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Tuesday 4 May 2004

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Mardi 4 mai 2004

Standing committee on justice and social policy

Commitment to the Future of Medicare Act, 2004

Comité permanent de la justice et des affaires sociales

Loi de 2004 sur l'engagement d'assurer l'avenir de l'assurance-santé

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

Tuesday 4 May 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE ET DES AFFAIRES SOCIALES

Mardi 4 mai 2004

The committee met at 1601 in committee room 1.

COMMITMENT TO THE FUTURE OF MEDICARE ACT, 2004

LOI DE 2004 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 Jim Brownell): I'd like to call the committee meeting to order. I'd like to welcome one and all, committee members and the deputants, to the hearing this afternoon. Just a bit of housekeeping: Number 12 of the "Summary of Decisions Made at the Subcommittee on Committee Business" says, "That the committee meet on May 17, 18, and, if required, May 31, 2004, for clause-by-clause consideration." May 18 is budget day and I'm wondering if there would be consensus around the table to have the committee meet on the 17th and 31st only. Any comments on that?

Mr Frank Klees (Oak Ridges): Sorry, I was on the phone.

The Chair: I was just indicating that the 18th is budget day and—

Mr Klees: I understand, but what is the purpose for our meeting on those three days?

The Chair: Clause-by-clause consideration.

Mr Klees: The clause-by-clause? So you're going to back it down from three days to two?

The Chair: I'm just wondering if because of that date—

Interjection.

The Chair: OK. Yes, the 17th and 18th were the two days, and if required, May 31 would have been the third day.

Mr Klees: Now you say the 17th and the 31st and, if required, another day.

The Chair: Is that satisfactory? Very good. We will change that. I just wanted you to understand that this was in the summary of decisions at that subcommittee. So we'll say the 17th and 31st. We'll have another day if it's required.

All in favour? OK, very good.

CANADIAN UNION OF PUBLIC EMPLOYEES, ONTARIO DIVISION
ONTARIO COUNCIL OF HOSPITAL UNIONS

The Chair: I'd like to welcome the Canadian Union of Public Employees, Ontario division, and the Ontario Council of Hospital Unions. Please come up to the table. Make yourself comfortable. Please state your name at the beginning of your presentation so that Hansard has a record of that.

You'll have 15 minutes. If you don't use the full time, we'll have questions from the three parties. We'll start with the official opposition and go in that order. I want to make it very clear to the committee that should we get done and there's just time for one, then we will start with the next in line. I'll make it fair, that if we get to that situation again, we'll have the next party.

Mr Michael Hurley: Thank you very much, Mr Chair and members of the committee, for allowing us to make a presentation today. My name is Michael Hurley and I'm the first vice-president of CUPE Ontario. With me today is Doug Allan, senior research officer for the Canadian Union of Public Employees.

Just as we begin, I'd like to thank the committee for the amendments that were made on March 9, which had the effect, we believe, of addressing concerns that our union, among others, had raised around the vulnerability of collective agreements to being moderated. We appreciate that those amendments were introduced. But we have outstanding concerns and I'd like to deal with those today, if possible.

First of all, in terms of why we are concerned, before the last provincial election the Liberal Party of Ontario promised to put the for-profit MRI and CT scan clinics into public hands. The party also promised to stop public-private partnership hospitals. Those promises helped, I believe, to secure for the Liberal Party the support of the Ontario voters.

Unfortunately, the government has, it appears, reneged on both of those commitments. There is no sign that we will move the seven for-profit MRI and CAT scan clinics into the public sector any time soon. The two P3 hospitals that the Conservative government proposed appear to have been given the go-ahead, and we also understand that a number of hospitals—as many as 10—have been given green lights to explore P3 project development. The Ministry of Public Infrastructure Renewal is conducting a review, looking at expanding P3s throughout the hospital sector as the form of redevelopment there.

When Bill 8 was introduced in late November 2003, the Ministry of Health and Long-Term Care claimed it would "put an end to the creeping privatization of the system in recent years." As we have mentioned to you in earlier appearances, we believe Bill 8 does no such thing. It will not impair privatized hospitals or for-profit clinics. Indeed, for reasons unknown to us, the bill as originally written could have been interpreted so as to override collective agreements, and those concerns have been addressed.

In our previous submission to this committee, we noted our concerns about the sweeping powers this bill confers upon the Minister of Health and Long-Term Care to restructure and reorganize health care. These powers could be used for health care reorganization; for example, the consolidation and privatization of laundries, laboratories, dietary departments and other services. In fact, the consolidation and privatization of many of those services has begun.

There are troubling signs that there is an increased focus on attacking health care support and administrative services. The ministry has made it clear that they expect hospitals to eliminate deficits—deficits that hospitals have been forced to run due to underfunding. Since this demand for balanced budgets was put forward, most of the focus has been on cost savings that can be squeezed out of hospital support services.

There are troubling similarities between the accountability and performance agreements in Bill 8 and the health care performance agreements adopted by the British Columbia Liberal government. Both tie the compensation of the chief executive officers of health authorities to the goals in the agreements. The most specific and concrete target in all of the BC agreements is a reduction in spending on support and administrative services. As you know, this year's performance agreement for British Columbia requires a 7% budget reduction for support services. Since the BC agreements, we have seen a heavy emphasis on privatization, layoffs and reductions in these services, and certainly that's highly topical lately.

The Daily News of Kamloops notes, "Chief executive officers of BC's six health authorities will pocket fat bonuses if they make cuts that surpass criteria set out by the provincial government." This from the same government that has forced 15% wage cuts on health support workers, primarily women.

In Ontario on May 7, the Ontario Hospital Association will sponsor a conference on integration of support services. The OHA has announced that it will establish a task force on efficiency and integration. The task force is being developed in partnership with the Ministry of Health and Long-Term Care.

The focus on support services is ironic. As we noted in our previous brief, this is the portion of hospital spending that has consistently reduced costs and cut staff, and yet it is vital for adequate infection control in hospitals and health care facilities, an obvious emerging issue.

With respect to the real costs that are driving up health care spending, we haven't seen any evidence—and certainly nothing in this bill—that would hold drug companies to account for the huge hikes that have happened in the cost of drugs, something that has cost the Ontario treasury and the Ministry of Health and Long-Term Care huge increases in a relatively short space of time: 200% in six years. Nothing is holding those parties to account for that.

We do not see any effort to rein in unnecessary costs like those lavished on consultants, lawyers and managers by hospitals that refuse to participate in the central bargaining process, even though central bargaining is adequately funded by the provincial government and supported by most hospitals in the province.

We have proposed that there should be one single joint benefits plan for all health care facilities in Ontario, a concept supported by all of the major unions in health care in Ontario. We have no take-up on that concept from the Ministry of Health and Long-Term Care. With respect to doctors' compensation, we haven't heard any measures to deal with the inefficient fee-for-service billing system.

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But most significant is the fact that the P3 hospitals are pushing forward. As you know, the cost overruns on the Brampton project—the construction costs in Brampton are now double what they were originally projected to be. The cost of borrowing is now projected to be $56 million more than if the project had been constructed in the normal way through public financing. We'll soon be extrapolating those costs across the entire hospital system, but trust it to say that they're entirely consistent with the huge cost overruns that were experienced in Britain, and we expect we'll see that same dynamic here. We're going to see the cost of these projects soar, and they will make the savings the government is seeking to achieve through its so-called efficiencies appear relatively insignificant in the big scheme of things.

Here we have a government that said it would not go ahead with P3 hospitals approving two that the previous government approved, and it looks like they're going to green-light another 10 and the ministry has now endorsed that as the model for redevelopment for all the hospitals.

We know there will be huge cost overruns. We know the borrowing costs will be hugely more significant than they would have been if it had been done in the normal way. We know the consequences of that will be staff reductions of around 25% overall, including 14% fewer

nurses and 38% fewer support staff. We also know we're going to see bed reductions in the neighbourhood of 30%. Everything that's folding out in Brampton is entirely consistent with what happened in Britain. The same advisers from Britain have been imported to give advice to the Liberal caucus and cabinet, so it should come as no surprise.

In this area, though, the government is not being held accountable to the people of Ontario. Although commitments were made, in the face of scientific evidence that that was bad policy, was inefficient, would lead to a huge downsizing in acute care beds, a huge downsizing in staffing and be way more expensive and that taxes would have to be increased in the future to make up for it, there's no accountability in that respect. We're very concerned about that, and we're very concerned that the emphasis on restructuring in health care is going to be, as it is in British Columbia, all about making sure that the women who deliver services like cleaning, who are already stressed—

Interruption.

The Chair: Sorry about that.

Mr Hurley: I think the thrust of policy here is to make sure that hospitals and other health care facilities can be coerced into making the kinds of changes that have happened in British Columbia through reductions to budgets, coercing managers to privatize services, to reduce costs, which means women will be driven into poverty. It means the next time that SARS emerges in Ontario and there are way fewer cleaners making $9 an hour and they have no pensions and want to go to work for somebody who will pay them $10 or $11 an hour, we'll see the benefits of that policy.

I have to ask you, in terms of accountability, how it can be that the government can apply such screws on institutions to achieve savings from support services and ignore the huge cost overruns that are occurring already and that are bound to occur through the P3 policy?

In conclusion, we would encourage the committee to radically rethink the accountability sections of this bill. One thing that's missing from health care in Ontario is true community involvement in health care decision-making, and certainly this kind of centralized health care planning that is driven from Toronto out into the regions is not going to facilitate democracy and community involvement. We'd ask you to rethink that and to limit the minister's power around accountability provisions and compliance directives. We'd ask you also to ensure that you, as a government, are accountable to the people of Ontario by delivering on the commitments you made with respect to P3 hospitals and private MRI-CAT scan clinics, which are hugely significant expenditures in the grand scheme of things.

Sorry to tirade you.

The Chair: We have three minutes remaining. Perhaps each party will have time for one very quick question.

Mr Klees: I rather enjoyed the tirade, and I hope the members are listening very carefully. A lot of promises that were made were broken. This is just one of them, but it obviously impacts you very much.

With regard to the sweeping powers you refer to that are still left in this legislation, I agree with you on that point. At least when health care reorganization or restructuring takes place now, it has to be initiated by the administration and approved by a community board that currently is empowered. What this legislation does is take that authority away from the community board and local administration and rest it with the minister. Can I ask if you have a specific amendment you would propose to deal with this accountability issue?

Mr Hurley: We'd like to see the accountability provisions withdrawn and rethought through a process of true consultation with the many people who are involved, either as citizens, as caregivers personally, as people who work in the system, or as people who care about it in terms of what a truly accountable health care system would look like. We'd like a process, really.

Ms Shelley Martel (Nickel Belt): I just want to focus on the P3s and the public-private MRIs, because as I see it, money that should be going into patient care ends up going into the pockets of for-profit providers. I'm particularly concerned about the P3 hospitals, because significant amounts of money will have to come out of the operating budgets of hospitals to pay what essentially is a mortgage. Where do you see that going when the hospital is forced to use operating dollars that should go to patient care to pay off what essentially is a capital cost, ie a mortgage?

Mr Hurley: It's no shock to anybody in this room that hospitals are already operating on the line. Our accountants estimate that it's going to cost an extra 14% on the borrowing, and an extra 15% to 25% a year would be the profit surcharge, according to the British Medical Association Journal. That money is going to come out of operating budgets, and that's going to cause downsizing of both staffing and beds at a time when the Ontario population is aging, growing and demanding more acute care services. So we're going to lurch into crisis. Britian addressed it, as you know, Ms Martel. They were forced to introduce extra taxes to make up for the shortfalls and the money flowing out of the system.

The Chair: A quick question, Mr Leal.

Mr Jeff Leal (Peterborough): I'll make it quick. Mr Hurley, I'll give you a real-life situation. Down in Belleville, money was provided to the hospital to hire nurses or other front-line staff. One of the reasons I think the accountability agreements are necessary is in order that we would make sure hospitals take that money and hire the front-line staff we need. I just want your comments: Instead of hiring front-line staff, they gave a 10% raise to their senior administrators. That's why I think these accountability agreements are needed, to make sure that money is allocated to hire your people. This is what happens.

Mr Hurley: There's no question that hospitals are not very democratic institutions.

Interruption.

The Chair: Don't worry about it. Keep going, sir.

Mr Hurley: With respect, how would you get institutions to conform to directions that were seen as being socially appropriate or important; in this case, hiring more nurses? There's got to be a process that involves people in the community being involved in that institution and having some ability to give it direction. Hiring more nurses is not only thought to be positive by the Ontario government; many citizens would agree with you there.

The Chair: We have run out of time. I would like to thank you for your presentation. I wish you a good afternoon.

Mr Hurley: Thank you.

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ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 348

The Chair: Next we have the Ontario Public Service Employees Union, Local 348, Lakeridge Health Corp. Welcome. As I said to the last deputants, you will have a 15-minute time period to use as you wish: if you want to use it for the full time of your presentation or we will have questions after. Also, make sure that you state your name for Hansard.

Ms Patty Rout: Thank you. My name is Patty Rout. I'm the chair of the OPSEU health care professionals. I have several chairs with me from the different divisions of health care in this province, of which we make up 29,000 people. To my left is Tony Morabito; he's the chair of mental health. To my right is Sue McSheffrey from community care. We also have Jamie Ramage from ambulance, Debbie MacDonald from long-term care and Jill McIlwraith from support hospital care.

I want to thank you again for allowing us to make this presentation. I was here maybe a month or so ago and didn't actually have an opportunity to have questions presented to us, so I'm hoping there'll be time for that today. We wanted to have the opportunity to talk with the committee once more about the challenges that face the workers in the health care system, to reinforce our concerns about what is happening in our health care sector and to talk about what a real commitment to medicare would mean.

The past round of hearings with respect to Bill 8 led to government amendments that dealt with our concerns about the power of government to open and change collective agreements. But this government has not dealt with P3s and it has not dealt with the MRI-CT situation, and this government promised that they would.

Bill 8 gave the Minister of Health broad powers without any form of democratic control and the right to order fundamental changes in our health care system with little or no public consultation, procedural safeguards, transparency or other checks and balances. Bill 8 essentially paves a legal path for the government to restructure Ontario hospitals through privatization, cost containment and the contracting out of services. Ministerial power can be used to force hospitals to reduce or consolidate services or to contract out health care services to private companies, and that's why we are afraid of Bill 8. It has little concrete initiative to protect the principles of the Canada Health Act or enhance medicare, despite its title.

Still missing from the bill are the following: concrete initiatives to apply the principles of the Canada Health Act; a prohibition on P3s and the return of private diagnostic clinics to hospitals to stop privatization; a health council that is an objective body with a democratic appointment process; the prohibition of for-profit providers; a requirement to report and make recommendations on how the health system meets the principles of the Canada Health Act; and the provision for accountability of health institutions and the health minister to the people of Ontario, which would include democratic control, meaningful public input and consultation, transparency and disclosure and whistle-blower protection.

We want to see a stop to the queue-jumping for so-called medically unnecessary procedures and to stop the fees and charges and the erosions that are due to delisting. We would like to see a stop to block fees, the boutique medicine and the extra billing, and support for progressive primary care reform. We want a stop to the delisting of medically necessary services and the relisting of those that have been removed, and a comprehensive range of medically necessary services to meet the population need, as per the Canada Health Act.

I would like to say a few words about the shortage in recruitment and retention. I'm a medical technologist, and there are very few of us left in this province. We are becoming kind of extinct. We have been unable to get people to come in to our profession for various reasons. This government recently announced lots of money for nurses, but not a lot of money for the rest of the health professionals who belong in this province, and it upset many of the professionals I work with. We would like to see this government address those people who are just as important to the health care system as doctors and nurses.

I'd like to open up for any questions at this point.

The Chair: OK. We have about six minutes—actually, seven. We will start with the third party.

Ms Martel: Thank you for being here again today. I've seen some of you before.

You are right to be worried about the compliance directives, because those can be unilaterally imposed by the minister, and it is very clear that those could be used to force the amalgamation or the contracting out of services, getting at jobs from some of your members in a backhanded way, so you should be worried about that.

I wanted, however, to focus on privatization, because you made it very clear that the bill should prohibit P3 hospitals; the bill should guarantee the return of MRIs and CAT scans now in the private system to public hospitals like the government promised they would before the election.

What is it that concerns you about privatization of health care services?

Ms Rout: Especially in the MRI-CT area, I have watched, with experience from my particular hospitals, where MRI techs have been pulled out of the hospital system to go into the private sector. They've been offered great deals of money to do that; they have better shifts, they have better weekends. Consequently, what has happened in our particular hospital and others: The lines have become longer in the hospitals.

The travesty of it is that people who have to come to the hospital for an MRI because they may have a brain tumour are in a longer line now than they ever were before. You cannot be done in a private clinic; you have to go to a hospital to have it done. So people who break their leg, or feel they might have broken their leg, and demand that they have an MRI go to a private clinic and get it the next day, and the person who has the brain tumour, whom you'd like to get treatment for as quickly as possible, has to wait six to eight weeks in order to get an MRI. I'm particularly afraid of that.

We're very concerned that there's to be privatization of labs. Right now there's a huge reform going on that seems to be built around Bill 8. We have had many presentations made to us about how it costs less to do services in the private sector, but there are many indications across the country that that's not true and that it actually costs more money, so why would you even look at a system like that?

Ms Sue McSheffrey: I work in community care. I met you in Ottawa, actually. This is my trip to Toronto. That's still a concern of mine. It's my specialty; I am a physiotherapist. I've seen that we've given less service for a lot more money since the system got privatized. And there's less accountability, because those private corporations are not subject to the same disclosure rules as the public sector. So you can't get information about what the profit margins are, what the cost of doing these RFPs is and even if there are extra costs going into wining and dining to get those contracts.

Mr Ted McMeekin (Ancaster-Dundas-Flamborough-Aldershot): I'm intrigued by your presentation. Just by way of background, I have been involved in health care for many years on a district health care council. My spouse is a medical doctor working in a community-based, multidisciplinary clinic and I'm fascinated with the whole area of primary care reform. It has not been taken up; I think 4% of the doctors have signed on to the voluntary route.

Let me ask you very directly, because I have a bias here, how you would respond to a government initiative that would see preferential funding provided to community-based, multidisciplinary, front-line health care service. If we had a choice between funding options and we decided to be preferential in our approach to actually provide greater funding for those who buy into that model, how would you react if the government were to take that kind of policy initiative?

1630

Ms McSheffrey: For myself, as a community health care worker at the primary care end, I think it would make a lot of sense. It's where you get the best bang for the buck, particularly around family medicine. This move toward having no family physician and going into small hospital emergency departments to see a doctor is very wasteful, and so is not having a doctor, because you have this sort of shopping around: "Well, he didn't say the right thing; I'll go somewhere else"—the whole part of consumer education around health care and the fact that with best practices maybe what happened 10 years ago isn't the best treatment now for that particular disorder. Personally, I think it's a very good way to go.

Mr McMeekin: So you would favour that kind of approach.

Ms Rout: Yes, I would agree.

Ms McSheffrey: Yes.

Mr McMeekin: I appreciate that. That's very helpful, because we've got some difficult choices to make, and that may be one of them.

Mr Klees: Thank you very much for your presentation. Do you feel let down by this government after all the expectations that they raised with you in terms of doing away with P3s and doing away—in fact, I just did an interview this morning with our local media. The local member was very strong on condemning the private MRIs in York region, for example, and the fact that they're still there. It's very obvious that the government has changed its position on that.

As front-line workers and as an entire profession, no doubt this was a key for you in terms of lending your support to this political party. Perhaps your profession was, because of—you say you have some 20,000 across the province?

Ms McSheffrey: Some 29,000.

Mr Klees: That's pretty substantial. When you take a look at the various ridings, in a number of ridings there is only one with 500 or 1,000 votes. Your profession may well have made the big difference between these folks being in government or not. Yet you've been betrayed on this issue. Is that how you feel? I'd just be interested in your thoughts on that.

Ms Rout: Yes, we definitely do. It's probably the first time I can recall that our members have gotten behind something during an election. They very clearly wanted to see MRIs and CTs stay in the public system. I don't think contractors should decide who's going to get the health care and who isn't, and we don't think they should be able to pay $300 or $400 more to somebody so that they can put it in their pocket rather than putting it in the system.

The other thing is, we have such huge shortages, that has just made the shortage worse. At work, it has made the line longer; it has made more complaints. It's difficult. It's like an assembly line—if anyone has been to an MRI room. This government said they would look after it. They promised it and they haven't done it. On a P3 level—

The Chair: Very quickly. We have half a minute.

Ms McSheffrey: OK. I just wanted to say that the feeling of betrayal is the worst thing of all, because we really believed that this government would make a

change. It has added to this distrust of government in general and elected officials, which is outrageous. You were elected on something that you said you would do. You have to do it; you really do.

The Chair: Thank you very much. We've come to the end of the 15 minutes. I would like to thank you for your presentation and wish you all a good afternoon.

MARC SIMBROW

The Chair: Next we have Marc Simbrow. I'd like to welcome you. As I indicated at the beginning, you will have 10 minutes for your presentation. If you do not use the full time for your presentation, we will have questions, and we will be starting with the government side. So you have 10 minutes.

Mr Marc Simbrow: Yes, sir. My name is Marc Simbrow. I would like to thank you for inviting me back again to address Bill 8. It is an honour, once again, to participate in open government. We have an equal health care system here in the province of Ontario, which is vital to every Ontarian.

I would like to ask all honourable members to thank every nurse here in the province, as today is nurses' day. Of course, with their hard dedication, that is something that we should never forget about.

Excuse me for coughing. My hay fever isn't fun.

As I was saying, where would we be without them? The nurses work so hard. Physiotherapists facilitate a faster recovery period; they help speed up the recovery period. I feel that they should remain on OHIP. Physiotherapists help your hands, your back and everything else. They help in conditioning those who really need it. Without physiotherapists, if you're injured, then it would be very hard to recover from this.

I have been following the debate very carefully, and there's one thing I must say. I have heard the nurses talking positively about health care and that change is coming for the better; they want to work. However, there is fearmongering going around. This must not happen, because if it does, then we'll get the nurses scared, we'll get the doctors scared, we'll get the public scared. That is not Ontario.

I'm sure that we all have different ideas on how health care should be run. That's fine, but fearmongering must not take place. If it does, then this is going to hurt the public; it will hurt the nurses, the doctors. What would happen if the nurses started looking toward the USA? A lot of them have stopped going to the USA, saying, "I want to stay in Ontario."

I also gave all honourable members—I picked this up on my computer the other day. It's called the Canadian Physiotherapy Association mobility quiz, which I gave to every honourable member.

I would like to thank you kindly for inviting me to speak to all the honourable members.

1640

The Chair: Thank you very much. We have four minutes remaining. We'll split the time, starting with the government side.

Ms Monique M. Smith (Nipissing): I'd like to thank you very much for coming today and for presenting to us. Thank you for the handouts you've provided, but we don't have any questions this afternoon.

The Chair: OK. We have the official opposition.

Mr Klees: Thank you very much for coming. I will do the quiz. What do I do with it when I'm done? Is there a score here?

Mr Simbrow: Yes, Mr Klees, there is. One is, of course, for the females and one is for the males. If you take a look on—let's see.

Mr Klees: Maybe while you're looking, I'll figure out which one is mine. But you say here—

Mr Simbrow: Here we go. If you—

The Chair: Half a minute on this. That's what's remaining.

Mr Simbrow: Mr Klees, right toward the end, there should be four pages. You're going to see number 4 to number 9. That will say "bending," "kneeling" or "stooping."

Mr Klees: Yes, I see that.

Mr Simbrow: Then right under that, you add your score.

Mr Klees: OK. Thank you very much.

Ms Martel: This is the second time that you've come to visit us, so I don't have any questions but I do want to thank you for taking the time to come and participate in the public hearings.

Mr Simbrow: Thank you, Ms Martel.

The Chair: Thank you for your presentation this afternoon. On behalf of the committee, I would like to wish you a good afternoon.

Mr Klees: Chair, while the next person is coming up, I think every member should do this quiz and submit their scores to you for grading, just so we know where we all stand on the mobility scale.

Mr Simbrow: Excuse me, Mr Chairman. Would it be possible if Premier McGuinty could have a copy? Maybe he would like to just fill one out.

The Chair: I'm sure we could get a copy to him. Thank you.

Mr Simbrow: Thank you kindly.

ONTARIO HEALTH COALITION

The Chair: Next we have the Ontario Health Coalition. I'd like to welcome you to the hearings this afternoon. As with the other organizations, you will have 15 minutes to make your presentation. Should you not use all the time, we will split the time between the parties. Welcome.

Ms Natalie Mehra: Thanks. I think you have our written submission, which includes who we are, so I won't go into that.

I wanted to start off by saying that we applaud several of the changes that you've made. The one that is important, we think, is the inclusion of the mention of public interest and the changing of "consumer" to "individual," which is symbolic but important. However,

we do have some serious problems that I'd like to draw to your attention, both with the process and the content of this bill as it has been amended.

The first is that on behalf of our membership across the province, this particular set of hearings, which is geographically located in Toronto and very short, really doesn't give them equal access to input this round. So I want to draw that to your attention and hope that you could find a way to open up the process and include people from other areas.

Also, the changes to the bill really seem to reflect the interests of a fairly narrow set of interests, specifically the Ontario Hospital Association. You can see that that's in there, that the Ontario Medical Association's interests are in there, but really, the recommendations made on behalf of patients' interests haven't made it into the amendments of the bill. So I'm going to reiterate at least the key concerns we had regarding the public interest and patients' interests in the hopes that you will hear them this time around.

The bill, in its original form and as in the amended version, actually does not provide any concrete initiatives to protect or enhance the application of the principles of the Canada Health Act. We believe that a bill titled Commitment to the Future of Medicare ought to protect, at least—and certainly, we would hope, enhance—the principles of the Canada Health Act. It provides no concrete initiative to protect or enhance accountability to the users of the health system. I'm not talking about the health system to the minister, but the minister and health providers to patients and the public. It provides no concrete initiative to stop the erosions and challenges to medicare with respect to privatization, specifically two-tier access for so-called medically unnecessary services, increased fees and privatization. As such, we believe the title, Commitment to the Future of Medicare, is unfounded and so are the commitments made in the preamble, although we support them.

Specifically, the government committed to an independent health council. In our original submission, we made some recommendations regarding a process that had both the appearance and the substance of objectivity in the appointment of that health council. We think it's a mistake for the government to be appointing the health council, that there will be the potential for that health council to be viewed as simply political appointees. We think it's important that the health council be seen as objective, and we reiterate our suggestion that you consider something like a tripartite appointment process or some other democratic process for the appointment of the people on the health council.

We also recommended that the health council specifically exclude those people who have a financial interest in a for-profit health corporation or are executives in for-profit health corporations. We see that in the amendments you have excluded executives and board members from not-for-profit hospitals; from for-profit hospitals; from long-term-care facilities, both for-profit public and not-for-profit; and several other types of not-for-profit agencies. But who are not excluded—and this may just be an oversight—are executives and shareholders from for-profit corporations such as pharmaceutical companies, biomedical corporations, private health services corporations etc. For example, we don't see what in the bill would stop an executive or shareholder from Carillion Canada Inc, which is one of the companies bidding on the Brampton hospital project—not yet in the health system, but could be in the health system—from serving on the health council, people who have a direct financial interest in the operations of the health system. We actually believe that these people have more of a conflict of interest than some of the people you've actually named in the amendments, and we urge you to look at that.

Also, given the lofty principles in the preamble to the bill, which we support, and given that this committee has received recommendations from dozens of organizations at the public hearings to this, we find it difficult to understand why the health council isn't, at minimum, charged with measuring how the health system is performing with respect to the principles of the Canada Health Act. It seems that that would be central to this piece of legislation. We don't understand that, so we reiterate that recommendation.

In the accountability language of the bill, we note that the amendments to this section seem to primarily reflect discussions that have occurred between the government and provider organizations. As it stands now, this section is notable for its indifference to the recommendations for improved public consultation, procedural safeguards, transparency and any other checks and balances.

We reiterate our recommendations for improved democratic control and diverse representation on hospital boards. As it stands, hospital boards in this province are largely white people from upper-middle-class backgrounds. They don't reflect either patients or staff in the facilities, and they don't represent communities of colour or other marginalized communities.

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We recommend improved public access to financial information. We recommend a provision for clear whistle-blowing protection. We don't understand how there can be accountability in the health system unless people who speak out are protected. Many health facilities include gag clauses all through them for workers in the facilities. We recommend a stop to the increasing commercial secrecy pervading the privatized sectors of the health system. Try to get financial information about the P3 project in Brampton, which literally covers almost $3 billion worth of public money. You can't get it. Democracy and public accountability regarding the delisting of services; accountability for the health minister and providers to meet population need for medically necessary services—that's what the Canada Health Act is about, and that's what protection of medicare would be about.

Public consultation and input from the people of this province, expressly including the users and workers in

the health system regarding proposed changes and restructuring: We're particularly concerned, since in your committee's debate about this section of the bill, several members from the government talked about the desire to basically order health restructuring. Since this province has already been through one very painful round of health restructuring, which has resulted in unnecessary costs and ultimately a diminishment of the scope of services offered under the public health system, we believe there are thousands of people across the province who actually have some meaningful information and input to share before you engage in another round of this. It's a very dangerous experiment to foist on the health system, especially at this point. So we can't urge you strongly enough to set up a process of open consultation, open discussion and public input before engaging in another round of bottom-line-driven health restructuring.

Block fees: Perhaps it isn't clear to the members that the way these fees work is that they're upfront fees charged by physicians for services. If you don't use the services, you don't get the money back. To think there is a fee for a service is pretty questionable. They're a lot more like a premium or a retainer that you give in order to ensure access, essentially. They're very open to abuse, they violate the principles and the spirit of the Canada Health Act—we actually think they violate the Canada Health Act—and they're being more and more widely used across the province.

We applaud the move in this bill to pull the governance of block fees from the College of Physicians and Surgeons into the hands of the government—we believe that's where it belongs—but we reiterate that these block fees should be banned. They're being abused. We've given you five examples of abuse; there are more. But even when they're not being abused, their legitimate usage is a barrier to service. It's a problem, especially in light of the shortage of access to primary care.

Privatization and two-tier access to care: We really went through this in detail in the last submission. I've copied the recommendations from the last submission into this submission, and I just want to say, in short, that if you want to destroy the public health system, if you want to ensure that the costs are unsustainable, that we'll have to shrink the scope of services in order to continue to afford a health system, then privatize it. If you want to ensure there's a universal, publicly accessible health system in this province, then you must stop privatization of the health system and the insidious commingling of two-tier access for so-called medically unnecessary services, which is completely ungovernable in the health system and which will ultimately destroy the public health system. We can't recommend strongly enough that you stop the privatization of the health system and stop the two-tiering that's happening. It's no accident that there is no public, universal health system in the world that's delivered by for-profit corporations, and we urge you to look at that more closely.

The Chair: Thank you very much. We have four minutes remaining. We'll start with the official opposition.

Mr Klees: I note your recommendations under the accountability section with regard to improved democratic control and diverse representation on boards and governing bodies. I agree with you with regard to the need to broaden representation on our local boards, and that all aspects of our community are represented there. Unfortunately it is true in many cases that often an appointment to a board, a hospital board particularly, is simply seen as a feather in someone's cap for something else they've done.

Having said that, I do believe there's a very important role for the local board, as I think you do. But regardless of who's appointed to the board, under this legislation, if it is passed, that local board has no authority any more, So to ask people to come and give their time to a board, any decision of which can be overturned by the minister at the end of the day because the minister chooses to do so—how motivated would people be to participate on that board? I'd be interested in your thoughts on that.

Ms Mehra: I know about the campaign of the Ontario Hospital Association regarding this, and I understand what you're saying about the minister's powers to basically order what he wants in the system—to order restructuring, which is what I think this bill is set up for.

Nonetheless, I think defending the status quo is a mistake. These hospital boards are not representative of the community. In fact, many of them hold closed-slate elections, and many of them don't actually involve or accept all community members as members of the corporation. That needs to be changed. We believe that accountability actually happens from them down, not up.

The Chair: Ms Martel.

Ms Martel: Thank you, Natalie, for being here today. I just want to focus on the P3s, because both the Ontario Health Coalition and Brampton have spent some time looking at what documents are available, despite everything that's scratched out on many of them.

What are your concerns with what has been seen in the disclosure of the documents with respect to the Brampton hospital in terms of increasing costs or in terms of what the private corporation will have control over, which isn't just the capital financing any more but actually some of the operations of the hospital?

Ms Mehra: We're trying to do an analysis of the costs, and the costs appear to be much, much greater than any of us imagined in the hospital. That's one concern—the borrowing rate is very high.

We're also concerned because in order to win changes to the deal, it looks like the government provided additional incentives for the corporations, including the ability to build for-profit, ie independent, health facilities on the property. The government ran against for-profit clinics but has actually added into the deal what wasn't there under the previous government, as far as I could find, which is allowing the building of more for-profit health facilities on the land.

So the costs are one problem. The second problem is the deepening privatization, the loss of public control over the facility, the fact that it doesn't comply with the

Public Hospitals Act and the fact that it threatens to kick in the trade agreements and open up the whole system.

The Chair: Next, from the government side, Ms Smith.

Ms Smith: Thanks, Natalie. We're glad you're here today. When you talked about the council, you stated, "We find it difficult to understand why the health council is not mandated, at a minimum, to report on the performance of the health system with respect to the principles of the Canada Health Act."

When I look at the functions of the council, it's to:

"monitor and report ... on,

"access to publicly funded health services,

"health human resources in publicly funded health services,

"consumer and population status, and

"health system outcomes; and

"to support continuous quality improvement."

Other than those things, what do you think is not being reported on by the council under the Canada Health Act?

Ms Mehra: The principles of the act are portability; comprehensiveness—that the system is supposed to provide a comprehensive range of medically necessary services, so how do the range of services offered in Ontario meet population need for medically necessary services; universality—access should be universal, accessibility etc; public funding; and it should cover all medically necessary physician and hospital services.

So delisting ought to be reported on by the council; the non-coverage of medically necessary services; the comprehensiveness of the system, which is shrinking; and the accessibility and universality of the system.

The Chair: We've come to the end of your presentation. I would like to thank you for presenting and wish you a good rest of the afternoon and evening.

Ms Mehra: Thank you.

1700

ONTARIO ASSOCIATION OF OPTOMETRISTS

The Chair: Next, we have the Ontario Association of Optometrists. Make yourself comfortable. You have 15 minutes for your presentation. If you do not use the full time, we will divide it among the three parties.

Dr Shirley Ha: Thank you for the opportunity to present before the committee this evening. As you may recall, this is our second appearance. My name is Dr Shirley Ha. I'm an optometrist, practising in St Catharines, and I am vice-president of the Ontario Association of Optometrists. With me today is Dr. Christopher Nicol, who is also an optometrist with a practice in Bolton. Dr. Nicol also acts as a policy consultant to the association.

The Ontario Association of Optometrists is a voluntary professional organization representing over 1,000 optometrists. We are specifically identified in Bill 8 as the organization representing optometrists for negotiation purposes.

The OAO again welcomes the opportunity to provide the committee with our comments and opinions on Bill 8, including comment on the proposed changes. Generally, we support the bill and the amendments proposed by the minister. We continue to support the establishment of the Ontario Health Quality Council, and we are now satisfied that the proposed changes to part III clearly exclude optometrists. We are pleased that part II, section 14, has been changed to remove the reference to uninsured services.

Notwithstanding these changes, there continue to be some areas that create problems for us. The OAO is particularly concerned with part II of Bill 8, as it relates to payment for an insured service. Optometrists, as well as physicians and dentists, are defined as "practitioners" for the purposes of the Health Insurance Act and the Health Care Accessibility Act.

The OAO regrets that, unlike the Ontario Medical Association, we were not invited to participate in redrafting the legislation. We are, however, prepared to use this opportunity to identify our concerns to the committee.

I'll now go over the funding history of insured optometric services. Optometrists are now providing the majority of primary eye and vision care in Ontario. More than three million patients a year visit their optometrist for comprehensive eye examinations, including the diagnosis of eye diseases and the management, in cooperation with physicians, of the ocular manifestations of systemic diseases like diabetes and hypertension.

These diagnostic services, for the most part, are considered "insured services" in the Health Insurance Act. Although part II, section 10, of Bill 8 empowers the minister to enter into agreements with the OAO to "provide for methods of negotiating and determining the amounts payable," there is nothing in this section that compels a negotiated agreement or provides for any recourse if negotiations break down. Consequently, a practitioner may never obtain an increase in the amount payable for an insured service despite increases in cost-of-living and practice expenses. Furthermore, section 9 prohibits a practitioner from charging more than the payment established by OHIP.

These two sections in the Health Care Accessibility Act place the OAO at a considerable disadvantage when attempting to negotiate a fair and equitable fee for primary eye and vision care services in Ontario. Consequently, the current fee payable to an optometrist for a comprehensive eye examination has not increased in 15 years. This fact has led to a crisis situation for optometrists and their continued ability to provide quality eye care to the public of Ontario.

During those 15 years without an increase, there have been significant advances in technology and examination standards required of optometrists to diagnose eye diseases and conditions. As independent practitioners, optometrists must assume the costs of these expanded services and new instrumentation. Presently, the fee for the insured service, now unchanged for 15 years, no

longer covers the cost of providing the service, and the profession is concerned about its ability to continue maintaining the standards of care established by the regulatory body, the College of Optometrists.

As the population of Ontario grows and ages, the demand for optometric services will only increase and the required capital investment in new instrumentation will become more and more difficult for optometrists. Optometrists should not be unfairly penalized for ensuring that they provide the highest standards of care to their patients. This sacrifice is not being asked of other health care practitioners.

Currently, optometrists are operating without a signed funding agreement with the provincial government; the most recent one expired March 31, 2000. Fees have not changed since 1989. When one considers inflation, optometric fees in Ontario have not only been steadily declining over the past 15 years, they are now the lowest in Canada.

The OAO is a relatively small organization with limited resources. We have no leverage in the negotiation process, especially when the legislation compels us to accept a fixed fee without recourse to conciliation. Without any provision in the legislation to require either some form of mediation or arbitration, the Ministry of Health and Long-Term Care can continue to force optometrists to accept a completely unrealistic fee.

Under the present Health Care Accessibility Act, optometrists are explicitly prohibited from billing in excess of OHIP fees, or balance-billing, and must accept a fixed payment for any and all services defined as "insured services" by OHIP. This is also the case for physicians and dentists. However, physicians, unlike optometrists, have had periodic increases in amounts payable for insured services from OHIP since 1989. Very few dentists receive payments from OHIP. Non-designated practitioners, such as chiropractors, can balance-bill and are able to offset rising practice costs with private fees. This inability to balance-bill, combined with the ministry's refusal to accept mediation in the negotiation process, has prevented optometrists from maintaining a sufficient income to adequately cover practice costs.

I'll go over some of the proposed solutions the OAO is putting forward.

With the proposed changes in Bill 8, optometrists will no longer be specifically designated in the act itself as practitioners who cannot balance-bill. The proposed changes in sections 7 and 9 of part II will provide an opportunity to permit the designation of optometrists as non-designated practitioners for the purposes of accepting payment. The re-designation to non-designated practitioner by regulation would provide some relief for optometrists from the draconian aspects of the act.

The OAO supports part II, sections 7 and 9, of Bill 8. Furthermore, the OAO asks the committee to recommend that an optometrist be considered a non-designated practitioner for the purposes of the act, at least until such time as outstanding funding issues have been resolved to the mutual satisfaction of both the Ministry of Health and Long-Term Care and the OAO.

While part II, section 10, authorizes the minister to enter into an agreement with the OAO for methods of negotiation, the type of agreement is not specified. Having established in section 9 that an optometrist must accept payment from the plan as full payment, there is neither a requirement for the ministry to participate in the negotiation process, nor is there a description of the type of agreement for negotiation. This section provides no recourse for the OAO in the event that the ministry either negotiates in bad faith or refuses to negotiate entirely.

The OAO recommends that part II, section 10, of Bill 8 be amended to permit some form of remedy for identified associations, should the fee negotiation process fail to result in an agreement. These protections could take the form of compulsory arbitration or at least mediation. Additionally, the minister should have some responsibility to create an agreement for a fair method of negotiation instead of doing so only at the minister's discretion.

In conclusion, we are pleased with the proposed amendments to the bill and we generally support the purposes of the legislation. Our recommendations to the committee, if accepted, will not only establish a fairer negotiating process for the associations referenced in part II, but will also allow the government to change the basis upon which optometric services are funded. These changes will immediately address the serious inequity of a 15-year funding freeze.

The Chair: Thank you very much for your presentation. We have six minutes remaining. We'll start with the third party.

Ms Martel: Thank you for being here again. I want to look at your proposed solutions, because we've had this discussion before and I just want to put this on the record. I remain very concerned about a proposal that in effect would provide for you to charge a fee. I understand why that proposal is there, but I've expressed to you and I'll put on the record my concern about what that will do for access.

I'm much more interested, if I might, in a proposal that would have some kind of arbitration process, which could be listed in the bill, that would allow your concerns to be addressed. I would be supportive of a recommendation, or a provision in the bill, that would allow that to happen. I think that would clearly point out the need for a fee increase and would at the same time protect as much as possible people's access by not having to resort to an additional fee being paid. I just wanted to put that on the record.

What would happen if recommendation number 2, which I gather would be a form of remedial action, were acceptable? Would that essentially deal with the concerns you have about having a fair way to deal with what has been a lack of a funding increase for 15 years?

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Dr Christopher Nicol: That would certainly address that problem. As you know, negotiations have broken

down now, and there's no requirement for the ministry to enter into negotiations again. So in lack of any impetus to create that negotiation or discussion, we have no recourse. We continue to have to accept a fee that's 15 years out of date. So if there was something that would compel negotiations to occur—and even after that, if negotiations broke down—something that would allow recourse to the association to occur—that would help us. Right now we have nothing.

The Chair: Thank you very much. The government side.

Mr Brad Duguid (Scarborough Centre): I want to start off by thanking you for joining us again here today. Thank you for your support for the amendments and your support for the purposes of legislation and for the bill. It's much appreciated that you've taken the time to come here and share your issues with us.

In the minute or less that you have to answer, could you just give us a little bit more in-depth comparison on how—your fees have been frozen for 15 years—that compares to the average fees for other practitioners, doctors and others in different professions?

Dr Nicol: I can't speak for other professions. Certainly, dentistry's fees have increased. Physicians' fees have increased. They have negotiated contracts with OHIP for fee increases continuously in the last 15 years. But because this legislation binds us, we have no way to obtain a fee increase unless the government decides to give it to us. I can't speak for other professions, but obviously other professions have increases in 15 years. Most people have increases in their fees in 15 years.

Mr Duguid: Is it the same across the country, in terms of other provinces? Are you familiar with the field in other areas?

Dr Nicol: Optometric services are funded differently in other provinces. In Ontario, we're the only province that continues to insure routine eye examinations for adults. Other provinces fund differently. Some provinces permit balance-billing: A fee is paid for the services through the provincial health insurance program, and then fees are also obtained from patients privately. But notwithstanding that, the general fee for a basic eye examination is higher in all the other provinces than we obtain from Ontario.

The Chair: Thank you. The official opposition.

Mr Klees: Thank you for your presentation. I'm interested in what your response would be to Ms Martel, who suggests that to allow you the latitude to charge a fee would somehow impact accessibility. I'd be interested in your thoughts on that.

Dr Nicol: All I can say is that it occurs in other provinces. It occurs in Ontario with chiropractors. Patients can access chiropractors—and do all the time—and they're permitted to balance-bill, and other professionals as well.

It's an opportunity for us to be able to maintain a practice, if we can do that. Right now we can't. So it's an option that we propose, and if accepted, it would alleviate the problem that we have.

Mr Klees: I think you're between a rock and a hard place here, because on the one hand, you're subject to a minister who is saying, "I'll negotiate an agreement with you, as long as the agreement is exactly what I expect and want it to be." He can drive you out of business. On the other hand, you're saying, "Well, if you're not going to give us what we need, at least allow us to survive." That is how I understand your submission here, which, for the record, by the way, I support. I think your request is a very reasonable one. I would hope that the minister would hear you on this.

The Chair: There are about another 20 seconds. Any comments? I would like to thank you for your presentation this afternoon. I appreciate it and wish you a good evening. Thank you.

CENTRE FOR ADDICTION AND MENTAL HEALTH

The Chair: Next we have the Centre for Addiction and Mental Health. Welcome, and make yourself comfortable. As with the other presentations, you have 15 minutes, and should time remain, we'll spread it between the parties. Welcome.

Dr Paul Garfinkel: Thank you. I'm Paul Garfinkel, president and CEO of the Centre for Addiction and Mental Health. I'm accompanied by Gail Czukar, vice-president of planning and policy. Thank you for giving us the opportunity to address you today as you consider Bill 8.

The Centre for Addiction and Mental Health, CAMH, had the opportunity to speak to this legislation previously. As you know, we have various mandates. These include a provincial responsibility for care, research, public policy and health promotion and prevention. We've made it a priority to promote positive change in government policy for people with mental illness and addiction, and to ensure that their issues are considered and responded to. It's only appropriate that this deputation take place during Mental Health Week, a week that is designated to promote good mental health and raise awareness about mental illnesses.

The impact of mental illness on our society is staggering. As a government of Ontario press release noted yesterday, one in five of us will experience a mental illness in his or her lifetime and 3% will suffer profound and persistent disablement. Mental illness accounts for 14% of illness-related disability and is the largest cause—about 36%—of short-term disability in the workplace. Despite these facts, mental health and addictions services are largely absent from mainstream health care reform and are not explicitly recognized as an integral part of our health care system. It's on behalf of Ontarians suffering from severe mental illness and addictions, and on behalf of their families, that we appear before you today.

When we addressed this standing committee in March, we made a number of recommendations. Today, in our limited time, we're going to focus on two main points

that bear most directly on Ontario's mental health and addictions community.

Specifically, we recommend that you amend the preamble of Bill 8 to acknowledge the needs of Ontario's citizens who suffer from mental illness or addictions, and to recognize the importance of mental health and addictions services in Ontario's publicly funded health care system. These simple amendments would go a long way to demonstrate that Ontario's elected representatives not only are interested in talking about the need to support the mental health community but are willing to support that talk with actions. After years of neglect, our community requires explicit recognition.

We have also recommended that the government of Ontario proceed with the creation of a health quality council, providing that this council's mandate include studying and reporting on the mental health and addictions sector. Again, we endorse the recommendation put forward by the Canadian Mental Health Association last spring that members of this council include experts in family issues and physical and mental health provision, as well as in patient and consumer issues.

When we appeared before this standing committee in March, we were heartened by the comments of committee members in support of the mental health and addictions community. Needless to say, we were extremely disappointed that the government did not introduce the necessary amendments to the preamble. We were further discouraged when a straightforward amendment to the preamble was voted down by the committee.

As I mentioned to you earlier, this is Mental Health Week, and this week you have another important opportunity to amend this legislation, an opportunity to demonstrate the strength of your convictions and support of the role that mental health and addictions services plays in Ontario's health care system.

The other issue I'd like to briefly comment on is accountability. In terms of the provisions of this legislation to establish an accountability framework, CAMH continues to support the initiative to identify opportunities for greater accountability within the health care sector. We were pleased with the amendments that will result in accountability agreements between hospital boards and the government. We're also pleased that Bill 8 now provides for consultation on regulations, and ask that assurances be given that mental health stakeholders are included in these consultations.

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We emphasize the need for the government to work collaboratively with health care providers to develop unique indicators and measures of accountability that meet the needs of the mental health and addictions sector.

Whatever approach the government takes to develop the proposed accountability agreements, it must be flexible to accommodate the special needs of the mental health and addictions sector. Indicators and measurement tools developed for general acute care service delivery have a very limited application to us. Length of stay may mean one thing in the acute care sector; it may mean something very different when we are so tied to community supports for our patients.

On behalf of the communities we serve, CAMH hopes that, as you consider further amendments to this legislation, you embrace the opportunity before you to make a meaningful statement to demonstrate that you are listening and that you are acting to tackle stigma, and respond to the need to support our mental health and addictions community.

Thank you for the opportunity to speak to this legislation. We welcome any questions you might have.

The Chair: Thank you very much. We have nine minutes remaining. We will start with the government side.

Ms Smith: Thank you very much for coming in to speak to us. I was aware that it was Canadian Mental Health Week because I did a statement on video that I think they're playing on our local cable station at home. "I'm happy to participate and help in making connections"—that's the first part. I can't remember more. It was a couple of weeks ago now. But thank you for being here.

I was interested in your comments about the accountability provisions and some need for change there. I'm a bit unclear from your submissions—perhaps they're in the attached appendix—about what you are looking for with regard to changes on the accountability side, other than, I understand you're looking for flexibility in how to come to accountability agreements because your measurables are different from those in acute care settings. Is that specifically—

Dr Garfinkel: That's the key issue.

Ms Smith: OK. Was there anything else on the accountability side that you—

Dr Garfinkel: I think the idea that now it's a board agreement goes a long way to what the previous concern was. Now we're really saying, be very, very thoughtful in addressing the actual agreement and individualize it for each sector.

Ms Smith: Right.

Dr Garfinkel: Hold us accountable for what is really important in our sector.

Ms Smith: Right, and for measurables that are attainable.

Dr Garfinkel: That's correct.

Ms Smith: OK. I believe my colleague Ms Wynne had a question as well.

Ms Kathleen O. Wynne (Don Valley West): Just briefly, thank you for coming. The way the preamble is written, it's not exclusive of mental health—it doesn't exclude mental health. I think the concern was—and I just wanted to check this out with you—that if we start listing physical and mental, what about emotional? I think the issue is to be broader rather than narrower so as not to exclude. I mean, we are talking about health as it's covered currently. Can you respond to that?

Dr Garfinkel: I think it's a really good comment. We feel our field has been stigmatized for so long that it does need a special—

Ms Wynne: I understand.

Dr Garfinkel: The Canada Health Act specifically excludes our patients. Sometimes when you've been down so long, you do need that extra leg up. But I understand your point.

Ms Wynne: I understand that and I am sympathetic. That's why I'm trying to struggle with it. It's really a societal issue, isn't it: What do we mean by "health"? I think that's why the preamble is written this way.

The Chair: We move to the official opposition.

Mr Klees: Thank you very much for your presentation today. I notice in your appendix you make reference to the importance of pharmacare to mental health and to the health care system. I would just ask you to comment, perhaps a little more specifically, relating to that. Some of us have had a concern that there really isn't anything substantive in this bill that provides direction relating to that. Just how important is that to you?

Dr Garfinkel: The field of treating mental illness and addictions has changed dramatically in the last 15 years. It's highly therapeutic. It's highly successful in helping people through a broad range of psychological, social and pharmacological means. The pharmacology revolution has been extremely important for the group of people with chronic and persistent mental illness who would be cared for in our facility. For many of these people, medication stabilizes them to the point where they are able to live successfully in the community.

Studies that have been done out of Montreal show that even when it's a relatively modest charge to our patients, the compliance falls dramatically and readmission goes up significantly. So we pay for it anyway. We might as well pay for it and have people have a very good quality of life.

Mr Klees: We'll certainly take note of that, and I trust that the minister will hear your message, because it's another of these circumstances where the investment up front is, first of all, the appropriate thing to do for the system and, more importantly, for the people who are being treated, and it saves us considerably in the long term. I appreciate your comments.

The Chair: Ms Martel.

Ms Martel: Thank you for being before us again. I probably will make a comment; I don't really have a question, because the presentation was straightforward.

Because you know there was a vote, I'm assuming you read through the transcript from the clause-by-clause. So you know I didn't put in any amendments because I didn't think the bill could be fixed. Secondly, to her credit, Ms Witmer did. She's not here today, so I want to put on the record on her behalf that she did move an amendment with respect to inclusion of "mental health" in the preamble, and that was voted down by the government majority.

I think it is a matter that will be raised again when we do clause-by-clause and I think there is a way for us to include this in the preamble, and we should do that. So I trust that since you're here again and raising it again, there will be reconsideration by the majority and we will look for a way to have this included in the preamble.

The Chair: Thank you for your presentation this afternoon. Have a good evening.

CREDIT VALLEY HOSPITAL

The Chair: Next we have the Credit Valley Hospital. Welcome to the hearings. When you make your presentation, if you'd state your names for Hansard it would be appreciated. You have 15 minutes. If you don't use the 15 minutes, we'll have questions.

Mr Norm Loberg: Thank you, Chair and members of the committee. Good afternoon, or perhaps good evening, as the case may be.

My name is Norm Loberg, and I'm chair of the board of governors of Credit Valley Hospital. With me today is Barbara Clive, our chief of medical staff, and Wayne Fyffe, our CEO. We're here today in the spirit of co-operation and shared responsibility.

Our board knows our hospital must be part of a health care system that is accountable to the people of Ontario, with access to high-quality health care. Our board is composed of a high-energy group of men and women, chosen for their particular professional skill set to advocate on behalf of our patients and their families. Our board members have gone through a rigorous application and interview process before being elected as members of our board of governors. Our shared commitment is to provide quality, compassionate health care to the growing communities of Halton and Peel through patient advocacy and accountability.

We therefore support the principles in this bill. We are pleased that many of our previous concerns have been addressed in the revisions at second reading, and we thank the minister and you as well. We remain concerned, however, about several aspects of the bill: first, the potential for arbitrary action by the Minister of Health; and second, our inability to advocate for the people in our community to have reasonable access to high-quality care.

In our submission to you on February 24, we asked that section 27 be deleted because it undermines the trust between boards and their CEOs as well as boards and government. We ask again that sections 26 and 27 be reviewed. The suggestions made by the OHA yesterday would eliminate the need for the proposed control mechanisms in sections 26.1 and 27.

Since you've heard from so many boards and CEOs already, we thought we would ask our chief of medical staff to comment on the importance of this bill from her point of view. Although we, as members of the board, feel we represent our community, physicians are closest to the patients, their concerns and their needs.

1730

Dr Barbara Clive: Good afternoon. I am a geriatrician. I care for some of the most vulnerable people in our community.

Accountability in health care must be about patients, meeting their needs and going beyond the black and white rules of legislation in order to better provide care.

That's the human element of running the business of health care. Rules and regulations set parameters, but the human element—the patients—require flexibility. Just as we, the caregivers, have taken a sworn oath to provide the best health care within our abilities, the board is accountable to the people in our community to provide the care they require.

As caregivers, we must advocate for our patients, and that is why I am here today. I do not believe Bill 8, in its current form, will allow us to effectively advocate for our patients.

The Public Hospitals Act clearly defines public interest. The fundamental problem with Bill 8, from my point of view, is the lack of definition of "public interest." Bill 8 gives the minister the authority to impose his will where "he, she or it"—interesting—considers it in the public interest to do so.

Public interest is all about accessibility. At Credit Valley Hospital, we have a big problem with accessibility. In our hospital, we have 34 stretchers in our busy emergency department. Last week, we had 32 patients waiting to be admitted to an in-patient bed. It is not in the public interest to have to delay emergency assessment and treatment, as well as cancel surgeries, in order to move these patients to an in-patient bed. How can we, as caregivers, and the board members, be held accountable when we aren't given the resources to meet our community's needs?

In 1987, the government announced that it would build an additional in-patient wing at Credit Valley Hospital. At that time, our hospital served a population of about 170,000 people. Today our population has more than doubled, and in 2004, 17 years later, we are still waiting for approval of the new in-patient wing.

Our board has been advocating for "A" wing since it was deferred the first time. Who was accountable? "A" wing is still urgently needed. The board is still advocating because our board believes it is in the public interest to do so, because they are accountable to the men, women and children who need hospitalization.

Let me tell you another story about a real patient. We'll call him Mr Smith. Mr Smith is an elderly gentleman who was born in Ontario, with no close relatives or support. He arrived at the Credit Valley Hospital requiring care without an OHIP number—he had not renewed it for many years. Under the Public Hospitals Act, we cannot deny care to a patient—the human element.

He improved and was ready for discharge. However, he required additional medical care at home or in a long-term-care facility. Without OHIP coverage, he would not be eligible to be admitted to a community care access service program or to a long-term-care facility. In short, our choices were to put him out on the street without adequate medical care or keep him in the hospital and do our best to continue to advocate for his care, which meant getting him his OHIP number.

Was it our job to get him an OHIP card? No. Was it our job to send Mr Smith home to his trailer without support so that a more seriously ill patient could take over his bed? Yes. Did we do it? No. Instead, our employees spent days—weeks—working through the bureaucracy to get Mr Smith his OHIP card. Was it a good use of our staff's time? The fiscally responsible folks would say no. The patient advocates, the caregivers, the CEO and the board of governors, who are accountable to the people we serve, would say yes.

Under Bill 8, the minister could determine that we were not upholding our accountability agreement—not under the current definition of "public interest." Our definition of "public interest," the one in the Public Hospitals Act, tells us we did exactly what we should be doing. The CEO, by condoning this effort to help Mr Smith, was living up to his employment contract or performance agreement with the board of governors. But under Bill 8, he could be seen as contravening his performance agreement with his new master, the Minister of Health. Conversely, in order to uphold his performance agreement with this minister and forgo a penalty or dismissal by the minister, the CEO might have to recommend to the board that we say, "Too bad, Mr Smith. Your time with us is over. It's time to fend for yourself. Out you go."

Mr Loberg: Thank you, Dr Clive.

In conclusion, we at Credit Valley Hospital believe in accountability. We believe in providing consistent, transparent, fiscally responsible quality health care, and that's Bill 8. But Bill 8 still needs work. It needs a clearer, more patient-focused definition of public interest that aligns with the Public Hospitals Act. It requires accountability agreements that are mutually agreed upon between the board and minister, reflecting equitable access to care and achievable standards of care consistent across the province. Through our accountability agreements with the minister, we will be accountable to government to ensure that our CEO and health care providers uphold the mutually negotiated components of the agreement.

We suggest the committee give careful consideration to the recommendations from the Ontario Hospital Association, in particular the need to clarify that access is part of accountability and the notion that a panel of commissioners be established to quickly arbitrate disputes between the minister and a board. In our view, sections 26 and 27 would not be necessary if the OHA recommendations to amend subsection 21(5) are adopted. We already have a performance agreement with our CEO, so the OHA suggestion that this be made mandatory by amending subsection 21(5) makes perfect sense to us.

Thank you. We'd be happy to answer any questions you have.

The Chair: Thank you. We have six minutes remaining, so two minutes, Mr Barrett.

Mr Toby Barrett (Haldimand-Norfolk-Brant): Thank you to Credit Valley. You've covered much of the waterfront on accountability, and I have heard from a number of hospital boards that feel the original legislation undermined the role of accountability of a hospital board not only to the community but to medicare itself.

You do recommend amendment, and I'm wondering if it goes far enough. I guess I have concerns where a

hospital is directed to sign an agreement that has not been negotiated or agreed to but is unilaterally imposed, effectively eliminating a major part of discussion, negotiation and decision-making. Is the amendment you're proposing going to wrap it up? Is that going to solve this issue? Are you going far enough with your proposed change or amendment?

Mr Loberg: I don't think you can say that in every respect the bill will be perfect, but I think it's a good compromise for a go-forward position.

Mr Barrett: If your proposed amendment—

Mr Loberg: If our proposed amendment is agreed to; yes.

Mr Barrett: Thank you.

The Chair: Ms Martel.

Ms Martel: Thank you for being here today. I don't know what the current Public Hospitals Act says about "public interest" in terms of the definition, and I see you've said we should have a more patient-focused definition that aligns with the current definition.

What happens if the government changes the definition of "public interest" to more closely reflect what's in the Public Hospitals Act now, but still keeps sections 26 and 27?

Mr Loberg: I'll ask Mr Fyffe to comment on that, please.

Mr Wayne Fyffe: Our main point is that the current act talks about access and Bill 8 does not. The second version of Bill 8 is a big improvement over the first. There is quite a long list of things that is included in "public interest," but access is missing. So that's our significant point.

Our point about sections 26 and 27 is the governance issue, in terms of the provisions in there for the minister to invoke penalties and intervene directly through the board, right to the CEO etc. OHA's suggestion of a panel of commissioners etc for the dispute at the front end, when the agreement hasn't been agreed on, and then at the other end where you have an agreement and it isn't being met, is that the same thing is there as a remedy.

Finally, the notion of whether or not a board has a performance agreement: If you just simply amended 21(5), then it would make it mandatory. In our view mandatory is great, because in our practice I've always had a performance agreement anyway, so it wouldn't be a change.

Ms Martel: Just one quick question, just so I'm clear.

Just changing "public interest," if 26 and 27 stayed in place, would not deal with all the questions that Dr Clive raised in terms of what your responsibility is as board and CEO. So it's got to be a combination of both.

Mr Fyffe: That's correct. We believe that access has to be in the public interest and 26 and 27 should go, and the way to make it go is the amendment to 21(5).

The Chair: Mr Delaney.

Mr Bob Delaney (Mississauga West): As the member representing western Mississauga, where Credit Valley Hospital is located, I want to thank you for your continuing and helpful input in the development of the bill and welcome you back to Queen's Park in its continued evolution. I believe Ms Smith has a question for you.

Ms Smith: I appreciate your being here as well. I just want to ask Dr Clive a couple of things.

On your OHIP example, I can assure you that your sitting member will be on the case and getting that gentleman an OHIP card quickly and assisting your staff in doing that, just for the record.

I also want to ask Dr Clive if you are familiar with the dispute resolution provision set out in section 21.1. If the minister were to give notice of non-compliance with an accountability agreement, there's a whole process set out where the notice would have to be given in writing. After receiving the notice, the health service provider has an opportunity to respond in writing. The minister shall consider that response in writing before any compliance directive is issued. I think in the circumstances that you outlined here in your example with Mr Smith, having given those circumstances, I doubt that this would ever be seen as being a violation of accountability agreement. But, that being said, if we're going to use this as the example, I think the dispute resolution provisions that are in the bill now would allow for a great deal of dialogue between the minister and the hospital before a compliance directive was even issued.

Perhaps Dr Clive, or Mr Fyffe?

Mr Fyffe: You're absolutely right. It's a big improvement over the first reading, and there is all that due process in there. But in the end analysis, if we don't come to an agreement—I should say if the board and the minister don't come to an agreement, and let's remember it really won't be the minister himself; it'll be someone else in the ministry until maybe the very end—then the minister will get a briefing and he'll make a decision as to whether or not he uses what we feel are still arbitrary powers in the act to intervene and say, "Thou shalt do that." What we're suggesting in support of the OHA recommendation is that there's another way of doing it that takes that element out of it.

The Chair: Thank you very much. I would like to thank Credit Valley Hospital for your deputation this afternoon.

I would also remind the committee that our next hearing will be on Monday, May 10, at 4 pm. The committee stands adjourned until then.

The committee adjourned at 1743.

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