J-16

ISSN 1488-9080

Legislative Assembly
of Ontario

First Session, 38th Parliament

Assemblée législative
de l'Ontario

Première session, 38e législature

Official Report of Debates (Hansard)

Tuesday 11 May 2004

Journal des débats (Hansard)

Mardi 11 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

Chair: Jim Brownell
Clerk: Susan Sourial

Président : Jim Brownell
Greffière : Susan Sourial

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

http://www.ontla.on.ca/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-3708.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7410 ou le 325-3708.

Copies of Hansard

Information regarding purchase of copies of Hansard may be obtained from Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Exemplaires du Journal

Pour des exemplaires, veuillez prendre contact avec Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311, ou sans frais : 1-800-668-9938.

Hansard Reporting and Interpretation Services
3330 Whitney Block, 99 Wellesley St W
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
3330 Édifice Whitney ; 99, rue Wellesley ouest
Toronto ON M7A 1A2
Téléphone, 416-325-7400 ; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

COMITÉ PERMANENT DE LA JUSTICE ET DES AFFAIRES SOCIALES

Tuesday 11 May 2004

Mardi 11 mai 2004

The committee met at 1602 in room 151.

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.

HALTON HEALTHCARE SERVICES

The Chair (Mr Jim Brownell): I call the committee hearings to order. I'd like to welcome the committee. First on the agenda, we have the Halton Healthcare Services. A 15-minute time period, and should you not require the full time for your presentation, we'll have question period at the end. Welcome.

Mr Shavak Madon: Thank you. Mr Chairman and members of the committee on justice and social policy, I would like to begin by once again thanking you for the opportunity of being here today. My name is Shavak Madon. I'm the chair of the board of directors for Halton Healthcare Services, representing Oakville-Trafalgar Memorial Hospital and Milton District Hospital. Joining me here today is Barbara Burton, our past chair.

We had the privilege of presenting to you in February, and we are pleased to be here again today. We congratulate you on the process you have undertaken. Your commitment to these hearings and your willingness to again listen to stakeholders and consider public input are commendable.

The board of Halton Healthcare Services supports the overarching principles of Bill 8. We are encouraged by the progress that has been made, but we still have a number of fundamental concerns.

We continue to believe that Bill 8 is a work in progress. We are still hopeful that the components of the bill will evolve to a point where the government, health care providers and, most importantly, the residents of our communities who rely on us for health care services will benefit from the fundamental principles this bill is based upon.

As we stated before, we support the key provisions of Bill 8, including establishment of the health quality council, embracing the five key principles of the Canada Health Act, adding accountability as the sixth principle, and thereby strengthening the provisions governing medicare.

Our first comments relate to section 9 and the provisions regarding physician payments. In February, the bill appeared to be too restrictive regarding physician payments by the hospital. Now the bill seems to allow for any type of payment to a physician by the hospital. This really concerns us. There is no black and white answer or solution to this issue.

The board is not properly positioned or equipped to effectively decide upon a continuum of ongoing requests for enhanced payments beyond the provincial standards. It should only be in rare and unique circumstances that physicians should be entitled to approach the board to seek additional payments. Given that physician payments are currently being addressed by the Ministry of Health and Long-Term Care, the Ontario Hospital Association and the Ontario Medical Association, we recommend that this complex matter be completely removed from the legislation.

Bill 8 continues to cause us concern regarding governance issues pertaining to the development of accountability agreements. We support enhanced accountability, including the development of negotiated accountability agreements between the government and hospital boards. While we are pleased that the bill now identifies the need to negotiate, we are very concerned that the government continues to have the power to impose agreements if they are not agreed upon within a 60-day period.

The process of negotiation allows for the community's voice to be heard and creates a sense of ownership and trust. This is lost if boards are forced to sign accountability agreements that do not fully recognize the needs of their community. The imposition of accountability agreements undermines local voluntary governance and silences the voice of our two communities. It removes the ultimate authority for determining service availability

and restrictions from the agendas of our board of directors and replaces it with a centralized provincial process. We should be striving for a more collaborative process, based on a relationship of mutual trust and respect, so the result is both fair and realistic and ultimately responsive to our stakeholders' needs.

One of the lessons we can learn from the BC Auditor General's report is that the process for establishing agreements should not be rushed. Enough time should be allowed for full collaboration between the negotiating parties to ensure local community and governmental needs are met. We support the Ontario Hospital Association's recommendation that accountability agreement disputes be referred to a neutral third party for resolution. This will ensure an open, democratic process of negotiation, which will result in a fair resolution that will ultimately be more conducive to achieving the goals and objectives set out in the accountability agreement.

Our board would also like to bring to your attention concerns we have regarding the sections of Bill 8 that will alter the relationship between the board and the CEO. Interference with this relationship, as contemplated by Bill 8, will jeopardize the success of our organization. It is our role and responsibility as representatives of our communities to establish performance agreements with our leaders. We will clearly articulate the expectations and responsibilities of this position, and it will be our duty to ensure that agreements are successfully implemented. Any ability of the government to come between this relationship will be detrimental to the hospital as a whole. We spoke on this issue at great length in February, and we urge you to closely examine the BC Auditor General's report to determine what worked and, most importantly, what did not work.

1610

Our presentation in February raised the issue of the conflict between Bill 8 and the Public Hospitals Act. We believe that hospitals still need clarification of health care acts that will govern our hospitals. Section 20 of the Public Hospitals Act very clearly states that we must provide service and treatment to those who arrive at our facilities seeking care. Our legal counsel has reviewed the amendments and has advised that accountability agreements between the board and the government, regardless of whether they directly or indirectly impact patient volumes, will translate into a restriction on the number of patients that can be treated at our hospitals. Furthermore, "these restrictions could place hospitals in direct conflict with their statutory obligations under section 20 of the Public Hospitals Act to treat every patient admitted under the order of a physician." When a person comes to a hospital for health care services, we do not, and we must not, turn them away. This legislation could restrict access to services and prevent us from meeting the essential and basic health care needs of the residents of our communities.

In conclusion, we are a strong community organization that is committed to the principles of the Canada Health Act and to our community. We have a strong commitment to value-added quality improvement, a commitment that is vital to the success of our health care organization and the industry as a whole. Our board is motivated by pride and professionalism in what we and our health care providers do. We believe in accountability. We are accountable to the government. We are accountable to the community, and we are committed to meeting and exceeding our community's expectations. It is this determination and commitment that will continue to ensure we are successful in our quest to provide quality health care services.

You are faced with the difficult task of marrying several distinct views to create the right compromise for health care in Ontario. You need to strike the right balance. In your consideration of Bill 8, as you review the suggestions and recommendations that have come before you, we urge you to consider actions that will add value and accountability, not complexity and unilateralism, to our health care system.

The Chair: Thank you for your presentation. We have three minutes remaining—one quick question from each party. We'll start with Mrs Witmer.

Mrs Elizabeth Witmer (Kitchener-Waterloo): I notice here that one of the outstanding contentious issues continues to be the dispute resolution mechanism to deal with accountability agreements in the event that a resolution cannot be found. You say that we need to learn from the BC example. Did they have a dispute resolution mechanism?

Mr Madon: Yes, they had dispute resolution and they have made some recommendations. I cannot tell you offhand what those recommendations were.

Mrs Witmer: So they have found that at the end of the day there is a need to make sure the community does have input to that accountability agreement?

Mr Madon: That's correct.

The Chair: Mr Kormos.

Mr Peter Kormos (Niagara Centre): I appreciate your submissions, and I appreciate your patience with this government. This is the second round of committee hearings. You know that.

Mr Madon: That's right.

Mr Kormos: And we have yet to return to the House. Who knows? There may well be a third.

The Chair: Mr Leal.

Mr Jeff Leal (Peterborough): Thank you very much for coming back. I want you to comment on a real-life situation: Belleville, Ontario. The government provided resources to hire more nurses in Belleville. Instead of hiring more nurses to improve outcomes of the health care system in that area, the CEO took the money and topped up the compensation for the senior administrators there.

To me, that's why we need accountability agreements, because I served on a hospital board, and sometimes boards just become rubber stamps for what the CEO proposes. One of the things we want to achieve through these accountability agreements is to avoid the kinds of problems in Belleville, Ontario. I just want to get your comment on that.

Mr Madon: I don't believe there would be any concern on the example which you have just given. If the funds are earmarked for, let's say, the nurses in your example, than it is the duty of the board to ensure that the monies are only spent on that and nothing else.

The Chair: That brings us to the end of the presentation. Thank you very much for your presentation this afternoon. Have a good afternoon.

CATHOLIC HEALTH ASSOCIATION OF TORONTO

SALVATION ARMY/TORONTO GRACE HOSPITAL

The Chair: Next we have the Catholic Health Association of Ontario and the Salvation Army/Toronto Grace Hospital. I'd like to welcome you. Once again, 15 minutes for the presentation; any time remaining at the end of your presentation will be used for questions.

Mr Ron Marr: Thank you, Mr Chair and members of the committee, for welcoming us this afternoon and allowing us to share with you some of our continuing thoughts on Bill 8. My name is Ron Marr. I am the president of the Catholic Health Association of Ontario.

Joining me today are Major Dennis Brown, the president and CEO of the Salvation Army/Toronto Grace Hospital, and Peter Lauwers, a partner with the firm of Miller Thomson. Major Brown is here with me today to demonstrate to you the concern that is shared among all of the faith-based providers of health services in the province regarding Bill 8. Mr Lauwers is here today to help us answer any questions that you may have, particularly around the amendments and the background to the amendments that we are proposing to you.

Our comments to you this afternoon will be relatively brief, as we have already shared our concerns with you during our last appearance before the committee, on February 24. Before I comment on Bill 8, I will first summarize the contributions of the faith-based missions of health resource providers to Ontario's health care system. Then I will share with you our continuing concerns with this bill and suggest two amendments that will address our concerns and, in our opinion, improve Bill 8.

The Catholic Health Association of Ontario is an umbrella group that represents the Catholic health ministry in this province. The CHAO is a voluntary association of all Catholic hospitals, long-term-care, mental health facilities, and community health services in the province. There are 29 such institutions and services in the province, ranging in size from large teaching hospitals, long-term-care centres and psychiatric hospitals in our major health science centres to smaller facilities in smaller communities across the province. Also included in the membership of our association are the seven religious communities of sisters and lay groups that sponsor these facilities, and the Ontario Conference of Catholic Bishops, which is composed of all of the Catholic bishops in the province.

The Salvation Army has provided spiritual and health care to Ontarians since the late 1800s, and remains the largest non-profit, non-governmental provider of health and social services in the country. The Catholic and Salvation Army health ministries represent only two of the many faith-based health ministries in Ontario. There are many faith-based groups that provide a variety of formal and less formal health programs to Ontario residents and that reflect the pluralistic and diverse makeup of Ontario.

Our comments and recommendations to you today are shared and supported by the following faith-based groups or communities: The Catholic community though our 29 health care organizations on 39 sites; the Jewish community through Mount Sinai Hospital; the Salvation Army community through the Toronto Grace Hospital, which also operates in partnerships at Hotel Dieu-Grace Hospital in Windsor and the Scarborough Hospital; and the Anglican community through St John's Rehabilitation Hospital.

Faith-based 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 partnership with other members of Ontario's health care system. We are dedicated to voluntary community governance to ensure accountability to the government and to the residents of the local communities in which we serve.

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

1620

Ontario is a truly pluralistic and tolerant province where a large variety of religious, cultural and linguistic traditions thrive and contribute significantly to the life, economy and health care system of this great province. It was often religious groups that responded to unmet community need by founding health care services from their own resources. These faith-based groups today sponsor approximately 20% of Ontario's hospitals, long-term-care facilities, mental health facilities and community-based services. We continue to respond to the ever-changing needs of the community from a mission-driven and faith-based perspective, adding a unique element to our health care system.

Over the last number of years, the leaders of all three political parties in Ontario have shown their support for this faith-based approach to health care by affirming their party's commitment to the maintenance of the mission and governance of the Catholic health facilities. Indeed, in an August 2003 letter to us, Premier McGuinty said:

"The Ontario Liberals recognize the invaluable contribution that the Catholic Health Association of Ontario ... and the caregivers you represent have made as partners in the delivery of quality health care in our province.

"As I have stated in the past, the Ontario Liberals are committed to preserving the Catholic health ministry in our province. We appreciate that governance issues are of

the utmost importance if Catholic hospitals, long-term-care facilities and home care providers are to preserve their ministry."

We support the need for accountability and express our desire to be accountable for public dollars. However, we continue to believe that the top-down, power-and-control approach of Bill 8 is not the best way to achieve accountability. We sincerely appreciate the amendments already made to Bill 8. However, despite these amendments, we are still concerned that the provisions and implementation of part III of this act could erode the mission of faith-based health resource providers in Ontario and jeopardize our ability to continue to contribute to the health of the communities we serve. The central problem with Bill 8 is that it continues to allow the government, through the Minister of Health and Long-Term Care or his or her designate, to impose anything it likes on health resource providers.

To mitigate these problems, we propose two amendments: the first to ensure that faith-based health resource providers continue to bring their unique contribution to Ontario's health care system, and the second to affirm the role of voluntary governance boards. We believe that our proposed amendments will achieve the government's objective of accountability while at the same time allowing the authentic continuance of faith-based health care in Ontario.

The Ontario Hospital Association has already expressed additional concerns of the hospital sector regarding Bill 8. The Catholic Health Association of Ontario has worked closely with the OHA, and we support their recommendations for amendments. We will not reiterate those this afternoon.

Let me be clear, before I share our amendments with you, that we are not asking to be excluded from the provisions of Bill 8 or from accountability. We believe in accountability and support the need for accountability. We are simply asking for some comfort that we will be able to continue to provide faith-based and mission-driven health care in this province.

We've taken the liberty of proposing specific language for your consideration in the two amendments we are submitting to you. I'll read those to you at this point.

Our first amendment is the inclusion of a clause in Bill 8 that we suggest be added as section 32.2:

"(1) Nothing in this part authorizes the minister or the Lieutenant Governor in Council to interfere, directly or indirectly, with the faith-based aspects of a health resource provider that has a faith-based mission or governance structure.

"(2) The powers under this part shall be exercised in the manner that is consistent with the faith-based aspects of a health resource provider that has a faith-based mission or governance structure."

The intent of this amendment is not unique to health care in Ontario. Yesterday, the Catholic Health Corp of Ontario shared with you the ways that other provinces have acknowledged the contribution of faith-based health care by entering into a variety of agreements that recognize and affirm the long-standing and valuable role of faith-based providers within the health care systems of the other provinces.

This amendment we are proposing to you today also finds its precedent in the language found in section 257.52 of Ontario's Education Act, which governs the minister's authority when a school board is to be taken over by the minister for failure to comply with the Education Act.

We are asking for nothing more nor nothing less than that which has been provided to faith-based health resource providers in other provinces and to faith-based and French-language schools in Ontario.

I'll now turn quickly to our second amendment. The intent of our second proposed amendment is the same as that proposed by the Ontario Hospital Association. It relates to a dispute resolution clause should negotiations for an accountability agreement between the minister and a health resource provider fail after the 60-day negotiation period. We believe that an agreement can only be successful if both parties enter into an agreement willingly and without compulsion. Our proposed second amendment, or a variation of it, is intended to facilitate the achievement of accountability agreements that are entered into willingly and without compulsion by the minister and the health resource provider.

Our second proposed recommended amendment reads as follows. Here we suggest the inclusion of a clause to be added in section 21.1 and section 26.1 as subsections (4.1) and (4.2).

"(4.1) Either the Minister of Health or the health resource provider may request the assistance of a facilitator to be mutually agreed upon and jointly appointed by them to assist in resolving the matters in dispute. If the minister and the health resource provider are unable to agree on a facilitator, then the Chief Justice of Ontario shall make the appointment."

"(4.2) The facilitator shall confer with the parties and endeavour to effect an agreement within five days of the appointment. The parties shall co-operate with the facilitator."

Faith-based and mission-driven health care providers wholeheartedly support the overall theme and intention of Bill 8—the preservation of a universal public health care system in Ontario. We are all committed to the five principles of the Canada Health Act: public administration, comprehensiveness, universality, portability, and accessibility. Also, and most importantly, the fundamental values of accountability and improvements to the system are important elements of the philosophy of faith-based health care.

We ask you, the members of the standing committee on justice and social policy, to give serious consideration to our recommendations and comments. We thank you for the opportunity to meet with you today and we would now be pleased to answer any questions you may have.

The Chair: Thank you very much. We are down to about three minutes. A quick question from each party.

Mr Kormos: I appreciate what you have to say, because of course down where I come from in Niagara region we have Hotel-Dieu Hospital in St Catharines.

My concern is there's been a hostility toward faith-based hospitals over the course of a number of years now. Governments seem to be trying to do through the back door what they wouldn't dare politically do through the front door in terms of shutting these places down. I find your proposition regarding the amendments restricting or, rather, exempting control by the minister—exempting the faith-based aspects from any control or interference by the minister, especially when they're so consistent with the sections in the Education Act that you provided us with—so I suppose, Chair, I would put as a question, how are these amendments in any way offensive or inconsistent with the goal of the government in terms of this legislation? The amendments make eminent good sense.

The Chair: We are at the end of one minute.

Mr Kormos: I've made my point.

The Chair: Next, Ms Wynne?

Ms Kathleen O. Wynne (Don Valley West): Thank you for coming today. I guess I'm just trying to work out—because we've heard this argument a couple of times and I know there's been a discussion in the ministry about this. My understanding is that there's nothing in the bill that would undermine the faith-based aspects of your delivery. I'm puzzled—the reverse of what Mr Kormos was saying—about why this is necessary. If there's nothing in the bill that is threatening, then why would this be necessary? What's the fear that you're trying to allay?

Mr Peter Lauwers: The accountability agreement is very broad in what it covers. We foresee a possibility of being directed by the minister to provide services that are inconsistent with our moral mission; for example, abortion, sterilization, euthanasia in the future, those sorts of things. We're concerned about shutting down programs on a cost basis, such as chaplaincy. We're concerned about being forced to share CEOs or senior officers.

1630

Mrs Witmer: Great presentation; excellent amendments. Maybe you can continue and use my time to tell me why you feel this is necessary.

Mr Lauwers: I don't know if I can add much more to it, but the notion of shared CEOs and shared senior officers is a problem for us because it would interfere with the faith-based mission of the system as the compromises begin to run through. These are all possibilities under the legislation. It doesn't expressly say so but it doesn't say not, either. So we don't believe that the protections we're talking about will interfere with the economic and systemic concerns of the government, but they will provide faith-based organizations with a measure of comfort to know that that part of their program is safe.

Mrs Witmer: I guess you've mentioned here that this type of commitment has been made in other provinces, and also in the educational system, so you're not asking for anything more and nothing less.

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

ONTARIO FEDERATION OF COMMUNITY MENTAL HEALTH AND ADDICTION PROGRAMS

ST JUDE COMMUNITY HOMES

The Chair: Next we have the Ontario Federation of Community Mental Health and Addiction Programs. Welcome. Make yourselves comfortable. Once again, a presentation of 15 minutes; if you don't require all the time for your presentation, we'll split it between the parties.

Mr David Kelly: Thank you. First, on behalf of the Ontario Federation of Community Mental Health and Addiction Programs and St Jude Community Homes, we want to take this opportunity to thank you for allowing us to come and make this presentation. I also want to thank each and every one of you for the support you've given over many years to addiction and mental health services in your communities. Believe me, we need that support.

This legislation speaks to issues that are very important for people with mental illness, for the volunteers who lead the organizations that provide services and for the public. The Ontario Federation of Community Mental Health and Addiction Programs envisions a community mental health and addiction system which is accessible, flexible, comprehensive, responsive to the needs of individuals, families and communities, shaped by many partnerships, respectful of human dignity and rights and accountable to those it serves. The federation brings over 200 community mental health and addiction programs and services together in the province of Ontario, all the way from Red Lake to Windsor, to help provide effective and accountable, high-quality services.

I'd like to turn it over to Angela for a second.

Ms Angela Shaw: So we're going from the big—200—to a little non-profit supportive housing program here in Toronto that is governed by a voluntary board of directors. Its mandate is to provide high-quality housing and support service for people who have serious and persistent mental health problems, and to support these people as they journey through to recovery. There has been a lot written about recovery but, simply put, it's learning how to deal with some of the stigma, the isolation, the low self-esteem and the poverty and get on with your life.

St Jude Community Homes opened in 1991. We serve 36 citizens and we hope to serve 30 more next year under the homelessness initiative. Today we're here specifically to talk about part III of the bill, which is the accountability piece, but we will interject little bits about the Ontario Health Quality Council and the commitment to medicare, and a little bit about insured health services. So you have before you 30 pages, but we're not going to read it; let me reassure you of that. We're just going to highlight bits and pieces that are our passion.

Mr Kelly: As Angela explained, in our presentation I just want to talk about Bill 8, which is receiving second reading and has been referred to committee here today. This bill would require health resource providers, in-

cluding hospitals, to enter into an accountability agreement with the Minister of Health and Long-Term Care. This agreement would permit the minister to issue compliance directives and impose sanctions in the event of non-compliance. Until the bill is passed, health care institutions are under no specific legislated obligation to account for the billions of dollars of public money they spend.

For community mental health and addiction programs, those accountability mechanisms are already in place. In addition, the current agreements seem to hold community mental health and addiction programs to much higher standards than are proposed in Bill 8. In fact, when you look at the accountability structures faced by community organizations, not only will they have the accountability with the Ministry of Health, but they will with every funder or ministry they deal with. So you can be looking as a community organization and face five or six accountability agendas, from the federal government to the United Way to other funding organizations.

Ms Shaw: Around 1998, the government directed the ministry to establish these written agreements. They were consistent with mental health reform and the work that the mental health accountability reference framework group was doing, as well as the document The Road Ahead, which sort of deals with the addictions section.

What was envisioned and what is now in place is a common transfer payment agreement for all community mental health and addiction programs. The Ministry of Health and Long-Term Care initiated this in 1998 and passed it on through all of the organizations, I believe, in September 2002. The whole point at the beginning was to raise awareness about accountability issues and to encourage continuous quality improvement with the transfer payment agencies and have them start to reference best practices. At that time, the government of the day stated:

"The experience of government overall is that clear expectations, terms and conditions of funding, performance monitoring and reporting requirements documented in an agreement between the Ministry of Health and Long-Term Care and funded agencies is the most appropriate way to provide certainty and protection for both sides."

As a taxpayer—and I know I'm editorializing—I don't know why people are having a problem with accountability. We've got these transfer payment funding agreements. They're consistent across the board. There's ease of administration, certainly with the ministry. They're not perfect. They could be improved upon. But the net result of not signing these for community mental health and addiction programs was that you wouldn't get funding. It would be gone. That was it.

So the TPA that each person, each agency, signs ensures that the funds are only used for the purposes set out in the annual operating plan, and you can't make changes to that plan without ministry permission. It also grants the ministry powers, among others, to impose additional terms and conditions on the use of funds as it considers appropriate, to inspect and copy financial and non-financial records on 24 hours' notice or to do a partial or full audit, and to terminate the agreement immediately under certain specified situations.

We're using tools to do outcome measurements and we're demonstrating that we're providing cost-effective services and we're accountable. I think, most importantly, we feel that, because we've got these statistics now, as pale as they might be compared to what hospitals collect, we are providing a good service and we're being accountable, not only to government but to the clients we serve and to the citizens of Ontario. We feel very strongly that taking care of the public interest states clearly the collective roles and responsibilities, that there is a transparency here, that there's an encouragement toward continuous quality improvement, that there's value for the monies received and how they're spent, because we know resources are very scarce, and there's a process for reporting. The consistency and trust are there, and there truly is a focus on outcomes.

My question is, we're so heavily accountable down in the community, so why should other health resource providers be handled differently? We believe that to truly transform the health care system, all parts of it must have similar accountability structures so we can compare outcomes on a level playing field. Privacy is one really good piece that's being worked on there, where we can all communicate back and forth and we know that the rules are all consistent. This accountability is another piece to really make it look like a system.

1640

Mr Kelly: We agree that all transfer payment agencies must be accountable, not only to the government but to the clients who use the services—the public—and we support the government's initiative to identify opportunities for greater and more consistent accountability.

As Angela just pointed out, though, the federation views Bill 8 as a key building block for transformation of the health care system. The privacy legislation will make all providers of health care in the province of Ontario use the same mechanisms when transferring client information. Bill 8 will set up an accountability agenda that will allow us to compare different services in the province, define roles and start looking at the outcomes of each and every service, so we can do cost comparisons on different case management models, like those that may be based in the hospital or those that may be based in the community sector. It makes a level playing field. If we are to transform and address some of the problems within our health care system, we need to have that for all of the providers within the system.

We get to our recommendations part. I'm just going to quickly start highlighting them for you, so if you have any questions, we'll have time for those.

Recommendation 1: In developing new accountability arrangements and reviewing current ones signed by community mental health and addiction programs, the government should be guided by the principles of

consultation, collaboration, transparency and acting in the public interest.

An effective accountability mechanism must provide information that can be used to improve the quality of services, minimize the time that staff providing direct service must spend entering data instead of working with clients, and have sufficient funding available to enable effective implementation.

Recommendation 2: That any accountability mechanism must take into account the principles stated above, and include adequate funding for implementation, so as not to divert resources from clients.

This is a great problem faced by the community mental health and addiction field, as we have accountability agendas that have come down on to our organizations with no resources, so what we continue to see is a shrinking of the availability of services. If there are not going to be resources, they're not going to be successful. I know you hear this continuously, but it really is a basic truth in this whole process.

Recommendation 3: The Minister of Health and Long-Term Care may require a CEO or board to enter into an accountability agreement only when there is an extraordinary breach of their legal responsibilities.

Recommendation 4: The government has a responsibility to provide chiefs, CEOs and/or boards the support they need to carry out their obligations.

Recommendation 5: The legislation must be clear as to the purpose for the intervention and what is the intended goal of that intervention.

Recommendation 6: We'd like to comment on the Ontario Health Quality Council, that factors to be considered in selecting members of the council should be amended to read:

"2(3) In appointing the members of the council, regard shall be given to the desirability of appointing,

"(a) experts in the health system in the areas of patient and consumer and family issues and health service provision, including mental illness and addictions and mental health services;

"(b) experts in the areas of governance, accountability and public finance;

"(c) persons from the community with a demonstrated interest or experience in health service."

Recommendation 7: That subsection 5(5) be amended to remove the exception to tabling the business plan and require the plan to be made public once it is approved by the minister.

Recommendation 8: That the council be authorized to recommend to the Minister of Health and Long-Term Care, or to any other appropriate governmental body, the collection of statistical information necessary to carry out its mandate.

Angela, do you want to comment?

Ms Shaw: The commitment to medicare and the Canada Health Act: I've been a nurse for 32 years. My nursing association holds true to the Canada Health Act. I hold true to the Canada Health Act. I can remember writing a thesis in the 1980s commenting on the declaration of Alma Alta that was promoting health for all by the year 2000, and here we are in 2004 and the Canada Health Act is really too narrow to reflect the changes since 1967. There is so much that is being done in the community that is not an assured service that is more cost-effective, and sections there do really need to be opened up a little bit to cover those kinds of things.

Interjection.

Ms Shaw: We have two minutes? OK, then we'll stop.

Mr Kelly: The rest of our recommendations are in—

The Chair: Go on with your recommendations. I just wanted to alert you that you have two minutes. If you want to talk about the other recommendations, feel free.

Mr Kelly: We'd also, at this point, like to acknowledge the Centre for Addiction and Mental Health and the Canadian Mental Health Association, because what we have here is a field of addiction and mental health providers in Ontario saying, "Move ahead on Bill 8 and let's level the playing field so we can all participate fully as providers in the health care system."

Ms Shaw: What you have in front of you is our position paper. There are 13 recommendations. You guys all read, I know.

The Chair: We do have one minute remaining. Perhaps the government side has a question.

Ms Monique M. Smith (Nipissing): We really appreciated your presentation, and you've given us a lot to think about. I just had a question. When you were talking about the funding agreements that you're presently obliged to participate in, you said, "They're not perfect. They could be improved upon." In 30 seconds or less, what would be some of the things you'd like to see improved upon?

Ms Shaw: One size does not fit all, and there was no collaboration; these were sort of sent down. They're not perfect, but they are a start. I did bring a copy—not a signed one—if you wanted to circulate it and just take a look at it.

Mr Kelly: One example is that community programs can lose their funding in 60 days; with hospital programs, it's 90 to 120 days. Again, I don't know why different parts of the health care system are treated differently.

The Chair: Thank you very much for your presentation. That brings us to the end of the 15 minutes. Have a good afternoon.

ONTARIO DENTAL HYGIENISTS' ASSOCIATION

The Chair: Next we have the Ontario Dental Hygienists' Association. Welcome and make yourself comfortable. There is water there. Once again, 15 minutes, and should we have time remaining at the end, we will divide it between the parties.

Ms Margaret Carter: Good afternoon. My name is Margaret Carter and I'm the executive director of the Ontario Dental Hygienists' Association, also called the ODHA. It is a pleasure for the ODHA to speak with you

again regarding Bill 8, the Commitment to the Future of Medicare Act, 2004.

As you know, the ODHA made a presentation on this bill earlier this year, when it was before this committee prior to it receiving second reading. We are pleased to be back to offer some of our recommendations that we believe will help further improve Bill 8.

The ODHA realizes the importance of this legislation to the future of health care delivery in the province of Ontario, and for this reason it makes it all the more necessary to conduct public hearings, to hear first-hand the advice and recommendations of not only the health care providers, but also the recipients of health care: the people of Ontario.

We congratulate the government, and the Minister of Health in particular, on what is, I believe, the unprecedented move to conduct public hearings after both first and second readings of Bill 8. With the changes that have already occurred after the first round of hearings, and with the amendments that will, I hope, be made after the second round, we can anticipate a bill that will indeed be a commitment to the future of medicare. It is incumbent on all of us—health care stakeholders, the government and the public at large—to work together to make sure that this bill achieves its stated objectives.

The ODHA represents approximately 6,000 dental hygienists across the province, accounting for about 85% of the total number of dental hygienists registered to practise in the province today. This makes us one of the largest health care professional associations in Ontario.

One of the primary objectives of Bill 8 is to ensure that all Ontarians have access to quality, affordable health care that is based on need and not on the ability to pay. It also strives to enhance accountability in the system for the benefit of the people of Ontario. The ODHA agrees with and supports these objectives.

As you may be aware, one of the issues facing dental hygienists today is the restriction on delivery of a very necessary health care service to the people of Ontario, particularly those in long-term-care facilities, as well as those in rural and remote areas and individuals who may not be able to afford access to a dentist. Many of these individuals are in fact some of our province's most vulnerable.

Without going into any great detail, the issue of which I speak concerns the requirement of dental hygienists to obtain an order from a dentist prior to performing our authorized acts. With the amendment to the Dental Hygiene Act that we are proposing, dental hygienists will be able to provide their services to all Ontarians, including those who are not necessarily able to travel to a dentist's office, whether because they are bedridden in a long-term-care facility or because they do not have the financial resources to see a dentist.

Studies have shown that good oral hygiene can reduce the incidence of pneumonia; that seven out of nine diabetics who improve their oral health reduce their need for insulin; and that some heart surgeries are delayed or cancelled altogether because the patient is in need of teeth scaling to reduce the risk of post-operative infection. If dental hygienists are permitted to fulfill their potential as prevention specialists, this will reduce the overall cost to the health care system through the prevention of oral disease and promotion of oral health and, therefore, overall health.

1650

This amendment will ensure that Ontario's health care system truly meets the objectives of Bill 8, in that it is a system that is truly affordable and accessible.

We have been working with the government and MPPs of all political stripes to help resolve this issue, and we appreciate the support of so many of you. To be quite frank, I look forward to the day, which I hope is very soon, when I no longer have to talk about this issue again and instead I can tell you how many individuals across the province are now receiving necessary dental hygiene services as a result of this simple amendment, when previously they were not.

In February of this year, when the ODHA first presented to this committee, we outlined a number of concerns and issues we had concerning Bill 8. We are pleased to see that, as a result of a number of amendments this committee and the minister have made, many of our concerns have been significantly reduced.

We stated in our previous deputation that the ODHA welcomes the provisions made in Bill 8 with respect to the establishment of the Ontario Health Quality Council. We are pleased that further changes have been made to this section of the bill that will ensure a more effective and productive council.

The ODHA is also pleased that amendments have been made with respect to the protection of personal health information specifically as outlined in section 13 of Bill 8. Our concern prior to the amendments was that this section of the bill would allow for another stream of access to, and disclosure of, health information. We were concerned that Bill 8 would prevail over Bill 31, the Health Information Protection Act, 2004. We are pleased that Bill 8 has been amended to provide a single regime for the protection of personal health information falling under the jurisdiction of Bill 31 on the condition that it is proclaimed.

Our concerns prior to the amendments made to Bill 8 were predominantly with respect to part III of the bill, which dealt with the issue of accountability.

The ODHA supports and encourages an accountable health care system. We appreciate the amendments that have been made to this part of the bill. In particular, we applaud the inclusion of the reference to "public interest" in subsection 20(2).

However, the ODHA is still of the belief that part III is far too draconian and heavy-handed, placing far too much power in the hands of one individual, namely the minister. While much of the wording may have changed with respect to part III of the bill, the heavy-handed unilateralism prevails.

For example, while the amendments allow for the minister and health resource provider to negotiate terms

of an accountability agreement, they will have just 60 days to do so, as set out in subsection 21(2). If, after 60 days, an accountability agreement has not been entered into, the minister will "direct" the health resource provider to enter into an accountability agreement set by the minister, and the health service provider will be forced to comply. In effect, this provision does little to address our concern and simply delays the unilateral imposition by the minister by 60 days. The minister would still have the power to impose a wide range of penalties on health resource providers for not complying with his or her directives, and these penalties can be quite onerous.

Many of the boards that govern the various health facilities, such as hospitals, long-term-care facilities and other facilities that would fall under the definition of health resource provider, are comprised of hard-working volunteers and dedicated members of our communities. Under the Public Hospitals Act and under corporate law, these boards are given the responsibility to make decisions respecting the institutions' administration and management. Imposing agreements on these facilities usurps the fundamental role of the board and effectively nullifies any authority that it has. As a result, forcing the imposition of an agreement silences the voice of the community.

We proposed to you in our previous submission that, without substantial revisions to part III, the ramifications of the bill's implementation would include an unworkable and even hostile relationship between the government and health service providers. The ODHA's beliefs remain the same today. Despite the major rewording of this part of the bill, it still grants far too much power to one individual and diminishes the authority of our valuable and community-based boards.

The Ontario Hospital Association has put forward an alternative to enforcing accountability agreements. The OHA proposes that, rather than enforcing an accountability agreement after 60 days of unsuccessful attempts at negotiating one between the minister and the health resource provider, an independent third party should step in and act as a mediator between the two parties.

The ODHA supports this recommendation. A mediator would ensure that both the government and the facility work together. A mediator will review the situation and will make recommendations on how best to achieve an agreement.

An approach such as this will not grant extraordinary powers to the minister, nor will it require the imposition of onerous penalties on board members or CEOs. Instead, an agreeable solution will be sought and an accountability agreement will be developed through co-operation and dialogue, to all parties' satisfaction. It will also help stifle any hostility created in the health care system as a result of the implementation of this legislation as it currently is written.

I began my presentation today talking about an issue that dental hygienists are currently facing with respect to access to necessary health care services, and I would like to end on the issue of accessibility.

Bill 8 is supposed to be about improving accessibility in the health care system. It was to reduce the wait times for such things as MRIs and CT scanners, and it was also to prohibit queue-jumping for important health care services. Bill 8 was introduced to protect the universality of our health care system, something Ontarians consider of vital importance.

Unfortunately, Bill 8 fails to meet these objectives. In fact, Bill 8 makes no mention of prohibiting private hospitals, private MRI and CT scan clinics. The bill also makes no mention of how wait times will be reduced.

If the intent of Bill 8 is still to improve the accessibility of our health care system, then these issues need to be incorporated directly into the legislation.

In closing, I would like to thank you for the opportunity for ODHA to speak before you again with respect to Bill 8. It is quite evident, given the increased opportunity for public consultation, that this government is serious about ensuring that Bill 8 is drafted so that it will accomplish what it was intended to do. We appreciate the dialogue and the debate, and we look forward to seeing a much-improved bill as a result.

I would be pleased to take any questions or comments you may have.

The Chair: Thank you for your presentation. We do have four minutes remaining. We'll start with the official opposition, Mr Hudak.

Mr Tim Hudak (Erie-Lincoln): Thank you, Ms Carter, for your presentation. It's good to see you again.

I think you've summed this up very nicely at the end, because the bill is not about accountability or access; the bill is really about central control. It puts tremendous power in the hands of the Minister of Health or, in reality, because we're talking about probably hundreds or even thousands of these agreements, tremendous power within the bureaucracy in the Ministry of Health. Having dealt with them on many occasions, I'm not confident they can get through these agreements in any kind of timely fashion or efficient fashion. The minister will be faced with hiring a whole lot more people to bring these agreements forward or he'll be faced with tremendous delays as a health care provider for this legislation. I think you hit the nail on the head in that respect.

The second question I had for you dealt with the amendments to the act and the Dental Hygiene Act that you're proposing, that you've been championing. Did you have any commitments from the Premier or the government before the campaign that they supported those changes?

Ms Carter: We had a commitment from the Premier that he supported the recommendations, yes.

Mr Kormos: Ms Carter, thank you kindly. I appreciated the opportunity to talk with you folks a few weeks ago here at Queen's Park.

As we get closer and closer to May 18, I'm starting to understand how important this bill is to the government, how incredibly critical this bill is, especially part III, to this government once their budget is announced because I believe we are looking at some major slashing and

cutting of health care services—chiropractic, physiotherapists, optometrists—and that this is the tool, reminiscent of governments past—the toolbox and the tools—whereby Queen's Park, the government, can suppress grassroots rebellion against their delisting of huge elements of health care. Just watch. I hope I'm wrong. I've been around long enough, I can connect the dots pretty good. I can even colour inside the lines. Just watch. May 18 is going to be all-telling. Thank you kindly.

Mr Ted McMeekin (Ancaster-Dundas-Flamborough-Aldershot): I'm very excited by what you said—a different perspective. I believe that our government has more tools in the toolbox than hammers and screwdrivers. In fact, we're very much committed to wanting to see a multidisciplinary approach.

I come at this with a particular concern about seniors. The requirements under the Long-Term Care Act or the Nursing Act or whatever the heck act it is—I know it's 35(3)(b) or whatever—that every senior needs a complete oral exam upon entering into a long-term-care facility is only happening about 44% of the time.

I think there's an incredible role here to play and I hope and pray that Bill 8 or some learning that we've had here can help us to move into that so that we could free that up and really use the skills that you have. I say that by way of affirmation. I would invite you to make any comment on that.

Ms Carter: Certainly we would like to see a change to the Dental Hygiene Act that would enable our members to realize their full potential for the health care system, absolutely.

Mr McMeekin: It needs some fine tuning.

The Chair: Thank you very much. That brings us to the end of our 15 minutes. Thank you for your presentation and have a good evening.

1700

OTTAWA HOSPITAL

The Chair: Next we have the Ottawa Hospital. We welcome you.

Dr Jack Kitts: Thank you very much. I'm Dr Jack Kitts. I'm the president and CEO of the Ottawa Hospital. To my left is Ms Peggy Taillon-Wasmund, who is the director of our executive services and chief privacy officer.

In the next 10 minutes or so I'd like to walk you through a brief history of the Ottawa Hospital and then talk more specifically about opportunities to partner in Bill 8.

In your package, which I believe has been circulated to you, there is a slide deck that provides a summary of the presentation. There's a delegation-of-authority policy that was passed by our board of governors that I think will be helpful as we move forward in performance agreements, and then a brief synopsis of what we believe are the attributes of a high-performing hospital.

The Ottawa Hospital is the product of a merger April 1, 1998, where two large teaching hospitals in Ottawa and two smaller community hospitals merged to form the Ottawa Hospital. In addition, a transfer from the Royal Ottawa psychiatric emergency services was achieved in 1999, and the heart institute and the rehab centre also form part of the Ottawa Hospital. In all, it's a very large, complex, tertiary care, academic health science centre with more than 10,000 employees, 1,200 physicians and more than 100,000 weighted cases.

The map there of eastern Ontario shows where Ottawa is situated, and I draw your attention to that not because I don't think you know where Ottawa is but to show how we provide a regional service right along the Ottawa River, from Deep River in the northwest all the way to Cornwall in the east. So we're a large regional resource.

Our mission: Like any other academic health science centre, we have a tripartite mission where we provide patient care—particularly tertiary complex care—educate future health professionals and provide innovative research. In addition, because of our situation in the region, we must provide regional care all the way from Deep River to Cornwall, and that becomes important as I speak later on about performance agreements. In addition, being in Ottawa, we function in a bilingual environment.

Our challenge, like other academic health science centres, is, how do we in eastern Ontario respond to community health needs, how do we develop as a centre of academic excellence, and how do we distribute a limited amount of resources across a wide range of programs?

First, let me be very clear that we are 100% behind the intention of accountability in the health system. The Ottawa Hospital has for the past few years supported and promoted initiatives to establish meaningful accountability in the Ontario health system. We believe that shared accountability will optimize Bill 8, and I'll elaborate on that further. Accountability mechanisms, however, must be practical and appropriate.

A fundamental problem with the system is that there is much inequity as to how hospitals are dealt with and funded. There is no clear funding formula, no clear measures on performance, and no transparency in the system. We believe that the system has been politicized to a great extent in the past. We believe that accountability, or the introduction of accountability, will help deal with all of these challenges.

Accountability, however, necessitates that we have clearly defined measures, agreed-upon targets or goals, and then the partners have the authority to be able to act in achieving those targets. Those are prerequisites to have an accountability agreement.

We believe that we should keep it simple. The framework should be quite simple. One such framework is outlined in the slide "Keeping it Simple..." whereby we look, somewhat like a balanced score card, at initiatives to improve integration, to improve quality of services on a regional basis, to improve access to services in coordination of care and, finally, to improve financial performance and sustainability.

Once this accountability framework is agreed upon, we must create alignment in the system. The performance agreements would serve to do just that. Alignment would be between the Ministry of Health and the board of the hospitals. The board then delegates the authority in the performance agreement to the CEO. The CEO then implements or executes the performance agreement, and the board monitors it back through the Ministry of Health.

In the past year and a half at the Ottawa Hospital, we have passed a delegation-of-authority policy whereby the board delegates the authority for the operations and direction of the hospital to the CEO. What that policy necessitates is that the CEO develops, with his senior team, a quality plan, a human resource plan, a maintenance and renewal plan and then an operating plan that supports that. These plans are brought forward to the board, the board approves the plans, and the CEO then executes the plans and brings back monitoring on a quarterly basis. This ensures that the board, the CEO, the management team, right down to the front-line staff, are all aligned in what the goals and objectives of the hospital are. We would argue that this sort of mechanism could be brought up to the ministry to ensure that alignment is with the ministry, the board and the CEO.

One other point we'd like to make is, being out in eastern Ontario, the Ottawa Hospital in the last couple of years has led a number of integration initiatives whereby we work collaboratively with our health partners in the large region. We're concerned that signing performance agreements with individual hospitals may negatively impact on the relationships and collaboration between the various health partners, in terms of working as a system. So we believe that looking at integration through Bill 8, and signing performance agreements that would look at the system and the region, as opposed to individual institutions, would be something that would be very important if we're going to truly create a better system.

We believe that there are also many best practices in the delivery of health care accountability and integration across the province. We would encourage building on those best practices across the province.

Working together: The Ottawa Hospital believes that improving accountability and enhancing performance within the hospital sector can be achieved through a partnership. It has to be truly a partnership between the government and the Ontario hospitals and I would argue for extending it further into the system.

In terms of the future, we believe, like most of you, that health care is not sustainable without significant change. We have adopted a culture at the Ottawa Hospital, including accountability, sustainability and leadership, in bringing about much needed change to try and improve the system. That's why we embrace this direction in terms of accountability.

In summary, then, accountability in the health system is absolutely essential and we certainly support that direction. Performance agreements that are mutually agreed upon will make a better health system by ensuring that we have alignment at all levels of the partnership. I think we must consider looking at the health system in regions, as opposed to individual organizations, if we're truly going to improve the system. I believe that implementation will be the key to success. Accountability and performance agreements, properly executed, will align the goals and objectives of the Ministry of Health, the boards of the hospitals and the CEO and their management teams. In turn, clear performance measures and targets will lead to improved health for the residents of Ontario.

The Chair: Thank you for your presentation. We have eight minutes remaining, so we'll split it. We'll begin with the third party.

Mr Kormos: Thank you kindly. A whole lot of participants in the hearings talked about dispute resolution mechanisms, to avoid the imposition of the agreement after what many perceive as such a relatively short time frame. What have you got to say about that?

Dr Kitts: If we keep the agreements simple, as I suggested in one of those slides, and agree upon a framework that allows us to do that. I believe that, as we suggested in here, a delegation-of-authority policy, if you will, which we've included, would include that the ministry says to the boards, "We want you to develop a quality plan, a human resource plan, a capital renewal and development plan, and then create the operating plan that supports that." Bring it forward. If we approve the plan, then we're all aligned in proper execution and the CEO executes it. If we can't agree on that, then I would agree that we do need some sort of alternate dispute resolution to bring about an agreement, because I think a unilateral agreement is not a good agreement.

1710

Mr Kormos: It's not an agreement. It's oxymoronic.

Dr Kitts: Exactly.

Mr Kormos: That's number one. I hear what you're saying, but I hear other folks—you were in the room, I suspect, when somebody illustrated the problem by saying, "Well, hospitals get money for nurses and then they spend it on CEOs." Right? My response is, "Lay charges." It sounds like fraud to me. People should be going to jail. I mean, Conrad Black's got his problems. Guité's got his problems. It sounds like, if that's the case, there are a few CEOs in hospitals who should have theirs. What do you say about that?

Dr Kitts: I would hope that this sort of agreement would take us up a level from how the money is spent, and agree that if you meet the quality targets, the human resource targets, the efficiency targets and the operating targets, I don't think it's important as to how much was spent on what.

Mr Kormos: Yes, there's that disjoint there between what you're saying and what other folks are saying. Thank you kindly.

Dr Kitts: I'd keep it at the higher level.

Ms Peggy Taillon-Wasmund: Just to add to that point, our board chair has made it very clear that if our CEO is not performing under this delegation of author-

ity—and our board has a very rigorous performance management review of our CEO's performance on a quarterly basis—our board chair isn't going to cut his salary. He'll fire him. So it's very clear that if you are aligned with true performance management, there are repercussions for that sort of activity.

The Chair: We move to the government side.

Ms Smith: We really appreciate your presentation, Dr Kitts and Ms Taillon. Thank you for being here today. I had just a couple of comments and questions. I really liked your ideas around adopting an approach to review and promote best practices, having just finished an extensive review of long-term care and supporting the promotion of best practices and sharing best practices. I think that's a great idea, especially on a regional basis. So I commend you for that.

I wanted to just go into a little more detail on your ideas around signing regional performance agreements. In your model, from what I understand, you're trying to create a broader scope for these accountability agreements, but I just wonder who would then be signing the accountability agreement. Who would be accountable on the side of the service provider in your model?

Dr Kitts: That's an excellent question, because somebody has to be held accountable. Right now, I hold a regional CEO forum for hospital CEOs, and as I alluded to in my statement, I think I need to expand that to include the broader system. But right now, we have 16 hospital CEOs come together on a quarterly basis to create a work plan. One is a regional electronic health record, a physician human resource plan that we then create and execute, and we all provide in-kind services and pay for what is necessary.

Right now, I think we would all have to sign off on it, the way the system is developed. But certainly in our region, we have that kind of collaboration.

Ms Smith: Can you sit back a little bit? We're losing you.

Dr Kitts: Yes. In our region, we have that sort of collaboration now, and I would think that if the Ottawa Hospital signed a performance agreement that said so much service provided, and Pembroke couldn't provide the service because they lost their orthopaedic surgeon, it would not be a collaborative model; whereas if it was a regional service, it doesn't really matter which organization does it, as long as we provide the care in a quality way.

Ms Smith: Just to tweak that a little, would it reach the same end if we looked at accountability agreements on a regional basis? They would still be entered into with each facility, but you'd look at it in a broader scope to make sure that you're allowing for that flexibility and that give-and-take within your various institutions.

Dr Kitts: I think considering the system now, that would probably be the ideal way to go, yes.

Ms Smith: That would work. OK. Thank you.

Mrs Witmer: Thank you very much for an excellent presentation. You've spent a lot of time here talking about some of the steps that need to be taken before you can actually move forward with the accountability agreements, one of them being you've got to define what accountability is and how you're going to measure that. I guess I would ask you—obviously, the government is going to move forward, and everyone who's come here has agreed with the need for accountability—what would be the preliminary steps that you would see the government taking, because another key issue that you've identified is the fact that there's not equity of funding? What does a government need to do before they'd even be able to go ahead and do that?

Dr Kitts: That's an excellent question. I think we're doomed to fail if we do enter into performance agreements where neither side can actually deliver and it's not clear what we're trying to achieve. In health, as you know, performance measures and targets are something we talk about but don't actually have.

I know the ministry is currently working with the OHA to look at a fair funding formula. I think a volume- and rate-based funding formula would help equalize the system. We need to look at what investment is needed at one time in terms of facilities and equipment, because not all the hospitals are starting from a level playing field. I think we need to look at information technology, IT, in hospitals to see what is required by each individual hospital to bring it up to speed, and then start entering into accountability agreements from a more level playing field.

The Chair: Thank you for your presentation. We wish you a good evening.

GTA/905 HEALTHCARE ALLIANCE

The Chair: Next we have the GTA/905 Healthcare Alliance. Welcome. Make yourself comfortable. There is water, should you require it. You have 15 minutes for the presentation. Should you not require the total time, we'll split it between the parties.

Mr Kirk Corkery: Thank you, Mr Chair. Good afternoon. My name is Kirk Corkery. I am the incoming chair of the GTA/905 Healthcare Alliance.

Before getting into the substance of our presentation, I would like to tell you a little bit about our organization. The 905 alliance is the collective voice of the 11 hospital corporations operating 22 hospital sites across the GTA/905 region, from Oshawa to Burlington and north to Newmarket.

For over eight years, the alliance has represented some of the largest community hospitals in Ontario. Together, our members offer care to over 2.5 million Ontarians, approximately 20% of Ontario's population. Each year, alliance member hospitals work closely with the Ministry of Health to respond to the many and increasing health care needs in our communities—communities that grow by 60,000 new residents each year, almost double the growth rate of the province. That's equivalent to having the population of Kingston added each year.

In terms of Bill 8, we would like to commend the government, first, for providing another opportunity for public input and, second, for already proposing amend-

ments to this legislation after listening to the many recommendations made during the first round of hearings.

We hope the government will continue to listen and give due and full consideration to the recommendations being made during this second round of hearings. The advice and recommendations we are offering are provided in a spirit of our historical partnership and collaboration with the government, and are based on our shared goal of ensuring that Ontarians continue to have access to high-quality health care when and where they need it, which means as close to home as possible.

As organizations operating under a structure of voluntary governance, alliance hospitals have a long history of being accountable to government, accountable to our patients and their families, and also accountable to the many health care providers and other staff working in our hospitals who provide treatment and care for patients.

Alliance hospitals have been accountable when the government's goal was to bring services closer to home. Our member hospitals worked with the ministry to expand the scope of services they provided—cancer care, cardiac care, dialysis services. As such, we've been pivotal in the success of various different governments.

When the goal of government was to address fiscal pressures, the alliance hospitals were accountable to the government and patients by becoming even more efficient and cost-effective. They pursued and achieved clinical and operational efficiencies while ensuring that care was not compromised. These achievements mean that the alliance hospitals are now some of the most efficient in Ontario and that, along with the other Ontario hospitals, we have made Ontario's hospitals the most efficient in Canada.

When the goal was to raise funds to augment government capital funding for much-needed hospital redevelopment and construction that was essential to bringing services closer to home, the alliance hospitals, through their boards and foundations, raised millions of dollars over the last five years.

1720

All of this is to say that, like the government, we have listened; we have heard what the government expects of us, we have responded and we have been answerable. And we will continue to work in collaboration and partnership with the various governments, because that is the public trust placed upon us. This is what is expected by Ontarians: to have timely access to quality health care services that are close to home.

Which brings us to the topic at hand, Bill 8. This bill, which seeks to maintain Ontarians' access to high-quality health care, could instead begin a process that erodes the trust and partnership essential to achieving the goal of increased access to care and shorter wait periods. It is a bill that seeks to enhance accountability, but in doing so, may instead serve more to weaken the collaboration between government and health care organizations.

Today, we would like to convey our concerns and offer our suggestions pertaining to three key aspects of the proposed legislation:

First, with respect to Bill 8's proposed definition of "public interest": As currently written, it fails to make the connection between public interest and timely access to health care services. As drafted, the bill's definition of "public interest" in section 20 makes no reference to the need for timely access to health care services. In comparison, the Public Hospitals Act, clause 9.1(1)(d), clearly refers to "accessibility to health services where the community is located," when defining "public interest."

Further, while public interest must be considered when the minister exercises authority under all parts of Bill 8, there is no explicit requirement in the act for the minister to take public interest, including timely access, into account before acting. Public interest should always be the basis for the minister to act when proposing to enter into an accountability agreement or issuing sanctions against a hospital, as per sections 21, 26.1 and 27.

Therefore, the GTA/905 Healthcare Alliance recommends that the definition of "public interest" in section 20 should be amended to include specific reference to "timely access to health care services on a local basis," making the definition of "public interest" in Bill 8 consistent with the Public Hospitals Act.

Section 21 of Bill 8 should be amended to explicitly specify that when the Minister of Health and Long-Term Care intends to enter into an accountability agreement with a health resource provider, he or she must consider the public interest, ie the public's expectation of timely access to local health care services.

With respect to the proposed imposition of accountability agreements, section 21: As Bill 8 is currently worded, accountability agreements can be unilaterally imposed on a hospital if an agreement is not signed within a 60-day period by using compliance directives. This provides the Minister of Health and Long-Term Care with the authority to impose an accountability agreement on a hospital without full discussion or mutual agreement.

We believe that the potential for the minister to act unilaterally by imposing accountability agreements on hospitals usurps the role of the voluntary hospital board. Our hospital boards have always acted in the best interests of their communities, and they continue to do so. Our boards take into account and respond to local health care needs, respond to the concerns raised by the Ministry of Health and Long-Term Care, operate within the constraints of limited funding, address staffing issues and work in support of the hospital foundations' goals to raise funds.

Accountability agreements, as defined in section 19, deal with a wide variety of topics and issues, and under section 19, clause (a), can be expanded to include any other prescribed matter. Therefore, accountability agreements provide the Minister of Health and Long-Term Care with all-encompassing and centralized powers over an extremely broad array of issues. This has the potential to deny hospital boards and the public their historic role to make and influence decisions affecting their health

care services based on local health care needs and other circumstances.

To respect the historical collaboration between hospitals and government and to maintain local participation in decisions affecting local services, where accountability agreements cannot be voluntarily negotiated between the minister and the health resource provider, the GTA/905 Healthcare Alliance supports recommendations for a time-limited dispute resolution process led by a third party. We believe a dispute resolution process, by its very nature, creates a more democratic negotiation process, where both parties can work together to achieve a solution in the best interest of the community.

Therefore, the GTA/905 Healthcare Alliance recommends that subsection 21(4) should be removed from the legislation and replaced with a mandatory 30-day, third party, arbitration/dispute resolution process. This will allow a more thorough review of local health care needs and service capacities in order to shape the contents of accountability agreements.

Third, maintaining accountability between hospital boards and their CEOs: Bill 8 inherently creates a conflict of interest, because it establishes a dual accountability for the CEO to both the hospital board and the Minister of Health and Long-Term Care. The CEO is placed in an untenable position of having two masters, both with the power to take punitive measures: The board has the power to fire the CEO; the minister, under paragraphs 1 and 2 of subsection 26.1(6), has the right to hold back, reduce, vary or redirect the compensation of the CEO. This undermines an effective local governance that has well served the public for decades and continues to work well today.

If the intent of the government is to create an environment that fosters change and improvement, we wish to point out that research shows that punitive measures are ineffective in successfully improving clinical or operational hospital performance. The OHA recently released the results of the task force on operational reviews and supervisor appointments. This report makes clear that intrinsic rewards for health care professionals and health system leaders are most effective when seeking to bring about change and improvement.

We would also like to note that dual accountability, potential conflict of interest and punitive measures in the bill have the potential for creating serious CEO recruitment and retention issues for hospital boards. Therefore, the GTA/905 Healthcare Alliance recommends that subsection 26.1(6) be removed in its entirety.

In summary, we fully support the concept of increased accountability. However, as currently proposed, Bill 8 damages the existing, functioning fabric of hospital governance and undermines the relationship between boards and their CEOs. At a time when we collectively are seeking to bring about systemic changes and improvement for the benefit of the patient, we would prefer to focus our energies on integrating the delivery system, enhancing the partnerships and collaboration, thereby ensuring access and delivery of quality care close to home.

Thank you for the opportunity to participate in this round of hearings and to share with you our thoughts. We feel this is a very important piece of legislation. For it to work and to achieve its goals and objectives, it is essential that it be right, reflecting the real world in which we all work and, most importantly, where we all could be patients, and that it build upon the successful partnerships and collaboration between the government and the hospitals.

At this point, I would be happy to take any questions.

The Chair: We have four minutes remaining. We will start with the government side.

Ms Wynne: It seems to me that Bill 8, as it's written, is based on an assumption of goodwill on both sides, and so that successful collaboration and co-operation is what's assumed in the 60-day negotiation period, where the needs of a community can be brought to the table in the negotiation with the ministry. I guess I'm not clear how this 30-day arbitrated process is a better one. In the hierarchy of decision-making processes, the most sophisticated is the one-on-one, the two parties sitting down. An arbitrated one is a less free process. So how is this a better process? I'm not understanding that.

Mr Corkery: In my other life, I do a little bit of mediation and arbitration, so allow me, if I can explain. Not everybody sees things from the same perspective. With two parties, both believing they are right, both believing there is only one right way, bringing a third party who can provide different perspectives independently allows both parties to see new possibilities and come to a meeting of the minds. Basically, by doing a third party, you get the independent and you will have it happen. I believe it is possible to do it within the 60 days as outlined in the legislation. By adding an extra 30 days, it's quick. Bringing in the third party means it will be independent, and everybody then can look at it and ultimately blame the arbitrator.

1730

Ms Wynne: Is your 30 days on top of the 60 days?

Mr Corkery: Yes, it is.

Ms Wynne: That wasn't clear to me. Thank you.

Mrs Witmer: I'd just like to ask you, which amendment do you think is most critical to the success of the accountability agreements and the quality of health that's going to be provided for people in the province?

Mr Corkery: The one I have the most concern with right now is the way in which the minister cuts between the board and the CEO and affects the relationship, because the impact of that is unknown at this point, but it undercuts and undermines existing relationships.

Mrs Witmer: I think you point out there's some concern about even being able to attract CEOs to the position.

Mr Corkery: Yes.

The Chair: We have half a minute. If you have one half-minute question.

Mr Kormos: I appreciate your proposition about the additional 30 days. It's a relatively narrow time frame. It's a valuable tool, because what can happen now is, the

government can lowball or highball, whichever you wish, to force the hospital into not agreeing and then the government imposes its will. This provides an escape valve or release valve, if you will, for the incredible pressure that could be generated during that brief 60-day period.

The Chair: That brings us to the end of the presentation, and thank you very much for your presentation. Have a good evening.

Mrs Witmer: Mr Chair, I would move a motion at this time that we would hear the delegation from the Ontario Medical Association, once we're finished at 6 o'clock this evening.

The Chair: Agreed? It's unanimous.

ST JOSEPH'S HEALTHCARE HAMILTON
ST MARY'S GENERAL HOSPITAL, KITCHENER
HAMILTON HEALTH SCIENCES

The Chair: Next we have St Joseph's Healthcare Hamilton. Once again, this is a 15-minute presentation. Any time remaining at the end will be split between the parties, and it will be the official opposition first. Welcome.

Dr Kevin Smith: Thank you very much. I'm pleased to be here. My name's Kevin Smith. I'm the CEO at St Joe's Healthcare Hamilton and St Mary's General Hospital in Kitchener. I'm also representing my colleagues today from Hamilton Health Sciences, a large hospital consortium in Hamilton.

By way of setting the scope, this is a follow-up to the board presentation made by our board chairs of the Hamilton hospitals. You'll recall that we serve approximately, as the academic health science centre for the south central part of the province, 2.5 million people. Our collective budget is in excess of $1 billion, with over 15,000 employees and 1,000 members of the medical staff.

We'd like to be very positive about the amendments that were proposed by Minister Smitherman and the standing committee. We believe the changes address the concerns raised by Hamilton's hospitals in the first round of public hearings for the most part.

I would like to reinforce that the minister's action in the public interest is an incredibly important endeavour in this legislation. Similarly, the minister's direct relationship with the board rather than with the CEO was well supported by our local governance structures and, of course, the mutually agreed-upon accountability agreements with mutual negotiation, something that we would certainly echo.

Some additional recommendations the committee may wish to consider: While not an easy task, the concept of rewarding both clinical and fiscal performance and incentivizing practice is an incredibly important part of this legislation or perhaps other legislation; similarly, some clear criteria for dispute resolution. As I know you've heard repeatedly, the parties need to be included and timelines for resolution should be expected and honoured.

Perhaps a point of process: My understanding is that the Ontario Hospital Association and others have suggested that they might offer input into the skills and abilities and possibly name individuals who would be mutually beneficial in the resolution of conflict, and we would certainly support that model.

Some additional recommendations the committee may wish to consider: One that came up in our discussion with some of our local governing bodies was the clause ensuring that the minister will receive the necessary support from other branches of government in order to deliver on the commitments to hospitals. In discussing this with some previous elected officials, the challenge of shepherding this, as well as the relationship with Management Board and possibly other branches, was highlighted as an important endeavour. This is legislation not only to be lived up to by the minister but to be lived up to by the government.

A narrow range and purpose for the hospital-to-physician payments would be something we would also significantly like to see. We believe that physician issues need to be dealt with locally or regionally or through the Ontario Medical Association. As you know, those negotiations with government are currently underway. Narrowing this, in my opinion, also offers the reduced challenge, especially at times of significant physician shortage and a volatile marketplace. So, as hospitals, the ability to work more closely with our physicians and have a narrower scope of remuneration outside those of the hospital insurance plan would be something we'd very much like to echo.

Some enablers that we would suggest: Recognize that the rate and volume model that has been offered in Ontario is a blunt instrument. I heard Dr Kitts mention this earlier. We really do need to look at additional markers and regressions, and we need to develop those jointly with the government of Ontario, as well as with our academic colleagues, both in Canada and abroad.

Similarly, the opportunity to learn from and work closely with colleagues who have been through this before—not unlike those in British Columbia. I'm sure you've seen the Auditor General's report on performance agreements in British Columbia. That was an incredibly important piece of work and our advice strongly would be to not miss the opportunity to learn from the work of others and improve upon it.

Similarly, the United Kingdom has been through a number of these initiatives, including a focused initiative on wait times. We also believe that there's a great deal of learning opportunity to leverage from our colleagues in the UK.

Lastly, as I listened to some of the discussion here today, I heard a lot of discussion about the issue of the CEO and the board and the minister, but underlying that I believe there must be some issue around board performance. If CEOs are performing in an abhorrent manner, obviously the intent would be for boards to act. We wonder in Hamilton about perhaps the model of a

governors' college, ensuring that our governors really do best understand the role of governance and similarly hear directly from the minister the expectations that they should be fulfilling beyond those which we as CEOs offer to them in our day-to-day existence. I would strongly encourage, as would our hospital governors, the evolution of a modern governance college, the evolution of modern governance models and collaborations and a model in which governors collectively do hear from government not only through the arms of those they employ on the day-to-day.

In conclusion, we certainly support the intent, purpose and principle of the bill. Accountability on both sides is an incredibly important endeavour. A number of us believe, having balanced our budgets in the past and into the future, that accountability has been a part of the system so far and we should certainly recognize that. That doesn't mean we can't improve upon it; we certainly can.

Hospitals welcome clear lines of accountability and, inasmuch as this legislation can help to clarify those, that will be an important step forward. Certainly we in Hamilton and Kitchener have been pleased with the amendments that the minister and the standing committee have proposed so far.

Once again, the bill needs to recognize the commitment of the government of Ontario and tie into that not only performance agreements but multi-year stable funding. Thank you very much.

The Chair: We have nine minutes remaining.

Mrs Witmer: Thank you very much, Dr Smith, for your presentation. As you heard from some of the other presenters, this need for stable multi-year hospital funding is going to be imperative if we're to put these agreements in place.

I really like your idea of a governors' college. I think it is important that everybody understands the expectations that are placed upon people in that position.

I wonder if you could just share with us: You talked about the need for the committee to consider the concept of rewarding clinical and fiscal performance. What do you mean, and why do you think that's a good idea?

Dr Smith: I believe as we look currently to the literature and the evidence that's being formed in our academic health science centres in Canada and beyond that oftentimes we may be incentivizing more service rather than looking perhaps earlier in the disease process to talk about, are we in fact preventing illness?

As we all know, the government of Ontario has currently explored the idea of improving on services for diabetics, but what about looking at a community and beginning to recognize that if we have a lower incidence of diabetics requiring admission to hospitals, we are (1) improving the health of the population, most importantly, (2) using the scarce resources of hospitals most efficiently, and (3) limiting that disease process in individuals.

1740

Beyond that, to be crass, in the past what seem to have been rewarded have been deficits rather than balanced positions. While we can make statements to the contrary, while in no way casting aspersions on those who have unique situations and have been unable to do so, it only has to happen for so long before those who have tried to balance their books—a balance of rewarding those who have lived within their means as well as recognizing those who have special pressures would be important.

Mrs Witmer: Thank you very much. I would agree with you that we have been, unfortunately, rewarding deficits. What do you believe we can learn from, for example, the United Kingdom in particular? Is there something they've done that we really need to take a good, hard look at?

Dr Smith: I think a number of things; we all have to look very closely at the health human resource planning that's before us. Crassly, we simply are not training enough physicians, nurses and others now. Just to focus on medicine for a moment, general internal medicine in our country and general internists are the backbone of most emergency rooms, all medical programs in almost every hospital I could think of. We qualified two in Canada this year. The majority have gone to subspecialty training. I would suggest one issue is, how do you incentivize services where we need those skills, abilities and people? Second, I believe it's high time to recognize that extended-role nursing is an incredibly important part of our health human resource planning now and well into the future. Physician issues are not always going to be thus.

Mr Kormos: Thank you kindly, sir. One of the comments you make that's consistent with that of so many other presenters—at least during the period of time when I've been filling in for Shelley Martel here—is about the need for a dispute resolution mechanism. That's what you're referring to, I trust, under additional recommendations.

You heard the presenter just prior to you talk about a 30-day time frame. I suppose what he's really talking about is mediation/arbitration within that 30 days. You see, you've got a 60-day time frame, and if the hospital doesn't acquiesce to the government's terms, then the government imposes the terms. That isn't even a framework for negotiation, is it?

Dr Smith: Probably not, but I would have to confess that I'm not sure I feel I could get to negotiate my budget currently with the ministry.

Mr Kormos: It's even more interesting, because one of the problems here, of course, when you're talking about wanting broader government support for the Minister of Health to be able to fulfill his or her commitment—you're talking about treasury and Management Board, people like that. My fear, and I don't know if you were here earlier: This budget is coming on May 18 and the government needs the provisions in Bill 8. Remember, we had three very brief public school boards in the province that stood up to the last government, who were prepared to say, "No way are we going to become tools of a government that has abandoned education funding." Ms Wynne knows all about it. Those boards stood up

with great courage. Mind you, they were suppressed, like the tanks moving into Budapest. The Tory government moved in with their surrogate board hacks. My fear is that this bill is all about suppressing the rebellion that's going to take place among grassroots—good, well-meaning, serving board members—when they learn what this budget holds in store for public health care. Maybe I'm wrong—I hope I am—but on some of these things I've been bang on.

Dr Smith: Should I try to respond to that?

Mr Kormos: Sure.

The Chair: You have a minute.

Dr Smith: There are I guess two issues. In my opinion, if we are at the point of needing either arbitration or dispute resolution, we, as partners, have failed. One would assume that well before this, that would occur. In my recent past, I've had the experience—I don't know that it's been the pleasure—of serving as a ministerial supervisor in another hospital. I believe no one ended up happy there, including the minister. At the end of the day, people want these issues to be resolved locally. For the most part, I believe they shall be. I'm interested in ensuring that we are left with legislation that supports the delivery of quality patient care in an efficient and effective model and does not undermine local governance, while also respecting that he who pays the piper calls the tune.

Ms Smith: Thank you very much, Dr Smith. We really appreciate your being here. I wanted to ask you two quick things. One, my colleague Mr McMeekin tells me that you speak eloquently on the need for stable multi-year funding. The minister has spoken about that as well, and I wondered if you could elaborate for a moment or two on the need for stable multi-year funding and how that will improve your ability to perform.

Dr Smith: Certainly.

Mr McMeekin: The plan.

Dr Smith: The plan. As we look forward and look at the demography in our communities across Ontario, I think we certainly see not a decline in those who will be in need of service, be that in their last six months of life or not. So while we may be pushing the envelope in terms of survival and pushing life expectancy, the reality is that the last six months of life are certainly among the most expensive in the care process.

That having been said, I believe that in order to plan ahead, in order to balance our budget on a rolling cycle, we need to look at what kinds of models we might implement. As an example, do we want to capitalize a very resource-intensive endeavour? I'll give one example that our hospital has looked at: a robot, for lack of a better term, in our pharmacy services to provide intravenous mixes. It's a very expensive endeavour, yet if one looks down the road, the endeavour might also find us some operational savings at a time when pharmacists are also in short supply. So looking at a rolling cycle, it would very much allow us to do some better human resource planning.

What challenges us in that endeavour is the ongoing debate around whether or not labour settlements would, should or could be addressed by government. While I think the historical approach has been that labour settlements are not addressed by government, it really is unrealistic to believe that the ONA settlement, the OPSEU settlement and the CUPE settlement don't have significant impacts on hospital budgets. I think perhaps being frank about what the pressure points are and also being frank about where we actually have the capacity for efficiencies with capital investment would be a great move forward with multi-year funding.

Ms Smith: Right. My second question, very briefly—I believe you were in the room for the presentation by Dr Kitts from the Ottawa Hospital.

Dr Smith: I was.

Ms Smith: I was intrigued by his ideas of the regional context for negotiating accountability agreements for various institutions. I just wondered how that would apply in your situation. I notice you're here on behalf of a number of health service providers, and I just wondered, in the regional context, how that would affect you or if you think that's a positive idea with respect to accountability agreements.

Dr Smith: Absolutely. I think it's an incredibly positive view. I think Jack Kitts and his colleagues in Ottawa have tried and succeeded in partnering with many small hospitals. We're undertaking that endeavour in our region as well. Similarly, a relationship between Hamilton and Kitchener has moved ahead. I believe that's an essential ingredient. For example, even in the absence of that full-blown plan, whatever performance agreement is decided between us and the government, I believe it would be incumbent on us to share those with our partner institutions. So in the model that says, "I'm going to reduce this service in order to balance my budget," if we and every other hospital in the region were to undertake that same reduction, I think we'd leave our patients ill at ease and, quite frankly, those physicians, nurses and others who make their living in that endeavour disadvantaged.

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

COALITION OF FAMILY PHYSICIANS OF ONTARIO

The Chair: Next we have the Coalition of Family Physicians of Ontario. You have 15 minutes for your presentation. Should you have time at the conclusion, we'll split it between the parties for questions. Welcome.

Dr Douglas Mark: Thank you, Mr Chair. Good afternoon. My name is Dr Douglas Mark, and it's my privilege to serve as the president of the Coalition of Family Physicians of Ontario. I have to commend the committee for staying this late and persevering through this wonderfully warm day.

Dr John Tracey and I are grateful to have this opportunity to once again share our concerns about Bill 8 with you. The Coalition of Family Physicians is a member-driven, voluntary, grassroots organization representing

over 3,600 family physicians that continues to grow. It is dedicated to protecting the rights and independence of family physicians across Ontario. On behalf of our patients and members, we advocate solutions to improve our health care system and health care delivery to the people of Ontario.

To present to you our main concerns, I would now like to introduce Dr John Tracey.

1750

Dr John Tracey: Thank you for allowing the Coalition of Family Physicians of Ontario to present our thoughts and concerns about Bill 8 to you today.

My name is John Tracey, and I'm a family doctor in Brampton. I speak as a member of the Coalition of Family Physicians, which made an original submission to this committee back in February 2004. We welcome the opportunity for further input and comment.

From the outset, we expressed our deep concern that the impact of this legislation as it applied to physicians was so daunting and overwhelming that we would not recommend amendments but felt that the legislation should be withdrawn. We believed that it was significantly flawed. Despite certain amendments, which we congratulate the minister for making, we are still of the same opinion.

The new Liberal government, elected to effect change and sweep out the excesses of the previous regime, claims it is dedicated to democratic institution-building and improvements to the delivery of health care, yet it is renewing a process that belies their integrity when it comes down to how physicians should be treated, promotes a continuous erosion of physician freedoms and rights and may be acting in a discriminatory fashion contrary to the Canadian Charter of Rights and Freedoms.

As you are aware, there are three key components to this bill.

Part I deals with the Ontario Health Quality Council. We will not be commenting on this particular section today.

Part II, accessibility, deals most specifically with physicians and health care practitioners.

The bill as it now stands conveys what we can only describe as extraordinary powers to the minister and to the manager of the Ontario health insurance plan. Section 9 imposes the OHIP schedule of benefits upon all doctors as a sort of unilateral employment contract, without any explanation or provision as to how this document is to be negotiated and agreed upon. Exceptions have been made allowing physicians the opportunity to receive on-call stipends and other benefits that may be forthcoming from hospitals or health care facilities.

Sections 9(1) and (2) state that physicians shall not charge more nor accept payment for more than that provided by OHIP for a particular service. It removes a physician's right to bill his or her patient directly for services provided. By removing choice, this could effectively conscript doctors to assume the role of employees or dependent contractors, possibly changing their status under Revenue Canada. Physicians would be compensated as the ministry sees fit since the government sets the schedule of payments independent of any proper bargaining process.

A ministerial order permits the minister to amend any fees or schedule of benefits, thus negating the value of any contracts that the minister may have entered into with physicians.

Coupled with the provisions in part IV, amendments to the Health Insurance Act, the right to opt out of OHIP and charge the patient directly for services rendered has been forever rescinded. Currently physicians are allowed to opt out, but are not allowed to charge any greater amount than that paid by the plan if the service rendered is an insured service. Most physicians—over 98%—choose to bill the plan, but this should not be construed as a de facto acceptance that they agree to have their civil rights infringed. Physicians have only their intellectual property to offer as a service. This bill will monopolize their intellectual property rights.

In fact, the Canadian Charter of Rights and Freedoms clearly indicates that, "Every citizen of Canada and every person who has the status of a permanent resident of Canada has the right to move to and take up residence in any province; and to pursue the gaining of a livelihood in any province." The removal of the right of physicians to opt out of the plan and set their own fees may be viewed as a discriminatory act under section 15 of the Canadian Charter of Rights and Freedoms and therefore challenged. No other group in Ontario is thus treated.

The charter goes on to say, "This court stated unanimously in Eldridge, 'A legal distinction need not be motivated by a desire to disadvantage an individual or group in order to violate s.15(1). It is sufficient if the effect of the legislation is to deny someone the equal protection or benefit of the law.'"

The shortage of physicians is a global phenomenon, and this legislation challenges the notion of attraction and retention of human resources. We believe that top-quality physicians will not be attracted to Ontario. Many will likely leave the province.

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

The Coalition of Family Physicians of Ontario objects to the provision in this act that recognizes and entrenches in law that the sole representative body for the physicians of Ontario be chosen by the government of Ontario to be the Ontario Medical Association. The Coalition of Family Physicians recently held a referendum for its membership which asked if they believed that physicians should be given the right to choose their bargaining agent. The results show that 92% of the 1,545 respondents clearly indicated that physicians should be offered a choice as to what body should represent them. This is, after all, a right of every other individual in this country.

Why would this act seek to impose a representative body of the minister's choice on physicians?

While it is not, in labour law parlance, "recognition" of the OMA as the legal bargaining agent for physicians, when read along with the exclusion in the Ontario Labour Relations Act and the practice of the government to date and for almost the past decade, it is, in effect, as close to statutory recognition as can be awarded.

Having acknowledged a representative body that would enter into negotiations on behalf of physicians and having removed the rights of physicians to bill for their services, there is no mechanism to enforce the provisions of the Canada Health Act, section 12, which provide for a legal framework for negotiations and a dispute resolution mechanism that includes binding arbitration.

From the Canada Health Act, section 12:

"Reasonable compensation

"(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(c) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

"(a) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

"(b) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman."

This is currently not what we're doing.

Physicians are denied the right to strike due to specific exclusion from the Labour Relations Act and currently have no legal framework for negotiation, no dispute mechanism and no regulations for binding arbitration. The public deserves a mechanism that ensures fairness toward physicians so that resolution can be obtained without service disruption.

Section 11 sets aside the provisions of the Statutory Powers Procedure Act and permits the manager of OHIP to make arbitrary judgments as to whether payment for a service is authorized or not. Then, based on those arbitrary powers, it empowers the manager of OHIP to declare a doctor as indebted to the plan and garnishee monies from other bona fide accounts payable to the physician.

Anyone can complain that a physician may have charged an unauthorized payment. It should be noted that the definition of what constitutes an unauthorized payment has not been defined. Given the regulatory powers of the Lieutenant Governor in Council, we will have to await this definition or, under tort law, observe developments as physicians are yet again brought before the courts.

If the manager decides that the payment was unauthorized, then he can pay back the patient and collect the payment from the physician through garnisheeing the next OHIP cheque. If the physician asks for a review of the decision, the manager will refer the matter to the board of the Ministry of Health Appeal and Review Board. This board will appoint a reviewer of its choice to make a judgment.

The general manager of OHIP can require that the physician submit information for the purposes of determining a contravention to the act and can suspend payments from OHIP during any period where the person fails to comply, whether or not the person is convicted of an offence. We have expenses to meet. We cannot have a situation where we're not receiving any ongoing cash flow.

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

Section 16 imposes restrictions upon or limits the charging of fees for services that are neither designated as medically necessary nor are a service covered by OHIP.

We are currently self-regulated on these matters by existing jurisprudence through the College of Physicians and Surgeons of Ontario. This act would impose on the ability of the college to regulate these fees. This would include the bundling of fees for uninsured services and offering patients the opportunity to pay a one-time annual fee, otherwise known as block billing.

Section 17 imposes penalties on individuals who contravene a provision of this part of the act. These penalties range from $1,000 to $10,000 fines.

Section 18 allows the Lieutenant Governor in Council to make regulatory changes to virtually any part of this act and specifically to those measures outlined above.

Part III, accountability: Originally, individual physicians were to be required to sign accountability contracts. This section of the bill has now been amended to specifically exclude physicians and trade unions. Nonetheless, there are concerns that may affect physicians collaterally, especially those who work in hospitals, nursing homes and long-term-care facilities.

We note that physicians are required to sign contracts to provide care as medical directors and/or attending physicians in long-term-care institutions and are concerned about the potential for trickle-down accountability in positions to be placed in these physician contracts.

1800

There are many aspects of part III that are left to be prescribed by regulation. It is possible that the minister, through later regulations, could use Bill 8 to require hospital physician executives and/or medical staff officers, chiefs of staff, chiefs of department, presidents of the medical staff association, to enter into accountability agreements and be subject to ministry-issued compliance directives. The Coalition of Family Physicians of Ontario is concerned as to the impact on the ability of hospitals to recruit physicians into leadership positions within the hospitals.

Dr Mark: Our Liberal government ran on a platform of the politics of inclusion. We are indeed perplexed by

the contradictory nature of this bill. Physicians seek to work in peace and provide the best care for their patients. We face tremendous challenges as the physician pool, especially the family physician pool, continues to dwindle. This bill will encourage the exclusion of physicians from Ontario. The doctor shortage is global. People are willing to relocate to areas of the country, and indeed the world, that promise and deliver respect, fair play and support. We ask ourselves why the Liberal government's actions seem to belie—there's a negativity and hostility to the very professionals who seek to provide first-class health care to Ontario citizens. What have physicians done to deserve such legislation, that treats them as second-class citizens devoid of the rights and freedoms accorded to the people of Ontario and Canada?

This bill does not uphold the true beliefs and sense of fairness inherent in the Canadian context. It is wrong on moral, ethical and humanitarian grounds to continue on this path. Mr Chairman, we respectfully request a serious reconsideration of the consequences to the rights and freedoms of a specific group of people that this bill will destroy. It is not a just bill and it is not in keeping with the central tenet of the Liberal Party of Ontario. This is why we have not made specific amendments to particular sections of this bill, simply because we believe that the entire bill, as it is currently constituted, is flawed and requires a complete revision. Therefore, we believe that Bill 8 should be withdrawn immediately. Thank you.

The Chair: We have three minutes, one very quick question for each party.

Mr Kormos: I appreciate your comments. New Democrats aren't voting for the bill; we're voting against it. I have no hesitation in telling you that. But I tell you, the government needs this legislation. It needs it to suppress local hospital boards, amongst which all Hades is going to break loose after May 18 and the budget, when they see the attacks on that community-based health care. So the government is desperate. I really believe that. As I've said before, I wish I were wrong. I don't think I am on this one. We'll see.

Ms Wynne: It's nice to see you again. Thanks for coming. You've made a lot of sweeping statements. I just want to focus on the opting-out piece. I just preface this by saying that this bill is not intended to pick a fight with doctors—absolutely not. The issue of opting out, the removal of the right of physicians to opt out of the plan and set their own fees—you don't really have that right now. I understand the philosophical opt-out argument, and we've had presentations on that. But in terms of setting your own fees, the whole issue of extra-billing, Can you just elaborate on that? I don't think you have the right to do that now.

Dr Tracey: It's not a question.

Ms Wynne: Setting your own fees assumes that you'd be going above the fee schedule.

Dr Tracey: The only option that physicians have in certain circumstances, if negotiations fall down and there's no consequence on either party, because during the course of those negotiations there's no legal framework for the negotiations, there's no binding arbitration—so at the end of these negotiations, if things fall apart, the only option that physicians may have to continue service is to opt out of OHIP and to then—

The Chair: Thank you.

Dr Tracey: Sorry?

The Chair: We do have to—

Dr Tracey: OK. So their option is to opt out of OHIP. Having had that option removed, we have nowhere to go.

The Chair: Thank you.

Mr Hudak: I think the government is trying to confuse the issues. It's not about extra-billing whatsoever; it's about a parallel system that has existed since medicare was born: a small number of doctors, mostly seniors, who are in the system. I agree with your point. At the very least, consider grandfathering these physicians.

A quick question on block fees: Is there anything in your encounters in the Ministry of Health that would give you faith that they would do a good job of administering the system of block fees in Ontario as this bill proposes to do?

Dr Mark: Absolutely none. John, can you elaborate on that?

Dr Tracey: I don't understand why the government wants to get into the business of actually taking over the regulation of block fees or fees that are for uninsured services. I do know, though, that the physiotherapists at one stage had a situation where they ran parallel fees, and now it's very difficult to get a physiotherapy treatment in Ontario that is in fact covered by OHIP.

The Chair: That brings us to the conclusion of your 15 minutes. I appreciate your attendance, and we wish you a good evening. Thank you.

ONTARIO MEDICAL ASSOCIATION

The Chair: Next we have the Ontario Medical Association. Make yourselves comfortable. Once again, 15 minutes for the presentation; if you don't use the full 15, we'll split it among the parties. Welcome.

Dr John Rapin: Mr Chairman, ladies and gentlemen and members of the committee, I want to thank you for extending your time to hear us. That's much appreciated. To that end, we will be brief.

I'm John Rapin, the newly elected president of the Ontario Medical Association. I'm an emergency physician who practises in Kingston. I also teach at Queen's, in the faculty of medicine. With me today is Dr Ted Boadway, who is the executive director of health policy at the OMA.

The OMA was pleased to see the amendments that came out of the first set of hearings and were subsequently passed at second reading. These amendments solve problems that would have arisen with regard to the payment of lab physicians, hospitalists and other physicians, and alter the accountability agreements such that important initiatives such as primary care reform can continue.

We are also pleased that the government has seen fit to continue discussion on some of the outstanding issues that we have with this bill. We will focus our comments today on a few areas where we believe some constructive changes can be made without transgressing the principles the minister made in his presentation.

The banning of opting out has been a concern to us. We have not accepted the thought that this is a necessary condition for the continuing of medicare and have seen no evidence produced by anyone that it is. There are very few physicians left in this province who are opted out, and almost all of them are senior physicians. These are physicians who perform valuable services, most of whom have practised in this style for decades. Most of them also have long-established patient lists and the patients are very accustomed to their method of practice. It would make sense to us that at the very least, if the government is determined to ban opting out, it should recognize the excellent, long-standing service of these physicians and demonstrate a desire not to disrupt their practice lives by grandfathering these physicians into the bill.

I would next turn my attention to block fees. Everyone recognizes that there are valuable services that physicians must perform for patients who are not covered by OHIP. It has become a matter of convenience both for patients and physicians to charge for these via the block fee method. In fact, physicians most likely to use block fees are full-service family physicians whose workload has become increasingly demanding over the years and who we all recognize are in drastically short supply. My belief is that we should do everything we can to ease their administrative and practice burdens. Block fees have been one way this administrative relief has been accomplished.

The way the bill is presently written would mean that immediately upon promulgation, block fees would become illegal unless the government had already written regulations to govern them. Physicians charging block fees have been very worried about the government's intentions and indeed have frequently asked me if it is possible that the government won't write regulations at all and thereby create a de facto ban without ever having to announce it.

The OMA has always felt that the charging of block fees is a professional matter, done on the private side of practice, and that it should remain entirely with the College of Physicians and Surgeons of Ontario. We believe that the government could go a long way toward demonstrating goodwill to this hard-working group of physicians by rewriting the bill in a manner that upon enactment of the bill, the college would continue to govern block fees in the absence of regulations. I believe this would allow the development of a co-operative endeavour between ourselves, the college and the ministry in the area of block fees, remove the perception of a precipitate ban, but allow the government a fail-safe mechanism into the future.

1810

Dr Ted Boadway: The last issue we will address today is the vexing situation that physicians practising occupational medicine find themselves in as a result of this bill. When we saw this bill after first reading, it was immediately apparent that the long-standing billing practices of these physicians—billing practices as ordered by OHIP—were about to be stood on their head. A few days later, upon our first meeting with government officials, it also became apparent that this had not been contemplated and was an unintended consequence of the way the bill was drafted. I believe there is no other topic from this bill that has occupied more discussion time between the minister, the ministry and ourselves than this one. The government, however, having reflected upon this issue, will continue with this policy direction.

Occupational medicine physicians have been practising in industrial settings for years, performing an extremely valuable service that, as far as I can tell, no one contests. Most of the services they provide are clearly industrial medicine services and not insurable. However, these physicians, being in a workplace setting, will sometimes find themselves providing a service that could, in other circumstances, be billed as an insured service—for example, binding an injured thumb before sending the employee to emergency or seeing a suddenly bereaved employee before they leave the workplace. Also, there are a great number of services that clearly have a large occupational medicine component but may have a small health service component. If you look at the nature of these services, you will discover that Solomon himself, brought back to life, would have difficulty finding the plane of cleavage between what ought and what ought not to be billed to OHIP. These physicians have had many discussions with OHIP over the years, up to and including the general manager of OHIP, where they have been told categorically that they may not charge OHIP for any of the services provided in these settings. That is the way the general manager has resolved this issue over the years, and it has been satisfactory to everybody up till now. Bill 8 will require these physicians now to bill OHIP for any service that may be construed as an insured service.

Imagine that you're an occupational medicine physician. You suddenly find your contractual relationship with your employer altered, your directions for billing changed without notice 180 degrees. You never knew there was a problem because you were following the directions you had been given by OHIP and were billing appropriately, so you thought. There had never been any policy statement from the government suggesting there was a need to change billing practices completely and, in fact, there has never been an acknowledgement from the government even now that this change was being considered. Suddenly, it is in the bill.

This will require employers to collect OHIP numbers from employees and will result in a significant inconvenience in the work setting for everybody. The general manager, under section 13 of the bill, will for the first time have the power and authority to see industrial health records any time he chooses. Beginning to bill in an area where everyone recognizes there is a broad grey area will guarantee that from time to time the general manager will

be unhappy with the billings and that we will not have enough Solomons to sort this out. Physicians worry that they will inevitably be referred to the MRC. Occupational medicine physicians are understandably confused, stunned at the sudden turn, and afraid they recognize a future nightmarish scenario.

This has resulted in a credibility deficit for the ministry with these doctors. Given the way the bill is written, we are at a loss as to how to advise the government on how to get out of this accidental policy lurch through a legislative amendment. However, we do have some constructive suggestions on how it could recover some credibility with this group and find an acceptable tomorrow.

We recommend some simple things. We recommend that the ministry acknowledge that this radical change is actually taking place; that the ministry state that it values the practice of occupational medicine and has no intention of disrupting the practice itself; that the ministry recognize there will be new and increased costs in billings to OHIP which it is prepared to accept; that the ministry recognize there is a significant grey area of billings and it is prepared to be fair and reasonable in assessing this difficult area; that the ministry recognize there will be a new administrative burden imposed upon practitioners of occupational medicine.

These matters are rather self-evident and natural outcomes of the bill. We believe there can be a productive dialogue but only when the ministry acknowledges just what it is doing.

Dr Rapin: We have tried to focus today on three issues that we think can productively be amended to make the bill more workable and friendly to physicians and their patients. We look forward to seeing the amendments to this bill as you conclude your committee hearings. Thank you very much for your indulgence.

The Chair: Thank you for your presentation. We do have six minutes remaining.

Ms Smith: Thank you, Dr Rapin and Dr Boadway. Good to see you again, Dr Boadway.

I had a question about the block fees. I read through your recommendations twice, and I just want to make sure I'm clear on what you're recommending: that in the absence of regulations we allow the college to continue regulating block fees, but you're not asking us to repeal the government's right to regulate. Is that correct?

Dr Rapin: Well, the government, of course, has the right to do as it will, and we recognize that. We would prefer that this stay with the college. However, we recognize there are some concerns the government has had, and we understand why this is in the bill. We would prefer to see it out, but we understand why it's there. We would argue that allowing the college and the OMA and the ministry to solve the problem, or to at least address the problem, would make it unnecessary for the ministry to take this over.

Ms Smith: What you're proposing is kind of a stopgap measure to allow those negotiations to take place between the college, the ministry and the OMA?

Dr Rapin: Yes.

Ms Smith: OK. But you do recognize our concerns about block fees and the accessibility question?

Dr Rapin: We may not totally agree with them, but we do recognize them.

Ms Smith: Great. Thank you very much.

Mrs Witmer: I certainly agree with your first two amendments. They seem to be appropriate and could easily be incorporated into the amendments that the government might be looking at. I guess this last one is a little more complex. You said that you've talked to the ministry and so far have not had a lot of success. What seems to be the stumbling block to resolving this issue regarding those who practise occupational medicine?

Dr Boadway: I think the biggest problem with success has been figuring out how to actually repair what's been going on, and that's been a real burden. As I say, we can't really figure out how to do that within the context of the bill. In my experience, whenever legislation is written, there is always an unintended consequence somewhere. I don't think I've ever seen one where there wasn't. The question is, can you repair it?

This is a difficult one, and I would say the discussions with the ministry have been quite productive but not in any tangible way that brings us anything yet. They now understand what the problem is; they recognize it. I think they need to make a public declaration of that, because, so far, the doctors don't know that—the very ones it's going to visit itself upon.

Last week I met with a large proportion of the occupational health physicians in this province, because we had our annual meeting and they were there. I have to tell you, this was right at the top of their minds. They're all very worried. They can't figure it out. They're totally confused. If we clarified that confusion, it would start the dialogue.

Mrs Witmer: How much additional money will this probably cost OHIP?

Dr Boadway: Good question. I don't know. I've actually put some time to try to figure out, and we just don't have a clue.

Mrs Witmer: Thank you very much.

Mr Kormos: I'm just interested. The OMA is perceived as one of the most potent professional associations in the province, certainly one of the most powerful lobby groups, the nemesis of many a Minister of Health; indeed, government. And here you are, lining up with the plain folk to make submissions to this. Did the ministry not talk to you about this bill before they drafted it?

Dr Rapin: Frankly, no. We saw the bill once it was in draft—

Dr Boadway: It had passed first reading.

Dr Rapin: OK, it had passed first reading. That's one of the problems. If we had been allowed some input earlier, I think we could have helped the ministry avoid some of the pitfalls.

Having said that, the ministry has been very forthcoming in helping us deal with our concerns.

Mr Kormos: You mean in a therapeutic kind of way?

Dr Rapin: No. As I mentioned in my presentation, I believe we have achieved a great deal to help the min-

istry repair the bill, not completely, but we have achieved some.

Mr Kormos: I just find it peculiar that you tell us you weren't one of the groups, one of the bodies consulted before the bill was first drafted. I find that very unsettling.

Ms Smith: You're unsettled, Peter.

Mr Kormos: Well, I just find it very disturbing. You should not be so complacent about that.

The Chair: Thank you very much for your presentation this afternoon. That brings us to the conclusion of our hearings and deputations.

Just a reminder to the committee: The deadline for amendments is 12 noon on Thursday, May 13. We will adjourn to clause-by-clause next Monday, May 17, at 3:30 in committee room 1.

The committee adjourned at 1821.

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

Chair / Président
Mr Jim Brownell (Stormont-Dundas-Charlottenburgh L)

Vice-Chair / Vice-Président
Mr Jeff Leal (Peterborough L)

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh L)
Mr Kim Craitor (Niagara Falls L)
Mr Brad Duguid (Scarborough Centre / Scarborough-Centre L)
Mr Peter Fonseca (Mississauga East / Mississauga-Est L)
Mr Tim Hudak (Erie-Lincoln PC)
Mr Frank Klees (Oak Ridges PC)
Mr Peter Kormos (Niagara Centre / Niagara-Centre ND)
Mr Jeff Leal (Peterborough L)
Mr Ted McMeekin (Ancaster-Dundas-Flamborough-Aldershot L)
Ms Kathleen O. Wynne (Don Valley West / Don Valley-Ouest L)

Substitutions / Membres remplaçants
Ms Monique M. Smith (Nipissing L)
Mrs Elizabeth Witmer (Kitchener-Waterloo PC)

Clerk / Greffière
Ms Susan Sourial

Staff / Personnel
Ms Lorraine Luski, research officer,
Research and Information Services

CONTENTS

Tuesday 11 May 2004

Commitment to the Future of Medicare Act, 2004, Bill 8, *Mr Smitherman /*
Loi de 2004 sur l'engagement d'assurer l'avenir de l'assurance-santé,
projet de loi 8, *M. Smitherman* J-585

Halton Healthcare Services J-585
Mr Shavak Madon

Catholic Health Association of Toronto; Salvation Army/Toronto Grace Hospital J-587
Mr Ron Marr
Mr Peter Lauwers

Ontario Federation of Community Mental Health and Addiction Programs;
St Jude Community Homes J-589
Mr David Kelly
Ms Angela Shaw

Ontario Dental Hygienists' Association J-591
Ms Margaret Carter

Ottawa Hospital J-594
Dr Jack Kitts
Ms Peggy Taillon-Wasmund

GTA/905 Healthcare Alliance J-596
Mr Kirk Corkery

St Joseph's Healthcare Hamilton; St Mary's General Hospital, Kitchener;
Hamilton Health Sciences J-599
Dr Kevin Smith

Coalition of Family Physicians of Ontario J-601
Dr Douglas Mark
Dr John Tracey

Ontario Medical Association J-604
Dr John Rapin
Dr Ted Boadway