdictions tells us it will lead to worse public services.

We urge the government of Ontario, in light of our comments, to reconsider this bill. Thank you for the opportunity to participate in this important discussion.

The Chair: Thank you, Mr Steep. You've left us about six minutes. That would be about two minutes each. We're going to start that with Mr Klees.

Mr Klees: Thank you, Mr Steep, for your presentation.

You're well familiar with agreements. You read legal agreements all the time. I wonder how long it took you, after reading Bill 8, to figure out that this is a major smokescreen.

Mr Steep: It's an awful lot to digest—the first couple of sittings of going through this—but eventually I have come to the conclusion that our collective agreements could be in jeopardy by the way it's written.

Mr Klees: There's only one other piece of legislation in this country that I think comes close to the kind of heavy-handedness, and that's called the War Measures Act. I'm not sure what Mr Smitherman's state of mind was when he agreed to bring this forward.

You make reference, for example, to the fact that in this bill, no one will be allowed to take legal action against the minister or the crown if somehow they don't like what the minister has done by way of his unilateral action. What's interesting is—and you'll hear from the parliamentary assistant—that the minister has agreed to make all kinds of amendments.

We have an outline of what those amendments will be. It's interesting that there are references to all kinds of clauses, but that one's still there. So the minister has made no attempt, in spite of everything that this committee has heard, about the offensiveness of this part where the minister can say: "I'm going to unilaterally tell you what the agreement's going to be, and you are going to be deemed to actually have sat down opposite and signed off on it. And by the way, if you were hurt by it, you'll have no legal right to claim compensation."

Does that sound like the War Measures Act to you, sir?

Mr Steep: I don't know whether it goes quite that far, but certainly it's an unfair and unjust way of putting it.

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The Chair: Ms Martel.

Ms Martel: Thank you for coming today to make the presentation.

I just wanted to deal with that section as well. I don't want to use the term "War Measures Act," but there is a contradiction here, and I guess the government's going to have to deal with this and explain it to the public.

Clearly, we have seen some proposed areas of change today—and Mr Klees is quite correct, as I had picked it up as well: There is no change in the section that says, "No compensation shall be payable by the crown, the minister, or any other person, entity or agency for anything done or purported to be done under any provision of this part or the regulations." So, the minister has essentially no liability.

Yet, when I go to the penalties for other people, while those have been changed, because they were very excessive and aggressive, the fact of the matter remains there are significant penalties that remain for everybody else who is not responsible. So we see that there will be reductions of penalties from maximums of $25,000 and $50,000 and they may be changed to $10,000 and $25,000. It looks like, "penalties associated with mandatory reporting (queue-jumping)" for example, will "be reduced to a maximum of $1,000 per offence."

I guess the point that has to be made is that the minister, through the bill, is making everybody else accountable, and if they're not, there are some penalties. The accountability with respect to the minister is very unclear, and there are certainly no penalties that are allowed. If accountability is a two-way street—and we've heard a lot about that—I don't see that happening on the part of the government. Do you have any reflection about that?

Mr Steep: That was my concern too, but I was certainly also worried about the fact they could make you change your collective agreement and if you didn't comply, they could fine you. I personally don't know too many local unions or individuals that could afford any kind of fine in those measures.

The Chair: Ms Smith.

Ms Smith: Thank you, Mr Steep. Are you aware that the minister wrote a letter to Mr Ryan of CUPE on Monday following his statement to this committee?

Mr Steep: I was just given a copy of a letter. I only had a chance to go over it very quickly. I did notice some of the changes but I didn't read it in depth.

Ms Smith: Just so we're clear, the minister did say on Monday that this piece of legislation would not apply to trade unions, nor would it affect collective agreements. Again, today he's provided this committee with a framework of some of the potential changes to the legislation, which includes changing "'health resource provider' ... to exclude solo physicians, group practices and trade unions. These entities would not be required to enter into accountability agreements under this legislation and therefore not subject to any provisions of part III." I think that goes some way to calming your fears. I would have expected that through your organizations you would have heard that by now, because we've had numerous presentations and we've made this point numerous times this week, but we'll continue to make it.

Mr Steep: Unfortunately, I just got it five minutes ago.

Ms Smith: OK. You mentioned that you were concerned about the focus of some of the issues that would be included in the accountability agreement, including fiscal responsibility. I do note, however, that in section 20 we talk about things like clear roles and responsibilities, shared and collective responsibilities, transparency, quality improvement, public reporting, consistency and trust. Do you have any concerns about any of those types of issues being included in an accountability agreement between a hospital board and the ministry?

Mr Steep: I think those things should be included, absolutely. I think accountability and transparency are the most important things. I think we need to look at what's going on and be able to evaluate it for ourselves.

Ms Smith: That's exactly the point of accountability agreements. Would you agree with me, sir, that accountability agreements between hospital boards and the ministry are a good thing?

Mr Steep: If they have the proper wording, absolutely.

Ms Smith: That's great. Thank you very much.

The Chair: Thank you, Mr Steep. Your 30 minutes are up. Thank you very much for the presentation. We did enjoy it.

LEAMINGTON DISTRICT MEMORIAL HOSPITAL

The Chair: We now go to a representative of the Leamington District Memorial Hospital. Cole Cacciavillani, the chairman of the board, is with us. Thank you for joining us today. You've got 30 minutes allotted for your presentation. You can use that any way you so choose. Any time that is remaining at the end of the presentation will be allocated for questions among the three parties. The floor is yours.

Mr Cole Cacciavillani: Good afternoon. My name is Cole, Cacciavillani and I am a local businessman and voluntary chair of the board of directors of Leamington District Memorial Hospital, a hospital with an excellent record of efficiency and balanced budgets over the last 10 years.

I am pleased to have this opportunity to submit our comments and serious concerns about Bill 8 this afternoon, because I am speaking on behalf of all the members of our very dedicated board of directors. They are all outstanding citizens volunteering their valuable time to serve on a very demanding board, not for any political gain or financial reward, but for the satisfaction that we have ensured the best use of our tax dollars for those who fund us and provide the best possible health care for our community that has elected us. We have acted and will continue to act on their behalf.

Let me first congratulate the government for introducing the following overarching principles, which are the intention of Bill 8, that our board is fully supportive of: ensuring accessibility to the health care system and enhancing accountability to Ontario taxpayers. Our board sees that these are the two fundamental principles which motivate every member of our board to dedicate our time and energy, year in and year out. I would like to submit that these would also be the founding principles for all

independent local voluntary hospital boards in this great province of ours.

We commend the government's commitment to medicare and accessibility as intended by Bill 8. Our board wants to indicate our support for the following key principles of Bill 8: establishing a health quality council, embracing the five key principles under the Canada Health Act, adding accountability as a sixth principle, setting a framework for accountability agreements, and strengthening provisions governing medicare.

However, our board also has serious concerns about a number of the provisions found in part III of the bill, dealing with accountability. The bill is unnecessarily one-sided. It focuses exclusively on how to make health care providers accountable to the government, yet is silent on the government's obligation with respect to ensuring the provision of health care. For example, it allows the minister to unilaterally terminate accountability agreements or change a directive at any time, and absolves the ministry and the crown of any and all liability.

Neither the bill nor the process for agreements nor the actions of the ministry to date lay out a clear vision and direction for health care for Ontario. We believe hospitals should be accountable and plan for the future, but we believe that this cannot be done in a vacuum.

One of the requirements under the Canada Health Act is access to services. Bill 8 may expose the government to charter challenges, as it does not provide for timely access to services. Access to services may also be reduced by some of the provisions in part II of the bill prohibiting hospitals from paying physicians and practitioners for insured services.

Therefore, the purpose of this submission today is twofold: to convey our board's support of ensuring and enhancing accountability and accessibility to quality health care on one hand, but on the other hand to urge the government to make extensive amendments to Bill 8 by removing those components of the bill that, if enacted and implemented, will actually reap the opposite effect of the principles of accountability and accessibility.

Our board strongly believes in accountability. Our board believes we are accountable to both the government and to the communities we serve. The track record of the Leamington District Memorial Hospital has demonstrated how our board has ensured that taxpayer dollars have been spent wisely while ensuring our communities have the best possible access to quality medical services that are appropriate for a community of our size. Our board has demonstrated that we have been leaders in accountability by engaging in all categories of auditing by external bodies: financial audits, radiation safety inspections and hospital accreditation surveys etc; by participating in the comprehensive hospital-specific Ontario report card series, which is the only one in the country; and by publication of our own hospital's corporate balanced scorecard in the last five years and annual community reports.

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Our hospital's operation efficiency and high productivity, as demonstrated by various performance indicators, has enabled the Leamington District Memorial Hospital to increase accessibility to services by introducing more than 20 new programs and services in the last seven years, with a history of balanced budgets while adequately maintaining our working capital. Our record demonstrates our board's commitment to the taxpayers and communities we serve. Therefore, let me make it absolutely clear that our board strongly supports the principle of accountability, and we want to do our part to ensure that this happens and that it can be enhanced.

However, we do take issue with the way in which Bill 8 attempts to enhance accountability. First of all, we believe that Bill 8 must be amended to make accountability provisions fair and effective. In order for accountability to be fair and effective in the provision of medicare, there ought to be a shared accountability between providers and government.

We believe Bill 8 as presently drafted fundamentally reduces government's accountability by removing the requirement for the minister to act in the public interest, as defined by the Public Hospitals Act. Public interest is defined as any matter related to:

"(a) the quality of the management and administration of the hospital;

"(b) the proper management of the health care system in general;

"(c) the availability of financial resources for the management of the health care system and for the delivery of health care services;

"(d) the accessibility to health services in the community where the hospital is located; and

"(e) the quality of the care and treatment of patients."

By removing the requirement of the minister acting in the public interest, the minister is less accountable to the public in ensuring the accessibility to health care services in the community where the hospital is located. Consideration of the public interest is very important in protecting medicare in Ontario, which is one of the objectives of Bill 8. Removing this requirement significantly reduces the government's accountability to the people of Ontario.

Section 21 outlines the power of the minister in directing a hospital to sign an agreement that has not been negotiated or agreed to but is unilaterally imposed. Forcing hospitals to sign performance agreements is contrary to the fundamental tenet of contract law, which stipulates that parties must enter into a contract freely. Such unilateral imposition of agreements not only effectively silences the voice of the community in meeting fundamental decisions about hospital services in their community, but also undermines local governance of public hospitals. We believe that accountability agreements must be negotiated and must be shared.

This leads to our second serious concern. As I shared with you earlier, the main reason why volunteers serve the board at the Leamington District Memorial Hospital and, I believe, every hospital board in Ontario, is to ensure that quality medicare is accessible to our com-

munity. Our motivation to serve is to make a difference for our community.

Bill 8, as it is presently drafted, seriously threatens and erodes the role of independent local voluntary governance structure. We believe Bill 8 fundamentally undermines the role of independent local voluntary hospital boards in two significant ways. First, it usurps the role of the board in representing their local community needs by imposing a non-negotiated accountability agreement with the hospital. Second, it fundamentally undermines the governance structure of public hospitals by having the power to make an order affecting an employee of the hospital—I'm referring to sections 26 and 27. Hospital CEOs are accountable to the board for their performance, and the board is responsible for the conditions of the CEO's employment. This direct intervention approach has been rejected by the BC provincial auditor in its review of BC performance agreements as "detrimental to governance of the organization" and "ineffective in improving performance." I refer you to subnotes 1 and 2.

We have grave concerns with this legislation as it is currently drafted. It may actually decrease accountability to local communities by fundamentally undermining the role of local, voluntary governance of public hospitals in communities across Ontario. This will irrevocably alter the relationship between hospitals and their communities.

I'm sure most of the people in the province recognize that one of the strengths of the Ontario hospital system is its local, independent, voluntary boards. I personally believe that if part III of Bill 8, accountability, is not extensively amended, you will see resignations of many fine Ontario citizens from their local hospital boards, and recruitment of qualified voluntary board members will become increasingly difficult. Therefore, while our board supports accountability and wants to enhance it, we believe Bill 8 must provide for government accountability as well. The Ontario throne speech in November 2003 stated: "Your new government understands it can only hold others to a higher standard if it subjects itself to the same standard." We believe the bill must include the requirement for the minister to act in the public interest in order to ensure "accountability of health services in the community where the hospital is located."

We also suggest that compliance directives in Bill 8 are inappropriate in the context of a negotiated agreement. We cannot support any provisions which allow the minister to make an order that may result in a material change in a person's employment, and believe these provisions must be removed.

In addition to my comments on accountability, I also wish to comment briefly on the two remaining parts of the bill: the health quality council and accessibility.

Our board supports the establishment of a health quality council for Ontario and believes that it could play an integral role in enhancing accessibility and accountability. We suggest the effectiveness of the council could be strengthened by: an independent council which reports directly to the Legislature, as described in the Liberal campaign platform and the speech from the throne; allowing representatives from health care system provider organizations to ensure the council has significant and sufficient expertise; providing the council with the power to monitor and report on the quality of and accessibility to publicly funded services by building on evidence-based information in studies undertaken by such bodies as the Institute for Clinical Evaluative Studies.

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

There is also real concern, in the accessibility section of the bill, part II, that there may be a prohibition on payment of hospitalists, lab physicians and other types of physicians to whom hospitals make direct payments. Paradoxically, this provision may have the effect of reducing access to health care services.

In conclusion, our board endorses the effect to ensure accessibility and enhance accountability but cannot support Bill 8 as currently drafted. Bill 8 must be extensively amended to ensure communities have a say in the services they receive and in how their local hospitals are managed; to ensure that responsibility for accountability and actions that are taken are in the public interest; to ensure that both providers and government are held accountable to Ontarians for health care they receive; to ensure that accountability agreements should be between the board, as representatives of the hospital and the community, and the minister as a representative of the government and the taxpayers; to ensure that Ontarians have access to the health care services they need in a timely way.

We believe, because the required amendments are extensive and have not yet been tabled, that it may be prudent for a committee to consider another round of consultations on this topic after the amendments are known.

Thank you for listening to me and our board of directors.

The Chair: Thank you, Mr Cacciavillani. You've used up 15 minutes, which leaves us with 15. We're going to start with Ms Martel.

Ms Martel: Thank you for being here today. I'm going to focus on page 5, the three points that you make at the top of the page. The first says, "We believe the bill must include the requirement for the minister to act in the public interest." We received a document from the minister today, via the parliamentary assistant, which outlines some of the areas the minister wants to make changes in. I want to be clear that we don't have the wording of the amendments. What we are dealing with are the suggested areas for change. So it does appear that the minister wants to include public interest, but he wants to do that in the preamble of the bill, which makes no sense to me whatsoever. Frankly, in this bill, the preamble has a huge disconnect with the rest of the bill. It's

a statement of important and valuable intentions, but the rest of the bill does very little to support the preamble.

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So would you agree that it would make much more sense, if we're talking about public interest as we do in the Public Hospitals Act, that that should go into part III, which is the section that deals with accountability agreements?

Mr Cacciavillani: Absolutely. Accountability has to be shared both ways. It has to be part of the bill.

Ms Martel: Two points: We had hoped that what the minister gave back to us today would give some comfort particularly to hospital boards, that have been coming forward to express concerns about accountability agreements. My concern is that I don't see anything here that's going to give anybody much comfort. I appreciate that you don't have this in front of you, so I will read this into the record as quickly as I can.

You also suggest "that compliance directives in Bill 8 are inappropriate in the context of a negotiated agreement." Let me tell you that the proposal that has come back from the minister is that the minister would "include notice and other due process provisions, including time frames for notice, to address development of accountability agreements, issuance of compliance directives and orders (eg discussion process, meetings, exchange of documents/information, representations that the minister has to consider before issuing a compliance directive or an order)." Does that sound to you like any kind of negotiated agreement?

Mr Cacciavillani: No, it doesn't, and the words "directive" and "order" don't lend themselves to a negotiated agreement either.

Ms Martel: OK. So your concerns would clearly still remain in that regard.

Let me deal with the next one: "We cannot support any provisions which allow the minister to make an order that may result in a material change in a person's employment," namely, the CEO, whom you have responsibility for as a board. Here's what the minister has come back with: "Include range of remedies directly in legislation that could be issued in a compliance directive or an order to address non-compliance (eg audit, budget review, etc). CEO compensation clawback or any other financial remedies to be applied to a CEO as a last resort only after all due process has been exhausted and in exceptional circumstances." It seems to me that the minister still has the power to deal with CEO compensation, ie, in terms of a clawback. Would that be your understanding of what I just read?

Mr Cacciavillani: Yes, and I'm not so sure what the difference is between what you just read and what those powers are right now.

Ms Martel: Neither am I. This is part of the reason I raise this. As I look at what's here and reflect on what we've heard, I don't think the minister has given very much comfort to very many people, so I suspect he's going to have to go back and have another stab at this.

Mr Cacciavillani: Yes. I would also say that everything the minister has said so far that I'm aware of is only in principle. They're not actual amendments to the act. So I would stress my last point, that since they're only in principle, I would still urge the committee to let the public at large take a look at the amendments as tabled. I believe they're going to be tabled at some time in March.

Ms Martel: March 9, yes. Great. Thank you.

The Chair: Ms Smith.

Ms Smith: Thank you, Mr Cacciavillani, for coming to speak to us today. As you know, we've brought forward Bill 8 after first reading in order to get input from the public. We've certainly had a lot of input from members of the public over the last four days, so we appreciate your being here to provide us with yours as well.

I was really pleased to see on page 1 your commitment to accountability and the commitment of your hospital to enhancing accountability to the taxpayers of Ontario. Certainly that's the intention of this government as well, so I think we're working from the same page.

I recognize that you've raised a number of concerns, some of which I think will be addressed in the revisions this government is proposing to bring, as Ms Martel noted, in the framework we've provided.

First off, though, I would like to just note that you are a member of the OHA, I assume.

Mr Cacciavillani: Yes, we're a member hospital.

Ms Smith: And you are aware that we have had a number of meetings and negotiations, including the minister himself, discussing some of these changes?

Mr Cacciavillani: Absolutely.

Ms Smith: So you are aware that the governance of your hospital is no longer in jeopardy, as we have confirmed that in future the accountability agreements will be between the board of the hospital and the ministry, not the CEO.

Mr Cacciavillani: I agree, but as I told Ms Martel, it's still only in principle. The minister has only said these things in principle. They're not amended to the act yet.

Ms Smith: The minister has made a commitment to bring those amendments forward for the act. Do you accept the need or the benefit of having accountability agreements between boards and the ministry?

Mr Cacciavillani: As long as they're shared accountability and they're negotiated. The problem with unilaterally having an agreement in place—somehow, the ministry has to take responsibility as well.

Ms Smith: When Ms Martel went through, briefly, some of the proposed changes, one of the things we have in the proposed changes is that we would "include notice and other due process provisions, including time frames for notice, to address development of accountability agreements." Does that, to you, speak to imposition of an agreement, or does the development of an agreement speak to you of some give-and-take on both sides?

Mr Cacciavillani: I think it speaks to the development on both sides.

Ms Smith: Section 21 is what I just addressed. I've addressed your concerns, I think, about the board and about direct—I did want to talk to you a little bit about your concerns on page 4 with respect to the auditor's report in BC. In what way do you see the BC legislation being similar to what's being proposed here?

Just so I can be a little clear, when I read through the footnote that you've quoted, it would seem to me that in the BC situation there is a much more direct relationship between the CEO and the ministry than what we're proposing in our legislation, where we have agreements between the board and the ministry.

Mr Cacciavillani: I guess I would bring to your attention that as we read the bill, if the bill is enacted as it's written, it would be very similar to this.

Ms Smith: Given the amendments that you know are going to be brought forward by the minister, would you agree that the BC analogy doesn't really apply?

Mr Cacciavillani: If I could see the amendments in writing, then I would comment on that.

Ms Smith: With respect to compliance directives—you've raised concerns about those—but in any contractual relationship between two parties, there are usually notice provisions for non-compliance, are there not? If you're in a contract with somebody and the other side isn't performing as they should, are there not notice provisions that you can then have a process to let them know: "I don't think you're doing your side of the bargain. Can you straighten up?"

Mr Cacciavillani: That's exactly why we want to be able to have negotiated contracts. So, yes, I would agree, as long as it's negotiated by both sides and not unilaterally imposed.

Ms Smith: Right. So compliance provisions would be acceptable if they were negotiated within the context of the—

Mr Cacciavillani: Yes. Compliance provisions are not in compliance with a negotiated contract, as they're written now. That's what I think I tried to say.

Ms Smith: OK. I think the intention is that they will form a part of the accountability agreements, and therefore be a form of notice provision if there's a disconnect between what's in the accountability agreement and what's actually happening on the ground.

You spoke just briefly about the health quality council, and you were advocating for allowing representatives from health system provider organizations. What we probably are going to be bringing forward in the amendments to this legislation is a provision that would preclude members of stakeholder groups, executives of stakeholder groups, from being on this council, ie, the OHA executive or the OMA executive, but not necessarily a member—such as yourself as chair—of a board of a local hospital. Does that satisfy your concern, or do you think that the stakeholder groups themselves should have representation on this council?

Mr Cacciavillani: I would suggest probably the stakeholder groups themselves. The information that you probably would require at that committee level is more accessible by the stakeholder groups than myself as chair of the board, or by people like me. That information can be provided to me, but it's just going to filter up from them—so possibly a mix.

1600

The Chair: Mr Klees.

Mr Klees: Mr Cacciavillani, did you notice the parliamentary assistant's silence when you suggested that there should be accountability on the part of the Ministry of Health as well? That should be telling to you and to anyone looking on.

I want to also point out that the whole issue of accountability here seems to focus very much on the CEO. For some reason, this government is drilling right down to the position of CEO.

I don't think the members of the government would disagree now, having had a chance to contemplate this, that there should be accountability on the part of the Ministry of Health as well. If in fact we're going to identify the CEO as someone who should be put on notice, who would the parallel position be in the Ministry of Health, in your opinion?

Mr Cacciavillani: Well, I don't know, but—

Mr Klees: Actually, don't answer that, because you're going to have to work with those people. But my point, I think, is a very valid one, and maybe the parliamentary assistant would like to tell the committee who in the Ministry of Health would be put into the same position of accountability—with the same consequences, by the way, for non-compliance and non-delivery of results—without compensation, unilaterally being able to change the compensation agreements. I'd be very interested. Shall we ask the parliamentary assistant? Why don't we do that? Parliamentary Assistant, who do you think it should be?

Ms Smith: I don't believe I'm required to answer your questions, Mr Klees.

Mr Klees: I think I'm going to ask—

Ms Smith: Are you speaking for the presenter again? You're doing it very well these days.

Mr Klees: I'm asking on behalf of the presenter, actually.

Interjection.

The Chair: There's no point of order here. Mr Klees can use his time as he wishes. The answer doesn't have to be given. It's quite clear: You can sing the national anthem; you can dance for your five minutes. You get to use it.

Mr Klees: Thank you, Chair. I'll save you the agony of singing.

The Chair: The point is, the answer doesn't have to be given.

Mr Klees: I think the parliamentary assistant would rather think about this, and I think she should think about it, and so should the minister and the government.

There's a principle here that you've touched on in your presentation that really goes to the heart of this bill. The parliamentary assistant, in answering one of your questions, also made reference to the whole issue of compliance directives, and yes, she referred to section 22

and the undertaking that the minister is prepared to make with regard to this matter. Yes, he makes reference to the fact that there should be due process provisions, including time frames for notice and so on and so forth. But it's interesting that she didn't finish the paragraph here that the minister sent us.

It goes on to say, " ... discussion process, meetings, exchange of documents … representations that the minister has to consider," and here's the rest of it, "before issuing a compliance directive or an order." In other words, he's prepared to put all of these processes in place; still, he holds on to the right to make a unilateral direction with, by the way, the same consequences. There's no reference to providing in any way relief, and you, or whoever it's directed at, will still be deemed to have agreed.

We've got a problem, and I see the Liberal members of this committee, as these hearings have been going on, becoming more and more dejected. I'm sure that they themselves, quite frankly, cannot believe what they are being asked to support here. I really feel for members of this committee who have to go back to their ridings and face their constituents and who have to deal with the reality that they are being asked to put a piece of legislation forward that is so draconian.

Mr Duguid: We'll deal with it.

Mr Klees: And they will deal with it.

I thank you, sir, for your presentation today.

The Chair: On that empathetic and co-operative note, your time has expired, sir. We do thank you for coming forward. Your input was greatly appreciated.

ESSEX COUNTY MEDICAL SOCIETY

The Chair: Our last delegation of the day, representing the Essex County Medical Society, is Dr David Paterson, the president of that society. Dr Paterson, if you'd like to come forward. You have 30 minutes to make your presentation. You can use that any way you wish.Any time remaining will be split among the three parties. This time the government side will go first.

Dr David Paterson: Mr Chairman and committee members, good afternoon. I'm Dr David Paterson, president of the Essex County Medical Society. Dr Desai, who was to be here, wishes me to express his regret that he was unable to speak to you this afternoon. Following my presentation, I'd be more than happy to respond to any questions that you have.

I have been practising family and emergency medicine in Windsor since 1976. I have been actively involved in the medical community throughout this time and have seen many physicians come to practise here, and, regrettably, seen many leave. I am very familiar with the many issues that confront our health care system, and I hope what I have to say will be of benefit to you in your work on this legislation.

At the heart of this bill is medicare and Ontario's commitment to its principles. As a physician and a Canadian, I am a strong supporter of a health care system that ensures universal access to quality health services. It is my opinion that if Bill 8 is passed in its current form, the result will be a system that's much worse, not better.

I'm sure you are aware of how concerned physicians across Ontario were when Bill 8 first arrived on the scene. I know that very shortly after Bill 8 was introduced, the Ontario Medical Association addressed many of these concerns with Minister Smitherman directly. My OMA colleagues assure me that ongoing discussions between the minister and other stakeholder groups will no doubt lead to vast improvements to this legislation. The OMA historically has been involved in the government process and was very disappointed that they were not consulted when this bill was conceived. We could have saved you a great deal of time and trouble.

The Canada Health Act was introduced in 1984 and since that time has not been changed—amended or updated. As physicians, we support the principles of this act but have to admit that it is not working the way it was intended. It simply does not reflect the modern demands on our medicare system. This should be a priority for the federal government, to allow provinces to adjust to the new reality of providing medical care in 2004.

The past few days, you've heard from colleagues of mine who have presented you with similar sets of recommendations to those I will offer today. There are several areas of this legislation I would like to address, but my time with the committee is short, so I've decided to focus my remarks on section 16, which deals with block fees; section 9, where the focus is on third party billing; and section 15, which deals with disclosure of information.

Block fees are one-time charges to patients by their physician to cover certain uninsured medical services for a period ranging from three to 12 months. Typically, a patient who opts to pay a block fee would be provided with services such as notes for sick leave from work or school, completion of various forms associated with medical assessments, services over the telephone—for example, test results, advice, prescription refills—transfers of medical records, photocopying, faxing, certificates for health verification, immunization etc. Please remember that these services are very time-consuming and incur a real cost to a physician's practice. They are not covered by OHIP, nor are they billable to the ministry. Block fees are not extra-billing. Patients are given the option of paying for these services separately or opting for the block fee. The physician is required to list each of the fees as well as a description of what the individual charge would be as an alternative to the block fee.

I have found these fees are an effective and easy way to ensure my patients get the kind of care they want. They allow a doctor, for example, to renew a patient's prescription over the telephone as an alternative to seeing the patient in the office and billing OHIP for that visit. This is a cost saver for the ministry and a time saver for both the physician and the patient.

1610

At a time of such an extreme shortage of full-service or comprehensive-care family physicians, the removal of a block fee option is just another nail in our coffin. Full-

service family physicians would be the most adversely affected by this aspect of Bill 8.

As I'm sure you are aware, the Ontario Medical Association publishes a fee schedule of suggested amounts a physician should charge for provided services. Much market research and professional comparisons, including comparisons with the other provinces, are considered when making these guidelines.

At the beginning, OHIP paid a doctor 90% of the OMA fee schedule. In 2004, this is 57.3% of the OMA fee schedule. This may not be such a problem for walk-in clinics, which usually see a high volume of patients and have low overhead costs, but it is an immense problem for the full-service family physician. The type of patient we see is much more difficult, more time-consuming, and usually requires tests, adjusting of multiple medications and consultations with specialists. Taking into consideration the higher overhead required to run a practice like this, the lower numbers of patients seen and our steadily declining income, it's easy to see why traditional family practice is dying out. This is outrageous, because this is the essential type of service the Ontario public—your constituents—requires.

A great many full-service family physicians rely on block fee income to help sustain our service. In my office, block fee income is applied directly to our overhead cost. If it is disallowed, my partners and I must rethink how we'll be able to afford to provide medical service. We are definitely not alone. In my experience, a great many of my patients pay the block fee because they understand the situation we are in and do not want to lose their family doctor. The last thing they want us to be is a walk-in clinic.

Physicians are a self-regulated profession, and I am sure the committee supports the right of doctors and other health care professionals to be regulated by their professional colleges. In our case, the College of Physicians and Surgeons of Ontario, or CPSO, comprised of both physicians and lay members, acts as such a body. The CPSO sets policy and disciplines the profession appropriately. The CPSO is currently responsible for regulating the use of block fees. In my estimation, it has done a good job educating doctors and resolving any concerns about this practice. I should note that the CPSO regulations with respect to block fees are based on a set of guidelines produced by the OMA in close collaboration with the government and the college together.

Another disturbing item is in section 17, which describes the penalties on physicians should they charge block fees. Bill 8 indicates a physician would be subject to a $25,000 fine and 12-month jail term. Goodbye family practice with Bill 8. Unless the government decides to change the way our profession is regulated, this section must be changed.

Section 9, third party billing: I must say at the outset that two-tier medicine already exists and is not going away, no matter how many rules you introduce. Examples of third party billing include the WSIB, insurance companies etc.

Outlawing third party billing will result in longer waiting lists for investigations, tests and consultations. It will potentially keep workers off their jobs for longer periods of time. Productivity will take a nose-dive. Employees as well as employers will feel the pinch, and the Ontario government will be facing millions of dollars in extra costs.

Insurance companies will not be allowed to get an independent medical expert's advice on claims that require arbitration. This could have far-reaching, dire consequences. Extra fees currently being paid for on-call services by hospitals will be affected by this section.

The provision of other third party services—for example, executive physical programs—generates revenue for existing programs. I got this information this morning. The cardiac wellness program at Windsor Regional Hospital is currently funded by the Ministry of Health, but the amount is not enough to run the program adequately. Third party services are provided before and after times advertised to the public and in no way affect their access to the service. A program such as cardiac wellness relies on this income. If Bill 8 outlawed their ability, services would need to be cut. I could offer many such examples. Outlawing third party services would be a huge error in judgment.

Section 15, disclosure of information: This section should also be deleted from the bill. It requires physicians to report their colleagues to the general manager for contravening the rules of Bill 8. We refer to this as the snitch rule. Please remember this is Canada, not North Korea. Physicians are in full support of mandatory reporting in cases where public safety is of concern. This is the usual test required for mandatory reporting. We are obliged to report, for example, child abuse, sex abuse, cases of unfit drivers and situations where persons may be harmed. The OMA and CPSO have been very successful in applying these rules. There is no issue of public safety here in Bill 8.

Bill 8 gives broad immunity to the crown and permits recoveries to be extracted from physicians directly. The penalties and the authority to do so are sweeping. To add to this insult, chiropractors are not affected because, although they are partially paid by OHIP, they are considered non-designated practitioners.

Physicians are rightly upset about Bill 8. The concepts of universal access and quality health care, two aspects which define medicare, are not addressed in any real way in Bill 8, the commitment to medicare act. There is nothing in this bill that offers real solutions to reduce waiting times for our patients. In fact, in its present form it will dramatically increase waiting times. We need measures that will offer a clear direction to finding ways to decrease waiting time and increase access to diagnosis and treatment.

At a time when we need to be doing whatever we can to recruit and retain our talent, it seems the government is doing their best to drive them away. Bill 8 will cause those looking to Ontario to look elsewhere for a place to practise their valuable skills.

Bill 8 reads like a feel-good statement. However, further analysis reveals that this legislation is a knee-jerk reaction to a problem that requires a lot more thought and effort. It makes health care delivery more complicated, bureaucratic and harmful to our patients.

As a physician on the front lines, whether in my practice or in the emergency room, and also in discussions with my medical college and the ECMS, I see at first hand the crisis that exists in our health care system, and it's getting worse.

When governments make changes to the system, these should benefit patients. Bill 8, in its present form, does no such thing. Perfecting this legislation will be a challenge, but please get it right.

Thank you for this opportunity to speak to you.

The Chair: Thank you, Dr Paterson. You've used up about 12 minutes, leaving us 18 minutes, which would be six minutes per party. We'll start with the government side.

Ms Smith: Thank you, Dr Paterson. First, I'd like to apologize for my phone ringing. I try to turn it off at all times, so I'm sorry that interrupted your presentation.

I appreciate your being here today. As you know, we brought forward this legislation after first reading to get as much input as we can from the public and from stakeholder groups in order to make it the best bill possible, so I appreciate your taking the time to come and discuss your concerns with us today.

I just wanted to address three things in particular. With respect to third party billing, you seem to be concerned that this will somehow impact WSIB issues and insurance companies, but those are considered uninsured services and would not be affected by this legislation. My understanding is that the types of services you're discussing in that section are uninsured at the moment and would not be impacted by this legislation.

1620

Dr Paterson: The way I read the legislation is that third-party services are outlawed, and the way the public would take it, I think, would be the same way I took it, that you are not allowed to get an independent opinion.

If I were an insurance company and I had a claim for somebody with a whiplash injury that begged to be investigated because of investigation of that particular client, I would ask for an orthopaedic consultation or a neurologist or a neurosurgical consultation. By your Bill 8, first of all, that's third party and would be disallowed, the way I read it, and second, even if it were allowed, they could only charge OHIP rates, which are ridiculous. So that physician who is to be consulted for his expert opinion would be paid the same rate, which is already too low; he'd have to take time out of his busy practice to get paid no more to stick his neck out and do an insurance examination. If you made us lose that ability, it would be just a terrible blow to the insurance system.

Ms Smith: But the provision in the act refers specifically to insured services, and what you're describing are uninsured services. What I'd suggest perhaps—I have a lawyer here from the Ministry of Health who could maybe go through it with you after this.

Dr Paterson: I hope that's the right approach, because that would relieve a lot of problems for me.

Ms Smith: I also wanted to talk to you for a moment about—

Dr Paterson: What about things like the executive physical examinations? A physical examination is an insured service, but an executive insured service is something that has been around for years and years and years. I use that example because it is an insured service that can be expedited at a cost to the company that asked for that service. Personally speaking, I am involved in that here, and it is very welcomed by the people who provide that service.

Ms Smith: Great. I'll suggest that perhaps Laurel can speak to you about that specifically, because I don't think that's addressed in this legislation. If members of the committee want further explanation of that, maybe we can do it offline with the lawyers at another time, if that's OK.

Dr Paterson: I should also mention here that we have in the past expedited things like MRIs and CT scans that are necessary to move a case along. Because the Workers' Compensation Board—an old term—can do this, other employers sometimes use this technique of trying to pay directly for an expedited MRI, and when these are done—and they're commonly done, not just in Windsor but all throughout Ontario. For example, an MRI done at our local hospital would be done before the patients from the general population are seen, so it doesn't put them out, but it is much-needed added income for that hospital. That's common. You be careful, because if you get rid of that, you're creating a huge problem here.

Ms Smith: I appreciate that, and again that would be a third party request, which would make it an uninsured service.

Dr Paterson: No, it's a covered system.

Ms Smith: Dr Paterson, I'll just let you take that up with Laurel, because I think she can explain it better than I.

I just wanted to go over a couple of other things in your presentation before my time ran out, to assure you that we are looking at changes to section 17 in order to amend the language to reduce some of the penalty clauses there that you were concerned about.

Dr Paterson: It was pointed out to me that a fine, a penalty, under some code, is no more than $5,000. Why would you make it $25,000 for a doctor? I don't understand that.

Ms Smith: I'm just telling you, sir, that we are going to be amending that to reduce those fines.

I was interested in your views on the section 15 disclosure of information. In that section, what the bill is trying to do is encourage people who work in the health care professions to report queue-jumping so that we can actually police queue-jumping in the system.

Dr Paterson: Why don't we get rid of the queues? We have ideas to answer that question.

Ms Smith: OK. I wanted to ask you a couple of questions about block fees. Am I out of time?

The Chair: You have had a couple of questions. You could probably ask a brief one.

Ms Smith: Great. I'm interested in your views as a family doctor on how we could manage block fees better. There's some concern being raised about excessive block fees being charged, or block fees being charged by physicians as a type of key money to ensure that they have a family doctor. I was wondering—

Dr Paterson: That's not correct.

Ms Smith: We have heard some examples of that. I was just wondering if you could foresee a type of system that would allow for payment of a fee that would then be credited against future services.

Dr Paterson: That's what a block fee is right now. There are regulations that cover it, and suggested amounts, although I have to admit that does vary from practice to practice. We would welcome a guideline to that, but we certainly would not welcome getting rid of the block fee.

Mr Klees: I just want to say that with regard to this discussion that has taken place, I think it's important that all members of the committee fully understand what Dr Paterson is saying and that we are all fully apprised of the dialogue that goes on there.

Ms Smith: If Mr Klees would like, we could have the person from the ministry speak to that issue right now.

Mr Klees: I'll take my time, and I'm happy to have her speak to that after I have my session with Dr Paterson.

Ms Smith: All right.

Mr Klees: Dr Paterson, your concern about block fees is an important one, and we hear you and we've heard representations throughout the committee hearings on this issue. But it's interesting as well that in the document we've received from the minister there is no reference at all to that section. In other words, there is no indication that the minister is prepared to change his position on that, and so I'm suggesting to you that you need to be vigilant here on this issue.

I am hearing the parliamentary assistant say that there seems to be widespread abuse of block fees being used as an access by physicians across this province to just have—

Ms Smith: On a point of order, Mr Chair: I don't believe I said it was widespread. I suggested that there has been some evidence.

The Chair: It's probably not a point of order, but the point ss taken. Mr Klees, continue.

Mr Klees: Thank you. I think it's extremely important that this committee fully understand, and the government understands, that this is not an initiative that is dreamed up by doctors, that it is in fact overseen by the College of Physicians and Surgeons of Ontario, that there are guidelines. I would think that a reasonable amendment to this bill would be to place block fees under the authority of the college and ensure that in fact there are guidelines that are enforceable through the college to ensure that the realities of your practice are, on the one hand, understood, and that patients are protected.

Dr Paterson: I agree 100%.

Mr Klees: With regard to the issue of the kind of penalties that you refer to, the minister did come back in his document here and he is saying that he's prepared to consider reducing the maximums of $25,000 and $50,000 down to, say, $10,000 and $25,000. So there you go. You can feel some comfort in that, right?

Dr Paterson: I feel no comfort in that whatsoever.

Mr Klees: What does it say, even though the Liberal government here is saying, "This is a unique situation. We're just putting this bill out, it's only first reading, and we really want to have some advice from stakeholders"?

Dr Paterson: We're trying to give you that advice. Take that part of the bill out.

Mr Klees: What does it further say when this first-reading bill comes out with such draconian measures that clearly target your profession, health care workers and boards of governors across this province? What does it say about the coming-out attitude of this government toward the entire health care sector?

Dr Paterson: I hope it says that they didn't really understand what they had in that bill.

Mr Klees: And if they did understand it, what does it say?

Dr Paterson: It says terrible things.

Mr Klees: Thank you, sir.

The Chair: Ms Martel.

Ms Martel: Thank you for being here today. I wanted to ask a question with respect to block fees. At the bottom of page 5 you say, "As I'm sure you are aware, the Ontario Medical Association publishes a fee schedule as a suggested amount a physician should charge for a provided service." That comes in the section just under block fees. "Provided service," I'm assuming, refers to an uninsured service.

Dr Paterson: The reason I included that is because the fees we are paid have been falling more and more short of what we need, that it's very expensive to operate a full family practice, and because our fees are so far behind what they were before that we really have no choice but to ask for a block fee to help pay for our overhead.

1630

Ms Martel: Can you get a list of what can be charged under a block fee?

Dr Paterson: Yes, I certainly can.

Ms Martel: As a member of the public, where would one get that list, if a member of the public wanted to know?

Dr Paterson: We produce that in our own office. I have to make the point that there are, to my knowledge, no specific guidelines on what a block fee should be, how much it should be. So yes, I guess there would be room for abuse in that, but don't take them away. We would

welcome a guideline as to what reasonable block fees would be.

The other thing I should mention here is that some doctors' offices do much more comprehensive, in-depth medical care than other offices, and the costs that they incur by running such a practice are much higher. So there should be room for an adjustment of block fees depending on the quality and the value of services you offer. Treating a cold and cough does not come close to treating somebody with angina, GI bleeding, depression etc.

Ms Martel: I'm just referring back to a presentation we had earlier today that talked about block fees. It said:

"Getting information on what charges are allowed at what levels and whether a physician can force patients to pay block fees is very difficult. We have been unable to get a list of services for which physicians can charge from the college. We can get the list from the Ontario Medical Association if we pay a fee of more than $100."

Do you know if that's correct?

Dr Paterson: I don't know if that's correct. I can give you a list of our personal block fee letter, which is open to all our patients.

Ms Martel: That would be from your practice.

Dr Paterson: From our practice, but it's pretty representative of what happens down here.

Ms Martel: But does the college now provide some guidance on this?

Dr Paterson: They provide guidelines: what is covered by a block fee, what it entails and that you have the choice of paying for each service independently.

Ms Martel: If the service is provided or isn't.

Dr Paterson: Yes.

Ms Martel: Does the college not make that available to the public?

Dr Paterson: Yes, the college has guidelines, and they have come out with the Ontario Medical Association, as well as working with the government, in making those guidelines. I don't know what the amounts are.

Ms Martel: My question, though, was: Is that something that is available to the public? This is the third presentation we have had that suggests that the college would not make that available and that there was a fee to get that from the medical association. I just wanted to know, if that is true, why that would be the case?

Dr Paterson: I don't think it's true, and I would be very happy to contact the OMA and the college on your behalf and provide you with that information.

Ms Martel: That would be great. Thank you.

The Chair: Thank you, Dr Paterson. We do appreciate you coming forward.

Seeing as it is the end of the day and it would not impose on any other member of the public's presentation time or anything, I wonder if the legal representative from the Ministry of Health would like to come forward and perhaps give a comprehensive and brief answer to the questions that were raised by Dr Paterson on what is actually an insured service.

Could you introduce yourself for Hansard, please.

Ms Laurel Montrose: My name is Laurel Montrose. I'm senior counsel with the Ministry of Health, and I specialize in the OHIP area. I worked on this bill, so I can give you some of the legal background. I can be comprehensive, but I can't necessarily be brief; I can be brief, but I can't be comprehensive.

Mr Klees: Can I just confirm that this in fact is being caught on Hansard?

The Chair: Yes.

Ms Montrose: This bill, with the exception of the provision on block fees—which, as you know, Doctor, deals with charges for uninsured services; the other provisions deal with charges for insured services. WSIB services are not insured services so they're not affected by this bill. Other uninsured services, include things that are commonly known as third party services, but that's a colloquial term; it doesn't have any legal meaning. Generally speaking, an executive physical is an uninsured service. As I said from the beginning, with the exception of block fees, the bill doesn't address WSIB and doesn't address uninsured services. So there's nothing in here that would preclude those services continuing to be provided and financed in the same manner in which they are currently provided and financed.

Mr Klees: Could I just ask, then: There are numerous services that are uninsured that are now incorporated into block fees?

Ms Montrose: What's in a block fee depends upon the person who's charging it. A block fee can be a contract for one uninsured service over a period of time, or it can be a contract for any number of uninsured services over a period of time. What the health care provider chooses to include is up to him or her.

Mr Klees: Right, so in that case, depending on the physician, there may be a list of 20 or 10 services that he or she is now getting paid for that, on passage of this bill as it is, they can no longer charge for?

Ms Montrose: With respect, I don't think that's a correct interpretation of the bill. It's not an issue of whether or not a physician or provider can charge for an uninsured service. There's no prohibition against charging for an uninsured service. The question is whether or not the charge is on a per-service basis or, if you'll excuse the expression, on a bulk-buy basis.

The bill simply says that if you're selling uninsured services on a bulk basis —and I'm sorry for the colloquial term, but it's the best metaphor to use—you will have to comply with regulations that are enacted under the legislation. So this bill does not purport either to prohibit block fees or to regulate the amount of block fees; it only deals with circumstances in which block fees can be charged. Again, it doesn't deal in any way with individual charges for uninsured services.

Mr Klees: Well, I'm more confused than I ever was.

Dr Paterson: I'm worried about being fined $25,000 or $15,000 for charging block fees that we need, and we're not sure what they really cover.

The Chair: It was my hope that in a short period of time we were going to be able to clarify this verbally, and that doesn't appear to be happening.

Ms Montrose: It's a complicated issue, but there's nothing in here that prohibits charges for uninsured services.

The Chair: Would it be fair to say, though, that in the next period of time, we would be able to provide a member of the public who asked with an explanation of what you're trying to describe verbally—not by the end of the day, but at some period in the future?

Ms Montrose: I think we could come up with some brief summary of what the provision says, yes.

Mr Klees: Not only for a member of the public, but for members of the committee?

The Chair: Absolutely, and that's why I asked, because I think that would be of benefit to all three parties represented here. And obviously, to the doctor. Thank you.

Just a little bit of housekeeping: For those of you who are going home tonight, the van leaves at 5:15. Could we have a very brief subcommittee meeting before that time to try to sort out some other particulars.

We're now adjourned to Toronto.

The committee adjourned at 1639.

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Also taking part / Autres participants et participantes
Ms Laurel Montrose, legal counsel, Ministry of Health and Long-term Care

Clerk / Greffière
Ms Susan Sourial

Staff / Personnel
Ms Lorraine Luski, research officer,
Research and Information Services

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