J-13

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)

Monday 3 May 2004

Journal des débats (Hansard)

Lundi 3 mai 2004

Standing committee on justice and social policy

Organization

Commitment to the Future of Medicare Act, 2004

Comité permanent de la justice et des affaires sociales

Organisation

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

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

Monday 3 May 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE ET DES AFFAIRES SOCIALES

Lundi 3 mai 2004

The committee met at 1552 in committee room 1.

ELECTION OF CHAIR

Clerk of the Committee (Ms Susan Sourial): I call this meeting to order. Honourable members, it is my duty to call upon you to elect a Chair. Are there any nominations?

Mr Kim Craitor (Niagara Falls): I'm pleased to put forward the name of Jim Brownell as Chair of this committee.

Mr Ted Arnott (Waterloo-Wellington): I'd be happy to second that nomination.

Clerk of the Committee: Are there any further nominations? Seeing none, I declare nominations closed and Mr Brownell elected Chair.

The Chair (Mr Jim Brownell): Thank you, ladies and gentleman, for the confidence in my position as Chair. I look forward to working with you.

ELECTION OF VICE-CHAIR

The Chair: It is now my duty to call upon you to elect a Vice-Chair.

Mr Craitor: I'm pleased to put forward the name of Jeff Leal as Vice-Chair of this committee.

Mrs Elizabeth Witmer (Kitchener-Waterloo): I know we don't have to but I'll second that.

The Chair: There being no further nominations—oh, are there further nominations? I should ask that first, I suppose. There being no further nominations, I declare the nominations closed. Mr Leal, I welcome you. You are elected Vice-Chair of this standing committee.

SUBCOMMITTEE APPOINTMENT

The Chair: Next on the agenda we have the subcommittee on committee business. Do we have that?

Mr Craitor: Yes. I'm on a roll, so I'm pleased to ask that Mr Duguid be appointed in the place of Mr Gravelle on this committee.

The Chair: OK, we have Mr Duguid as a replacement on the committee. Any discussion? Any comments on the appointment to the committee? If not, I welcome you to the committee, Mr Duguid. Carried.

SUBCOMMITTEE REPORT

The Chair: Next we have the report of the subcommittee.

Ms Kathleen O. Wynne (Don Valley West): I'll read the report of the subcommittee.

Your subcommittee on committee business met on Tuesday, April 20, 2004, and recommends the following with respect to 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.

(1) That the committee meet for the purpose of holding public hearings in Toronto on May 3, 4, 10 and 11, 2004, from 4 pm to 6 pm;

(2) That the committee invite the minister, if he wishes to appear, on Monday, May 3, 2004, for a 10-minute briefing statement followed by 10-minute statements by the official opposition and the third party;

(3) That the committee clerk, with the authority of the Chair, post information regarding the hearings on the Ontario parliamentary channel and the committee's Web site;

(4) That interested groups and individuals who wish to be considered to make an oral presentation on Bill 8 should contact the committee clerk by 5 pm, Wednesday, April 28, 2004;

(5) That if all groups can be scheduled, the committee clerk, in consultation with the Chair, be authorized to schedule all interested parties;

(6) That if demand exceeds availability, groups and individuals be chosen on a first-come, first-served basis;

(7) That late requests be accommodated if availability exceeds demand;

(8) That groups be offered 15 minutes in which to make a presentation and individuals 10 minutes;

(9) That the deadline for written submissions be 12 o'clock noon, Friday, May 7, 2004;

(10) That the research officer prepare an interim summary and a full summary of the testimony heard;

(11) That amendments be filed with the clerk of the committee by 12 noon, Thursday, May 13, 2004;

(12) That the committee meet on May 17, 18 and, if required, May 31, 2004, for clause-by-clause consideration;

(13) That there be no opening statements at clause-by-clause consideration; and

(14) That the clerk of the committee, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair: You've heard the summary of the decisions made at the subcommittee on committee business. Are there any comments or questions? Seeing none, I would like to ask, all in favour of the report? Carried.

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.

STATEMENT BY THE MINISTER AND RESPONSES

The Chair: We have with us this afternoon, and I would like to welcome, the Honourable George Smitherman, Minister of Health and Long-Term Care, to our hearings. Mr Smitherman will have 10 minutes to make a presentation, followed by the official opposition having 10 minutes, and then the third party will have 10 minutes. Welcome, Mr Minister.

Hon George Smitherman (Minister of Health and Long-Term Care): Thank you. I feel welcome.

I've got George Zegarac, I think well-known to you now, as assistant deputy minister.

It's a privilege to have another opportunity to address the committee on Bill 8, the Commitment to the Future of Medicare Act.

Since February, our government has heard from a cross-section of Ontarians and stakeholders as the committee travelled the province during the first public hearings. The bill has been the subject of spirited debate in the Legislature and in the media. And ministry staff have had the opportunity to meet one on one with groups about amendments that we introduced after first reading.

We've listened to Ontarians and we've made amendments that ensure Bill 8 is clear and true to its purpose: to make our public medicare system responsive, accessible and accountable. This open and transparent dialogue has resulted in a bill that our government is extremely proud of.

I want to acknowledge and personally thank my legislative colleagues on the standing committee on justice and social policy from all parties. I'd like to recognize the past committee Chair, Kevin Flynn, Vice-Chair Jim Brownell and my parliamentary assistant, Monique Smith, for their leadership. I'd also like to congratulate Mr Brownell, who was elected committee Chair, and Jeff Leal, who assumed the role of Vice-Chair today. You're moving up.

I also want to thank all people who took an interest in this crucial bill and took the time to offer their perspective and their constructive criticism.

Bill 8 reflects the values of our government and the values that give medicare its life and meaning. I've said on many occasions that medicare is the very best expression of Canadian values. Our government believes in a universal, publicly funded health care system that gives us the care we need, on the basis of need, not on the size of our bank balance or on the quality of our Rolodex.

1600

Medicare does need our protection. There are various forces alive and well in Canada that claim that the only way to fix public health care is to abandon its principles and to offer a parallel private system for those who have money. Our government disagrees entirely. In Canada, health care is not a commodity to be bought or sold; it is a basic right. Are changes needed? Absolutely, but the changes we are talking about will bring our public system back to its founding values. These changes will breathe new life into medicare. Real, significant, system-wide change is needed to make medicare more responsive, more focused on quality outcomes and more accountable to the 12 million Ontarians who own the health care system.

No one has made the case for medicare renewal as passionately and as persuasively as Roy Romanow. He laid out the challenge ahead this way: "Canada's journey to nationhood has been a gradual, evolutionary process, a triumph of compassion, collaboration and accommodation, and the result of many steps both simple and bold.... That next step is to build on this proud legacy and transform medicare into a system that is more responsive, comprehensive and accountable to all Canadians." Bill 8 gives us an effective tool to change the status quo in Ontario.

The purpose of this landmark Bill 8 is to protect the defining values of medicare and to modernize and sustain medicare for future generations of Ontarians. During the debate about Bill 8, we heard a lot of what Bill 8 isn't. Today I want to celebrate what Bill 8 is and how it paves the way for the future of medicare in Ontario.

First, Bill 8 protects and promotes the accessibility of our public health care system. Accessibility is a tenet of the Canada Health Act. It is the notion that every citizen, regardless of economic means, where they live, their age

or ethnicity, should never be denied the health care they need. Ontarians and other Canadians tell us time and time again that accessibility is the health care issue that they care about the most. When it comes to health care, there's only one kind of Ontarian, and Bill 8 takes real action against two-tier medicine.

Bill 8 is transformative legislation because it reinforces the principles of the Canada Health Act by strengthening prohibitions against two-tier medicine. Bill 8 requires mandatory reporting of activities like queue-jumping and extra-billing and it gives the ministry greater ability to uncover potential instances of extra-billing and queue-jumping. For example, the general manager of OHIP would be able to collect key information from providers if they suspect that payment for queue-jumping has taken place. Today, consumers and providers who witness queue-jumping and extra-billing have no protection against reprisals if they speak up. Bill 8 would protect whistle-blowers who expose two-tier activities because we believe that the people who own the system ought to be involved in helping to defend it.

In the past, doctors were able to opt out of OHIP and bill patients directly for insured services. This bill puts an end to that practice. Bill 8 would make block fees that physicians charge for non-OHIP services more transparent. It guarantees that no Ontarian is discriminated against or denied care if they refuse to pay a block fee. It protects the consumer against excessive or inappropriate fees for uninsured services. Bill 8 poses a direct and potent challenge to two-tier health care.

You'll hear from some people over the next few days who have distorted the debate about Bill 8 and who say it gives government the power to privatize health care. They could not be more wrong. They could not be more misleading. Let's look at the facts. The bill is designed to root out and ban the activities that charge people for medically necessary insured services. It prohibits people from being able to pay their way to faster care. Bill 8 is about ensuring that medically necessary insured services remain publicly funded, publicly controlled and universally accessible, period. Full stop.

We decided to explicitly state in the bill that it will not allow collective agreements to be opened, or reduce or change the protections provided to workers under current labour laws. We did this to provide absolute certainty and allay the misplaced fears that some labour unions have created amongst their members. Collective agreements and labour rights were never a part, and never intended to be a part, of this bill.

One of the aspects of Bill 8 that I'm most proud of is the Ontario Health Quality Council. Our approach to government and to politics is to be clear about what we're trying to achieve, to be candid about how we want to get there and to be honest about the success that we're having. We believe that accountability is a cornerstone of the relationship between the government and its citizens. Our government has laid out a clear agenda for positive change. We stated where we intend to go, how we intend to get there and the results that people should expect. The bottom line is this: We will be measured against what we promised, and we welcome that test.

As a government, we face scrutiny every day—from stakeholders, from the media, from the opposition in the Legislature, but most of all, from the people of the province of Ontario. Our democratic system holds us to account every day. But we want to go farther than that.

The Ontario Health Quality Council is the tool that will provide meaningful, timely, unbiased information to the people of Ontario about the state of health care and about the state of their personal health. Its purpose is to track continuous quality improvement. Ontarians have never before had a way of knowing how our system was performing. Hospital report cards and other sector-specific reports have given people some useful information on how different parts of the system are working, but there has been no mechanism that monitors and tracks health care performance as a whole.

Ontarians deserve to know the facts. Roy Romanow argues that results-based information is critical if health care is to be truly accountable to citizens. Roy Romanow said that accountability is the missing sixth principle of the Canada Health Act. Our government is correcting that by adding the principle of accountability to medicare.

Roy Romanow also proposed the creation of a Health Council of Canada as a mechanism to bring the provinces and territories together around measuring and reporting to Canadians on system performance. In a similar way, the Ontario Health Quality Council would monitor and report to Ontarians annually about how the system is performing in the areas that matter to people most, areas such as wait times for cardiac care, hip and knee replacements or cancer care, or whether they have a family doctor or family health care that's close to home. The council would report to people not only on access to publicly funded health services, but also on health human resources, population health status, and the prevalence of serious and preventable diseases such as diabetes. It would track rates of physical activity, obesity and smoking.

The council would enable people to hold the government and our health care sectors to account, and by helping people understand their health care better, it would enable Ontarians to take greater responsibility for their personal health.

The council exists to serve the broad and diverse interests of Ontarians. It would be composed of independent people drawn from our communities who are dedicated to the pursuit of quality health care.

The council cannot be allowed to be captured or sidetracked by narrow agendas or siloed thinking. We've made sure that the council does not represent individual stakeholder groups, but allows the broadest perspective possible to advance the agenda of our most important stakeholders—12 million Ontarians who are counting on us.

As I've said before, accountability is a two-way street, and Bill 8 effectively brings the notion of shared accountability to life. I'm glad to report that my ministry has worked diligently with hospitals through the joint

policy and planning committee to draft a framework for accountability agreements. When completed, the framework will no doubt form the basis of the accountability agreements we will be developing with all hospitals.

We look forward to continuing the public dialogue about Bill 8. We all have an enormous opportunity to deliver on Roy Romanow's vision. To quote Roy Romanow a few weeks ago at the RNAO annual general meeting, "Ontario's Bill 8 has some very important features that reinforce what we had in mind regarding accountability. It seems to me that Ontario wants to do the 'real work' required to ensure medicare sustainability. And Premier McGuinty played a key role in breaking the log-jam that led to the creation of the Health Council of Canada."

I'll close on the point, because I do believe this is work that has been inspired by the work that Roy Romanow did on behalf of our country, and I'm very proud to have his comment the last one as relates to my opening remarks.

The Chair: Thank you. Next we have the official opposition, 10 minutes.

Mrs Witmer: If I take a look at Bill 8 and I take a look at what I've just heard the minister say, I don't hear any comments regarding the amendments that have been made to Bill 8 and the willingness of the government to make additional changes to the legislation. Regrettably, many of the concerns that have been expressed have not yet been addressed. Despite the many, many nice words that both the federal and provincial governments have for the Roy Romanow report, we've seen little real action in response to that.

1610

I guess my question to the minister would be: You talk about two-tier, and you talk about the fact that this bill is going to eliminate queue-jumping or extra-billing. I would suggest to you that the key problem is the fact that the reason we have two-tier, the reason people queue-jump, the reason people do this is because the waiting lists are too long. And I guess one of the things I don't see addressed in this bill at all is the whole issue of waiting lists or an improvement in the access to care.

Hon Mr Smitherman: That seems like more of a comment than a question. Here's what I'll say to some of what you just said. Firstly, I did highlight some of the amendments we have made as a result of comments that have been made through this debate. Secondly, I don't want to prejudge what will be said over the course of the next three or four days of committee hearings, but I have sent the message—and I send it again today—that I'm listening. While I accept some of your point that concerns remain from some groups, I think there is also widespread acknowledgement, if I might characterize it, that the gulf of difference of opinion has been narrowed dramatically as a result of the amendments that have already been brought forward.

On your last point, I don't think it's very helpful or healthy to have the debate about Bill 8 turned into a discussion about everything a person might want in health care. I've never suggested, as an example, that this is the health care bill for our government for four years. In part measure, we've already had Bill 31 on the health privacy side.

Wait times are a critical focus of our government. We're increasingly results-based. Romanow says there is progress. Romanow says this bill is progress toward his report, because in part measure his report called for bringing accountability as the sixth principle of the Canada Health Act, but I think his words stand well on their own.

My final point to you, to go back to what you said with respect to waiting lists, is we don't even have a mechanism for proper capturing of wait-time challenges as they exist on a region-by-region basis. I think you know that from your days as minister. But our drive toward that is really an essential ingredient in the Ontario Health Quality Council. I think that Romanow sees progress in Bill 8, but I'm not here to suggest to you that Bill 8 is the be-all and end-all for what our government is about but an important framing for much of what we intend to do.

Mrs Witmer: Thank you very much, Minister. On the issue of accountability, I guess one of the complaints we've heard over and over from presenters is the fact that this bill does not hold you accountable for your actions. Instead, it does bestow some tremendous power. I guess one of the questions I would ask, and I know it was a concern for the stakeholders, is why is accountability only a one-way street in this bill, if it's such a key principle of medicare? The accountability is only on the health care provider group; it's not on the ministry or the minister.

Hon Mr Smitherman: I wish I could answer a question with a question. Part of it would be, when you were the Minister of Health, did you feel a shortage of accountability? In a certain sense, that's what you're saying.

What I would outline is that there are many mechanisms for accountability that are already in the system. But I believe that a government that's willing to establish the Ontario Health Quality Council, which will on an annual basis report to Ontarians about the state of their health care system, is developing one of the most extraordinary tools of accountability that's ever been done in health care. The reason I believe so strenuously in that point is that in the six months and a few days I've been the Minister of Health, I've been astonished by the bevy of information that comes, the barrage on a daily basis, saying, "Make this expenditure and gain that benefit. Make this expenditure and gain that benefit."

Ontarians would be hard pressed to see through that and determine what priorities ought to be focused on. I think the Ontario Health Quality Council will play an incredibly effective role of actually making health care information accessible to people in a format they can come to terms with at a glance. Just as an example—I'm not ragging the puck—if we had an Ontario Health Quality Council report that showed a growing wait list on

a particular problem, that would stand out and would be an incredibly powerful source of accountability. As the public said, "Your commitment is toward continuous improvements on results. This is diminishing. What are you going to do about it?", that's accountability. That's what the Ontario Health Quality Council is about.

Mrs Witmer: Let's talk about the Ontario Health Quality Council because, regrettably, what your government promised in the speech from the throne was an independent council that would report directly to Ontarians, and what this bill gives us instead is a council that will report to you, who will then table a report in the Legislature. So this council has absolutely no power to make any recommendations. It's not independent; it's totally beholden to the Ministry of Health.

Again, this is a promise that simply has been broken, and I don't think people expect this council to have any teeth whatsoever.

Hon Mr Smitherman: Before you prejudge what the Ontario Health Quality Council will do, you should have something of a more open mind, because what I've said very clearly is that independence can be found in many different ways and, in part measure, independence can be found from the quality and reputation of the individuals who will form it.

The message I send to you, and that I send to Ontarians, is that we will harness among the capacity of Ontarians representatives who have capacity independence and provide confidence around the information they're presenting. We have made it clear that the information they develop and present in the form of their report is information that will of course be for the public of Ontario. I think that much independence will be found from the quality of the representation that we intend to appoint.

My last comment on this would be that that's why we've really staked this out as the territory for 12 extraordinary, impressive Ontarians, not representatives on a day-to-day basis as stakeholders here and there, but people who bring to their role a sense of responsibility and independence around presenting information that will be to the benefit of all Ontarians.

Mr Arnott: On a quick point of order, Mr Chairman: It's customary when a minister appears before a standing committee of the Ontario Legislature that the members of the committee are furnished with a copy of his or her comments. As of yet, we still haven't received a copy of the minister's comments. I'm not sure if it was deliberate or not, but it makes it more difficult for us to respond if we don't have a written copy. I was just wondering why we haven't as of yet received those copies.

The Chair: I understand they are being photocopied at this moment and they will be here.

That does bring us to the end. Thank you. Next, we have Ms Martel.

Ms Shelley Martel (Nickel Belt): I'm going to use the time I have to make comments in response to what the minister has said and to reinforce again the New Democrats' opposition to this bill. I'll repeat the points I have made before because, frankly, they're worth repeating.

We oppose this bill for three reasons: (1) because of the arbitrary and unilateral powers that are given to the minister, despite the minister's assertions that accountability agreements will be negotiated; (2) because the bill does nothing to stop the ongoing privatization of health care that was started under the Conservatives and that, frankly, your party seems intent on continuing with; and (3) because there is a complete lack of any concrete power given to the health quality council to hold the government accountable. Let me deal with the three of those in that order.

First of all, with respect to the arbitrary, unilateral powers of the minister who has said on numerous occasions that accountability agreements will be negotiated, frankly, nothing is further from the truth, because the provisions in the bill after clause-by-clause still make it clear that the government has the unilateral right to impose either orders or compliance directives. I just want to highlight some of the sections to point that out.

Subsection (4) on page 25 says the following: "If the health resource provider and the minister do not enter into an accountability agreement within 60 days after the minister gave notice under subsection (1), the minister may direct the health resource provider to enter into an accountability agreement with the minister and with any other health resource provider on such terms as the minister may determine, and the health resource provider shall enter into and shall comply with the accountability agreement."

Page 27, subsection (4), "The minister shall consider any representations made under subsection (3) before making a decision to issue a compliance directive or an order under subsection 26(1)."

Subsection (2), page 28, under "Compliance":

"(2) The health resource provider shall comply with a compliance directive."

1620

Then on page 30 of the bill, under "Compliance" again:

"(2) The health resource provider shall comply with an order issued under subsection (1)."

Then with respect to "Directions," on page 32 of the bill, with respect to the CEO in particular, it says:

"(6) An order issued under subsection (5) may require the chief executive officer and health resource provider to comply with any directions set out in the order relating to any or all of the following:

"1. Holding back, reducing or varying the compensation package provided to or on behalf of a chief executive officer in any manner and for any period of time as provided for in the order and despite any provision in a contract to the contrary.

"2. Requiring a chief executive officer to pay any amount of his or her compensation package to the crown or any person.

"Compliance

"(7) A chief executive officer and a health service provider shall comply with the directions set out in the order."

It's not just me who is of the opinion that the minister, even in the amended bill, continues to have arbitrary and unilateral powers. The Ontario Hospital Association wrote to the minister on March 17, 2004, and committee members were copied. It says the following:

"While progress has been made, the amendments made on March 9 have not yet corrected what hospitals see as the most serious aspects of the bill. We believe further changes need to be made to sufficiently safeguard the critical role of community governance of hospitals.

"The central problem with Bill 8 is that it gives the provincial government the power to impose anything it likes on any individual hospital, bypassing hospital boards, the people who know the most about the hospital and the services it provides to the community."

Then the letter goes on to point out the sections that they think need to be changed and the particular section that they think should be dropped altogether. We'll hear more from them this afternoon. I'm not sure if that's still their position, but it certainly was as of March 17, after the bill had been amended.

This is a letter we received April 7, 2004, from North Wellington Health Care. It says the following:

"The ministry is steadfastly painting the picture that all is well and that with the help of the province, hospital governance will be fine. I have over 25 years' experience in hospital governance—and from that experience, I have concluded that will not be the case. We need, and historically have had, real governance at the local level by voluntary boards made up of community members. This is in tune with the rural and northern health care framework. If the public wants to knowingly change that governance model, so be it. The problem with Bill 8 however is that the change is being made in the shadow of that worthwhile and now ubiquitous term 'accountability.' The public (and likely some hospital board members) don't generally understand that. It is difficult enough now to recruit good, committed volunteer board members—if Bill 8 becomes law, as amended, I predict that current and prospective board members will decline the job of being local window props for the provincial level of government." Signed by G. W. Deverell, who is the board chair.

Again, that was sent to the committee members after the amendments that were made.

So it's clear to me both from the provisions of the bill and the response that we have received by the OHA, which normally acts on behalf of its member hospitals, and one particular hospital that I pointed out, that the powers of the minister continue to be arbitrary. There is no semblance of negotiation, and the government should, as I've said many times before, have an independent dispute resolution mechanism that can be used to deal with disputes. That way you're not seen to be taking over the community; that way both parties can have their say; and that way everyone lives with the response and recommendations that come from someone or some body that is seen to be independent, because the ministry and the minister will not be seen to be independent in this regard.

Secondly, the bill is about protecting medicare. That's what the minister said, and he pointed to Roy Romanow's work to show that no one had done more to try and make public health care a public issue. I agree. I guess the problem I have is that I don't understand why this government continues down the road of privatization of health care services started by the former government. Let me give three examples.

P3 hospitals: The commitment that was made by the Premier before the election was very clear. Dalton McGuinty said the following to the Ottawa Citizen on May 28, 2003:

"What I take issue with is the mechanism. We believe in public ownership and public financing (of health care). I will take these hospitals and bring them inside the public sector."

The fact of the matter is, the only change we now have is that the Conservative mortgage has become a Liberal lease. We still now have the onus on the hospital and the board, through the operating grant, to pay a mortgage payment, where previously hospital construction and reconstruction would have been done through a capital grant, therefore never putting at risk operating funds, which should be dedicated and directed to patient care.

We're going to pay a whole lot more for the private sector to do this capital construction. We're going to pay more because the private sector consortium will have to borrow money at a higher interest rate than government will and because the consortium is not going to do this work for free. Of course the consortium is going to want a profit on top of the building costs. So the public pays more for the private sector to build a hospital or renew a hospital than we would if the government was doing so itself. And my argument continues to be that the hospital in Brampton and the hospital in Ottawa and any other hospital renovations and reconstructions that you're going to undertake should be done by the government through a capital grant. That way, we can ensure that money that should be going to patient care goes to patient care and doesn't have to be redirected to pay a mortgage, which is what's going to happen when it has to be paid through the operating grant.

Secondly, and I raised this with you last week in question period, Minister: the whole issue of the private MRIs and CAT scans. You will know what your government had to say in your health care platform about both of these things and you will know that you clearly made a commitment that you would close these private sector clinics. You said:

"We will cancel the Harris-Eves private clinics and replace them with public services. The Romanow commission proved there is no evidence to support expanding private diagnostic services.

"Many communities have already raised money for a new MRI or CT for their local hospital but have been

denied operating funds by the Harris-Eves government. Instead of opening private clinics, we will work with these communities to expand access in the public system."

Six months later, we're still waiting. We need to shut these down. You need to put this technology into the public health care system, and you need to do that by providing the operating funds to those hospitals that have already raised the capital funds for that technology.

The third problem with privatization is the murmurings and the musings about ending the universality of the drug benefit program. If you do that, people will pay user fees, which will be exactly contrary to the preamble stated in the bill.

The final note on the health quality council: If you really want to give this group some teeth—and I have no doubt you will find excellent people to serve—you will allow them to make recommendations on their findings. You will allow them to make recommendations to you with respect to the spending of health care dollars, the allocation, changes to government policy, changes to government health care legislation. If you don't, their work will be for naught.

The Chair: Thank you. That brings us to the end.

Thank you, Mr Minister, for your presentation.

CAW CANADA

The Chair: Next, we have the Canadian Auto Workers. We have three representatives, I believe. Just make yourself comfortable at the table.

Before making your presentation, please state your name for Hansard. I'd also like to remind you that there will be a time period of 15 minutes for your presentation. If you don't use the 15 minutes, then we will have a round of questions, starting with the official opposition, the third party, and to the government side. Should we only have a minute, we will start with the official opposition and then the next time we only have a minute we'll go to the third party and work it that way.

I welcome you, and you have 15 minutes for your presentation.

Mr Paul Forder: I'm Paul Forder, the director of membership, mobilization and campaigns for CAW Canada. With me to my right is Corey Vermey, our national representative on health care issues in the research department; and Darlene Prouse, vice-president of Local 2458, a health care local that stretches from Windsor to the southwest, with 4,000 members.

It is indeed a pleasure to be back before the committee. We'll keep coming back as long as you are open to some suggestions so we can try to get this right. We believe this is essential to the well-being of Ontarians, and we know you agree.

You've probably heard as many opinions as you have had presenters. We do represent 180,000 members in Ontario, 20,000 of whom are health care workers. So you can see this interest for us as representing workers in the industry, as well as being people who enjoy the benefits of a good health care system. We require having more dialogue and hopefully trying to impress upon the committee the importance of our particular views.

1630

Our comments today reflect the understanding of the act and are based on Bill 8 as debated and carried to second reading prior to being referred back to the standing committee. The tabled amendments to Bill 8 by the Minister of Health and Long-Term Care generally provided the specific language for potential changes mentioned in the February 19 letter from the minister to the standing committee.

In overview, while the vast majority of the adopted amendments indeed did reflect the minister's announced intention to address concerns of our union and many other organizations and individuals, the amended Bill 8 remains far from being complete. For completeness, to accurately reflect the commitment to the future of medicare that the current government campaigned so earnestly to express and defend and that the public in Ontario clearly endorsed in October 2003, we believe the following has to be taken into account and incorporated into the act:

(1) That concrete initiatives were receiving legislative enactment to apply the fundamental principles of the Canada Health Act;

(2) That the legislation would clearly prohibit public-private partnership schemes (P3s) and ensure an immediate return of testing being performed in private diagnostic clinics to hospitals—we really are at a loss as to why this cannot be entertained;

(3) That the legislation would clearly enshrine as a public policy goal in Ontario a determination to end the creeping privatization that has occurred in recent years;

(4) That the legislation would ensure that the proposed health quality council be an objective body with a democratic appointment process, including a prohibition of membership by for-profit providers, and a requirement to report to the public and make recommendations on how the provincial health system meets the principles of the Canada Health Act;

(5) That the legislation ensure effective accountability of the health institutions and the Minister of Health to the people of Ontario, including democratic control, meaningful public input and consultation, transparency and full disclosure of whistle-blower protection;

(6) That the legislation clearly eliminate such practices as block fees and any other form of patient charge or fee, delisting and queue-jumping for what purportedly are medically unnecessary procedures;

(7) That the legislation lay the foundation for a robust and collective effort to build and extend the values and foundation of medicare to ensure a high-quality, accessible, publicly delivered health system capable of ensuring effective services and outcomes.

We acknowledge that the changes to the preamble in Bill 8 is an effort to ensure a balancing of the public interest or community with the imperative of efficient delivery, as well as a replacement of the term "con-

sumer" with that of "individuals." Both are welcome changes but of little substantive effect. The substance of our earlier submission on the inadequacies of the preamble in such a significant legislative tribute to the fundamental values Ontarians hold remains germane.

Mr Corey Vermey: I would like to just take the committee members through a number of key points and observations in our submission. The first is with regard to the health quality council. The key argument that we wish to present to you is that fundamental to the role of the council must be an accounting, an annual report to the public in Ontario of the extent of privatization in our health care system.

We have specified how that could be achieved, consistent with our understanding of the requirement by the federal government under the Canada Health Act. Surely, if the commitment is to at least assess, if not stop, the creeping privatization, we have to measure it and acknowledge in what direction it is moving. So we would urge the committee members to again look at that issue and find it within the mandate of the council to provide that information to the public in Ontario.

We are reiterating earlier comments. With regard to the candidates for the council, we are somewhat concerned with the new elements in the definition. We would be concerned, for instance, that very reputable individuals in the field of health policy, by virtue of their association with organizations such as the Ontario Cancer Society or, for that matter, the Ontario Nurses Association, would be precluded from membership on this council, but another individual such as Michael Kirby, who sits on the board of Extendicare, may in fact be eligible for membership by virtue of his role as a member of the Senate of Canada. We believe that definition needs to be reconsidered and the intent of the language clarified. Obviously, the government will have the discretion in making the appointment, but we believe that there are a considerable number of esteemed individuals—Roy Romanow is certainly a lead individual in Canada, but in Ontario many others come to mind—who, as advocates for the expression of our commitment to medicare, would do well on this.

The related comments, again, turn to the issue of the role of experts in this council and its size. Certainly, we believe both can be gainfully reconsidered with a view to the importance that many have already expressed this afternoon that the council should attain in this province.

On the issue of accessibility, our contribution, hopefully, to the work of the committee is to specify some of the key elements of whistle-blower protection. We acknowledge that there is provision in the act for whistle-blower protection. Regrettably, it is very specific to provisions of the act dealing with block fees, dealing with queue-jumping, dealing with specific practices. We submit that, in a bill such as this, with regard to accountability the whistle-blower provision should be a very general provision that makes legislative room in this province for the employees in the system to step forward when in the course of the performance of their duties they observe matters that, in good faith, they believe the public in Ontario should be aware of and the government in Ontario should take action on.

Mr Forder: Darlene Prouse will do our wrap-up.

Ms Darlene Prouse: In conclusion, we commend the government for its commitment to securing the future of medicare in Ontario through adoption of several of the recommendations of the Romanow commission. As the Minister of Health stated to the Legislature on November 27, 2003, in presenting Bill 8, the Romanow report came to one pivotal and irrefutable conclusion: the pursuit of corporate profit weakens—not "strengthens"—health care.

However, on March 23, when Minister Smitherman rose to move second reading of the bill, at no point did he refer to the threat of creeping privatization, the threat of corporate profits weakening health care in this province. In the past month, thousands of concerned members of the public gathered at Queen's Park to urge the government to hold to its commitment to end P3 hospitals. In recent days, the pre-election Liberal commitment to close for-profit MRI and CT scans and expand accessibility in the public system was jettisoned by the minister when he indicated that he is not prepared to force for-profit MRI clinics out of business.

In recent days, nursing home operators began announcing layoffs among their nursing staff in response to the reduction in supplementary funding for municipal property tax expenses. In recent days, several municipal homes for the aged have reconsidered their original intention to rebuild non-profit long-term-care facilities due to lack of provincial capital funding support.

The test of Bill 8 in recognizing the legacy of the deep and profound commitment of Canadians to medicare is the ability of the people of Ontario to hold their government and health care providers accountable for strengthening health care and resisting the creeping privatization that threatens access, quality and sustainability of universal public health care. We agree that medicare is the best expression of Canadian values. However, any effort or intention to renew and transform medicare to make it sustainable for future generations must confront the unsustainability of permitting further for-profit encroachment in this vital area.

1640

Mr Forder: We'd be happy to take questions.

The Chair: We have about four minutes, so a quick question from each caucus.

Mr Arnott: Thank you, Mr Forder, to you and your colleagues for coming forward and expressing again to this committee your views on Bill 8. The opportunity that you had today is due in no small part to the efforts of our party's health critic, Elizabeth Witmer, and the good work she did when we concluded the government was unprepared to move forward with some of the amendments we felt were important. As a result of the public hearings, we, as a party, called upon the government to refer this bill in its amended form back to this committee. So you've had a chance to have another kick at the cat, so to speak, and express your views on the amended bill.

You've said that you feel the bill is still "incomplete"—that's the word you used. I'd like you to summarize again very briefly what you see lacking in this bill, specifically as to your role in representing your 20,000 members who are health care workers.

The Chair: Briefly.

Mr Forder: We need some toughening up on the whistle-blowing protection. We need a safeguard.

We have to get away from having any part of the health care system privatized—that's either through the delivery or the building. It should remain in the public domain. We learned from the Honourable Minister Pettigrew how sensitive an issue this is across the country. I hope this committee gets it right; I hope this government gets it right. I think they're on the right track.

We also think that this council has to have some authority to report on what's happening, to follow up on the recommendations and to make recommendations to the minister that will enhance medicare and the future of public health.

Ms Martel: I want to focus on privatization. The minister, in his opening remarks, said, "Bill 8 takes real action against two-tier medicine." In the province of Ontario, we still have P3 hospitals, and he made it pretty clear last week that he was in no hurry to shut down the private MRI-CAT scan clinics. There are no provisions in this bill to shut them down. There are no provisions in the bill to shut down the P3 hospitals either. What do you think about a bill where the minister purports to protect medicare through the bill when there are absolutely no provisions to do that, and further, when the direction of the current government seems to be very much like the direction of the old?

Mr Forder: That is our biggest disappointment. We believe that they didn't create the problem, but they can, in fact, with the power they have today, shut the door on P3s. It's not there, it's not evident, and this is not going away. I can tell you that in our membership this is the number one issue. We were participating in the P3 demonstration not long ago. This issue will not go away until we get it right, so that people have the assurance that it will remain in the public domain well into the future.

Ms Monique M. Smith (Nipissing): On the membership of the Ontario Health Quality Council, you made reference to people who had affiliations with different organizations and might not be eligible. I would just draw your attention that the bill states it's only those who have a position of "A member of the board or the chief executive officer or an officer of a health system organization may not be a member of the council." Just because you're a member of ONA or a member of the CAW doesn't mean your affiliation would disqualify you from being on the board.

Conversely, you made mention of the fact that Senator Kirby would be allowed to be on the board despite the fact that he's on the board of Extendicare. That, in fact, is not correct, because he is on the board of a health system organization. Sorry, I have to get back into the lingo; it's been a couple of weeks. The health system organizations are defined in the act as "any corporation, agency or entity that represents the interests of persons who are part of the health sector." Therefore, as a member of the board, he would be disqualified. I just wanted to clarify that for the record.

Mr Vermey: We're very grateful for the clarification. We were concerned how the government would consider Michael Kirby as a candidate for the council, and it's reassuring to hear what you've expressed.

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

YORK REGION HOSPITALS JOINT EXECUTIVE COMMITTEE

The Chair: Next we have the York Region Hospitals JEC, Damian Bassett, the chair. Welcome. Make yourself comfortable. You will have 15 minutes. You can use it as you like. If there's time remaining, we'll do as we just did and have questions. We'll be starting with the third party.

Mr Damian Bassett: Thank you, Mr Chair. Good afternoon, ladies and gentlemen. It's my pleasure to be here. My name is Damian Bassett. I'm the past chair of the Markham Stouffville Hospital. I've spent nine years on that hospital board, with three of those years as chair. I'm currently on the board of the Unionville Home Society.

I'm here today in my capacity as chairman of the York Region Hospitals Joint Executive Committee. Our member hospitals include, in addition to Markham Stouffville, York Central Hospital in Richmond Hill and Southlake Regional Health Centre in Newmarket. Although the Health Services Restructuring Commission formalized the joint executive committee of our hospitals in 1997, we have in fact been working collaboratively for many years prior and have enjoyed great success in attracting new health care services to York region and in sharing others. Examples include implementing a shared MRI in 1997, shared specialist physician on-call coverage between our hospitals, regional geriatric consultation and regional speech therapy. More recently, we have achieved significant success in our joint presentation to York regional council and their support of our respective hospital development projects.

As a group, our hospitals are committed to working together to achieve clinical and financial efficiencies and to expand the availability of secondary, tertiary and regional programs closer to home for the residents of York region. Ultimately, we believe it is in our collective interest and responsibility to improve the delivery of health care in York region to ensure that we can meet the needs of our very rapidly growing population.

We appreciate having the opportunity to speak to you today to present several continuing and significant concerns with respect to Bill 8. You may recall that both York Central Hospital and Southlake Regional Health

Centre gave presentations to this same committee on February 25, and we are very encouraged by the amendments that were introduced to the bill following those hearings.

Several major concerns remain outstanding. They are primarily to do with provisions in sections 26 and 27. Section 26 gives the minister the authority, 30 days after notice of non-compliance, to issue an order to a health resource provider. The order may be to comply with any directives set out in the order; to comply with any part of a compliance directive; to hold back, reduce or discontinue payments to a health resource provider; to require a health resource provider to enforce any provision of a performance agreement with a CEO; or to vary any term of agreement as set out in the order between the crown and the health resource provider.

We understand that the provisions of this section apply to the negotiation period of the new accountability agreement between the minister and the health resource provider. From a very practical perspective, it is unreasonable indeed to expect that the ministry will be able to negotiate accountability agreements with 150 hospitals, 43 CCACs, over 500 nursing homes and others in a manner that will not result in the majority of health resource providers finding themselves non-compliant from the outset. Sixty days provides little opportunity to negotiate an agreement as significant and complex as this. The proposed remedy—the ability of the minister to invoke section 26 to order a health resource provider to sign an accountability agreement on terms determined by the minister alone—is inherently unreasonable and unjust, and impedes the good-faith negotiations and relations with ministry staff that so many have worked so hard to achieve. It surely cannot be the ministry's intention to subvert the process of true negotiation and impose accountability agreements on health resource providers by proposing such an unwieldy and unworkable process. And yet, given the sheer number of agreements to be negotiated, the ministry may have no choice but to allow the 60-day period to expire for many.

Our second concern with section 26 is the absence of any impartial appeals process. We strongly recommend the addition of a legitimate review mechanism utilizing either a mediation or arbitration process, with the recommendations binding on the ministry and, in our case, the hospital.

Our third concern with section 26 relates to the imposed interference between the CEO and the board of the health resource provider. In this case, we are referring to an order that requires the health resource provider to enforce any provision of a performance agreement with a CEO. In our view, it is up to the board to determine what kind of binding contractual arrangement it has with the CEO. It is not appropriate for the Minister of Health to impose directives on a board that include the requirement to transpose those directives on to the CEO.

1650

With respect to section 27, we understand that when there is a change to a CEO's terms of employment as a result of the health resource provider entering into a performance agreement, this section provides that the CEO shall be deemed to accept the change without compensation, and apparently without recourse through alternative legal avenues. We find this provision to be particularly punitive and contrary to the intent behind the effort to enhance our substantive accountability. It is our view that the hospitals in York region have always been accountable—to each other, to the Ministry of Health and Long-Term Care and to residents in our communities who rely on us for high-quality health care services close to home. It has always been acknowledged by the investments made to renew and expand our hospital infrastructure—investments made by the provincial government, our regional government, and our community members through their various and vast fundraising efforts.

For many years, the hospitals in York region were also among the most efficient in the province. For example, in 1997-98, all three were ranked in the top 20 from the 120 or so hospitals in their peer group. We acknowledge that our relative efficiency rankings fell over the past few years, and we believe this is related, at two of our hospitals, to our attempts to accommodate extreme growth pressures in outdated and inefficient buildings while at the same time undergoing extensive renovations and redevelopment activities. In addition, the expansion of tertiary regional programs has produced significant implementation and learning costs. We acknowledge that we have ground to make up; however, we remain committed to improving the financial performance of these new programs and of our hospitals overall.

I thank you on behalf of the three hospitals in York region for the opportunity to present our feelings on these sections of Bill 8.

The Chair: Thank you. We have eight minutes remaining, so I'll split the time.

Ms Martel: Thank you for coming here today, Mr Bassett.

The minister has said on more than one occasion that accountability agreements are going to be negotiated. He said that publicly; he said that to this committee. When you read the provisions of the bill, do you get some comfort at all that these are going to be negotiated? Do you have any sense of that, given the provisions in the bill?

Mr Bassett: Our reason for being here today is to take the minister at full face value and to expect that the opportunity presented through committee hearings, through submissions of this sort, will result in the modest changes, I think, that we're proposing to this bill. You'll note that our comments are restricted at this point to those two areas in which we feel the bill in its current form has fallen slightly short.

Ms Martel: Would it be your view that those two sections should just be deleted from the bill?

Mr Bassett: No. I think our hospital understands the need for the accountability agreements and supports them. We believe we've identified a shortcoming in the

process to ensure compliance and to ensure the appropriate form of negotiation and consultation so that we're not forced to be in a non-compliant situation which doesn't benefit any of the parties.

Ms Martel: So in the sections that you've referenced, you would need some reference to an impartial appeals process, binding arbitration—

Mr Bassett: Mediation.

Ms Martel: Mediation. I'm assuming you want some changes around the minister's ability to deal with your CEOs as well.

Mr Bassett: Again, further consultation and the ability to understand contractual commitments and have the process respected. The current structure of governance in the hospitals in Ontario does empower the board in each hospital to negotiate those contracts with the CEO.

Ms Martel: And that has to remain in your power.

Mr Bassett: At this point in time, that would be our position.

The Chair: We'll move to Ms Wynne.

Ms Wynne: Thank you for coming, Mr Bassett.

I want to step back from the piece that you've just been talking about with Ms Martel. I'm making an assumption that you think introducing accountability into the system, or more accountability—I understand you've said that the hospitals have always been accountable, and I accept that. But you're not opposed in principle to the introduction of further accountability into the system?

Mr Bassett: Not at all.

Ms Wynne: OK. I guess I was a little disturbed that you make a blanket assumption that there's going to be non-compliance or that there's going to be a problem. My assumption would be that there will be ongoing dialogue between the ministry and the hospitals and the components of an accountability agreement will be ongoing. It won't be a discussion that starts on the first day of that 60 days. So I'm just wondering why you would make that assumption that there will be massive non-compliance, or potential non-compliance, around the province.

Mr Bassett: With all respect, we do operate in good faith on both sides, Ms Wynne. We assume that the government, the ministry and the minister will enter into these discussions with an intention to find an appropriate resolution and not to be non-compliant. But we're also facing the stark reality of the calendar. The program years effectively start for each of the institutions that I referenced at the same time, and 60 days puts all of them at the same point in the calendar process. The reality is that the majority of hospitals in this past year were unaware of their funding through the budgeting process for perhaps 90 days beyond the start of their fiscal year.

All we're suggesting is that the anticipation be put in place that in the event that the timetable proves to be too strenuous for all the parties, it not automatically result in a forced solution when we believe the intent of all parties was to negotiate a solution. I think that just building in the provision for an arbitration or mediation process would indicate not that it becomes the preferred course, but that it would at least be available in the event that the timetable were to overcome you, notwithstanding the best wishes of all parties.

Ms Wynne: But the other piece of that would be some reassurance that the logistics of these negotiations or conversations would be worked out in a reasonable manner and that they wouldn't be expected to be sequential, that they could be done within the 60 days. You want some reassurance that they could actually be done in the 60 days. Is that what you're looking for?

Mr Bassett: That's it exactly. We don't want to create an incentive for either party—and pardon the basketball analogy—to run the clock.

Mr Arnott: Thank you, Mr Bassett, for your presentation today. I'm really pleased that you've had this opportunity to come in once again to express the views of the hospitals that you represent with respect to the amended Bill 8, because I think it's important that we continue the dialogue in the hopes that the minister and the Ministry of Health will listen to what the health care providers have offered in the way of advice.

You mentioned the number of accountability agreements that would have to be negotiated in a very short period of time, and I would very much question whether the ministry has the resources to do individual accountability agreements. So most likely there's going to be some sort of a framework that will be for large hospitals, and maybe some small alterations considered.

The thing that concerns me the most is the idea of the discussions, the so-called negotiations, that might take place, because there's no way there can be a level playing field in terms of these negotiations unless the government listens to the hospitals' suggestion that there be some sort of impartial appeals process which is binding upon both the government and the hospitals. Have you any thoughts as to how that process might be set up? How would we set up a binding appeals process?

Mr Bassett: There are those who are more learned than I on that structure, but I know the hospitals that I'm speaking on behalf of would be happy to participate in any sort of a facilitated session to arrive at such a conclusion. We're also supportive of the Ontario Hospital Association, as it's made known some concerns in this area too. So a bringing together of the stakeholders in this particular arena that stand to benefit most from negotiated settlements and the ability for the hospital system to work uninterrupted by these mandatory conformance requirements would be in our interests.

Mr Arnott: This afternoon, the minister told the committee that the ministry is working through the joint policy and planning committee to draft a framework for accountability agreements. Have you heard about the progress of these discussions?

Mr Bassett: I haven't personally, but that doesn't mean that some people within the three hospitals haven't.

The Chair: Thank you very much for your presentation this afternoon, and I wish you a good rest of the afternoon and evening.

1700

ONTARIO HOSPITAL ASSOCIATION

The Chair: Next we have the Ontario Hospital Association: Ms Hilary Short, president and chief executive officer; and Mary Lapaine, past chair and trustee for the Goderich general hospital. Welcome. Once again, you will have a 15-minute period. I would ask that you identify yourselves for Hansard at your presentation, and the time remaining will be split between the parties for questions.

Ms Mary Lapaine: Thank you very much and good afternoon. Thank you for having us here. I am Mary Lapaine. I am the immediate past chair and current board member of the Ontario Hospital Association, and I am also a trustee with the board of directors at Alexandra Marine and General Hospital in Goderich.

With me today are Hilary Short, our president and CEO, and Sheila Jarvis, chair-elect of OHA and president and CEO of Bloorview MacMillan Children's Centre.

Ontario hospitals are leaders when it comes to accountability. Ontario is the only province in the country with hospital report cards. It was the hospitals of Ontario that first advanced the idea of accountability agreements with the provincial government more than two years ago. From financial performance to patient satisfaction, hospitals have never been afraid to answer questions about how they do their job. Ontario hospitals are also leaders when it comes to efficiency. Just last week, we released two studies that show Ontario hospitals are more efficient than their peers in other provinces.

Given the serious and principled nature of our concerns about Bill 8, we are very pleased that additional public hearings are being conducted on this proposed legislation. We are here to provide constructive advice to the committee. This proposed bill is far too important not to get right. It will have far-reaching implications for hospitals and the wider health care system for many years to come.

As you well know, when Bill 8 was first introduced, we had a number of very serious concerns with the bill. We are pleased that the bill has been amended so significantly since that time. The OHA favours many of the changes that have already been made, especially the amendments that ensure the public interest is considered when the government considers using the bill's accountability provisions. We also favour the change that ensures accountability agreements are established between the minister and the board, not the CEO.

Hospitals want to work with the government so that it has the tools it feels it needs while maintaining the fundamentals of good governance. This is at the heart of the issue for trustees across Ontario. We believe we can strengthen accountability in the province without undermining the role of the hospital board, which this bill continues to do.

We were delighted to hear the minister on two separate occasions last week strongly endorse the role of voluntary hospital boards throughout Ontario. Local boards play a critical role in representing their community, take their job seriously, and are actively keeping abreast of the issues through educational opportunities such as OHA's Health Care Trustee Institute. Hospital boards are very aware of community needs, but they also keep in mind their financial responsibilities to the taxpayers of Ontario.

As incoming chair of the Canadian Healthcare Association, I have had the opportunity to hear the experiences of my counterparts across Canada. They have told me that by and large they have not found government board appointments to be advantageous. We should value the tremendous contributions our volunteer board members play in advancing patient care needs in their community.

Now Hilary would like to tell you some of our proposed solutions.

Ms Hilary Short: OHA is committed very strongly to supporting initiatives that further advance governance and accountability in Ontario. We are collaborating very productively with the government in the development of accountability agreements through the JPPC, the joint policy and planning committee. You heard the minister reference this earlier in his talk.

We, the OHA board, have now endorsed the framework developed through the JPPC for accountability agreements that will be used in 2005 and 2006. We're very pleased to announce that here today. That accountability agreement, in fact, proposes a ladder of remediation that would culminate, as Ms Wynne has said, with the enaction of Bill 8, and beyond that the Public Hospitals Act. So with the culmination of the accountability agreement remediation provisions, Bill 8 in its amended form and the Public Hospitals Act, I think the government can be very satisfied that there are provisions to deal with any incident where difficulties arise.

We are going to establish a governance leadership council here at OHA, a panel of distinguished experts to guide our education programs and to provide tools and templates that support excellence in governance. But to preserve good governance, we are also seeking amendments to Bill 8 that will achieve the government's objectives while enhancing local community governance. A copy of our proposed amendments is included in the material distributed to the committee members.

Here are our proposals:

First of all, on section 21, the imposition of accountability agreements, which continues to be a serious problem. Currently, the legislation enables the minister to impose an agreement on a hospital in the event of a dispute. OHA had originally proposed that there be a dispute resolution process, which the minister felt would be too cumbersome. As an alternative, therefore, to imposing the agreement after 60 days, the OHA is proposing that the matter be referred to an independent commissioner, or panel of commissioners, chosen from a roster, appointed by the minister with input from hospitals.

The commissioners would review the matter and issue a report and recommendations quickly. We are suggesting at this point that it be within 30 days. This report would be made public. This process would provide for a true third party review in a manner that is streamlined to ensure expedient resolution of the matter. In addition, it would provide the parties with independent advice and give the sector valuable information respecting how disputes over the agreements are being addressed. The commissioners would have the authority to deny a review if they felt a review was not in the public interest.

Another important amendment, we believe, would be to ensure that at the end of the day the power to impose the agreement be made by order in council, or alternatively, that it be subject to ministerial approval.

Secondly, let me turn to our suggestions with respect to 26 and 27, which we refer to as the issue of preventing blurred accountability between the CEO and the board. Instead of the sanctions set out in sections 26.1 and 27, the OHA is proposing that Bill 8 be amended to make more explicit the lines of accountability between the minister and the board, and between the board and the CEO, via the performance agreements provided for in the bill.

We recommend that the accountability agreements between the minister and boards be required, that the boards be required to implement CEO performance agreements that would include performance objectives and regular monitoring capabilities—this could be achieved by amending section 21(5) to make the performance agreement between the board and CEO mandatory—and also developing a regulation specifying some of the key components in the performance agreements between hospital board and CEO.

Further, if the minister wanted to review the performance of a CEO, the minister could request the board to appoint a commissioner or commissioners, as we referred to before, to conduct a review of the CEO's performance. Alternatively, the board could unilaterally appoint a commissioner to conduct a review of its CEO without the minister's approval.

We think the appointment of this third party roster of commissioners could provide the government with what it needs: speedy resolution where a dispute is in play, without interfering with good governance or interfering in affairs which are more properly the responsibility of the board.

In our view, making these changes would eliminate the need for the proposed control mechanisms in sections 26.1 and 27 of the bill, which would have a counterproductive effect on hospital governance and accountability.

Finally on the issue of physician payments, which is section 9: The original bill prohibited such payments. However, hospitals depend on their ability to pay physicians for certain specific programs. The amendment proposed, however, makes it too wide open.

This is a complex issue. We believe that the matter of payments by hospitals to physicians cannot and should not be resolved by means of legislation. These payments are, and continue to be, the subject of considerable debate within the ministry, the OMA and the OHA, and all parties currently are actively engaged in seeking an appropriate resolution to this issue through a combination of the current OMA negotiations and other venues.

Accordingly, we recommend that section 9 be deleted in its entirety. In addition, we would propose that a tripartite body be established to study and resolve issues of hospital payments to physicians on a provincial basis. The solution we need is to ensure payments are negotiated on a provincial basis so that individual hospitals are not whipsawed by demands or requests from their physicians.

With that, I'll ask Sheila Jarvis to conclude.

1710

Ms Sheila Jarvis: I'm speaking to ensuring timely access to care. Hospitals are proposing that the right to timely access to health care be incorporated in this proposed legislation. When people come to a hospital in need of health care, hospitals don't turn them away. We have a duty to provide timely care to our patients, and we feel very strongly that this principle needs to be included in the Commitment to the Future of Medicare Act for the legislation to live up to the promise of its title.

If wait times cannot be specified in the bill, then hospitals recommend that at the very least the definition of "public interest" be expanded to include a clear and definitive statement about the crucial importance of including timely access to care as a key factor for the government to consider when it is thinking about using its power under this proposed legislation; otherwise, there will be not legislative provisions in the bill to hold the government accountable for service levels.

Timely access to health care services is the cornerstone of our medicare system. Incorporating it into this bill would send a powerful message to the people of Ontario about this government's priorities as it moves forward with its May 18 budget and makes decisions about the future of this most cherished of our national institutions.

Thank you for your time. We'd be pleased to answer questions.

The Chair: We have about three minutes remaining. Perhaps we'll take one quick question from each party. It's the government side.

Mr Jeff Leal (Peterborough): Ms Short, physician payments: Are we talking about hospitalists there?

Ms Short: No, we're not. The original bill prevented hospitals from making payments to physicians at all. Clearly, as you say, hospitals need to make payments to physicians under certain circumstances. Then the amendment laid it way open. We need to have a way of settling disputes about how hospitals are going to make those payments to physicians and have some provincial approach to it, so that individual hospitals are not approached by their physicians. Yes, indeed, they do need to pay hospitalists; many of them are on salary, which is a little different. We need to work out some of

these new ways of making sure that hospitals are able to get the physician services they need but look at the issue on a provincial basis.

Mrs Witmer: I just have a question about accountability agreements. Obviously, we don't want the minister/ministry to be able to impose agreements after 60 days. You've suggested here that the issue should be referred to an independent commissioner. Could you just give me a little bit more information? What's the rationale for this, and how is this going to still ensure accountability?

Ms Short: The issue behind that is that if they are truly negotiated accountability agreements, there needs to be a dispute resolution mechanism. We had suggested originally a number of options, including binding arbitration, which had been rejected as being too cumbersome and time-consuming.

We're suggesting something that would provide the minister with what he needs in terms of speedy resolution to this while also preserving good governance, so that this would be a compromise, if you like, where you'd have a third party of experienced people who are accustomed to doing this. They would be appointed and they would be able to help us resolve that. They would be able to report expeditiously, and then there would be the ability to make a decision, but there would be some third party review, and it would protect the hospitals from what they see as arbitrary decisions.

The Chair: One quick question, Ms Martel.

Ms Martel: You've suggested a number of options, because we saw this kind of language in the first bill and we see it yet again. I read into the record earlier some of the comments in your March 17 letter. You've got some proposals on the table. What will the situation be, though, if the government doesn't move off the provisions in the current bill? What will that do to you as an association, to your board members, who are very concerned about being taken over and not having negotiated settlements?

The Chair: One minute.

Ms Short: We fear very much that this will undermine governance and that it will be a demotivating impact on people serving on hospital boards. We have a trustee here who can testify to that. That's our big concern, that in its present form it does sort of undermine the whole concept and the principles behind voluntary community governance of hospitals.

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

REGISTERED NURSES ASSOCIATION OF ONTARIO

The Chair: Next we have the Registered Nurses Association of Ontario: Doris Grinspun, executive director. You will have 15 minutes for your presentation. Should you not require the 15, we will break it up, as we did, with questions from each party, and we'll be starting with the opposition. Welcome.

Ms Doris Grinspun: Thank you very much. Good afternoon. My name is Doris Grinspun, and I am the executive director of the Registered Nurses Association of Ontario.

RNAO is the professional association of registered nurses across the province. Our mandate is to speak out for health and to speak out for nursing. In doing so, we advocate for healthy public policy and for the role of registered nurses in shaping and delivering health services. We welcome the opportunity to comment on Bill 8, as it has significant implications for Ontarians and for the profession. We will comment on each part of the bill.

First, the preamble: In its preamble, the bill endorses the Canada Health Act, primary health care, pharmacare for catastrophic expenses and home health care, and accountability. We believe this is actually quite excellent. RNAO endorses, of course, all of the recommendations in Romanow's final report on the future of health care in Canada, and we expect our government to do the same, as it has promised every single time.

We are concerned, however, that the content of the bill does not include these positive elements of the preamble. Indeed, the bill fails to address how it will protect medicare and how it will expand primary health care, home health care and pharmacare. The bill also makes no mention of the government's promise to ban for-profit MRIs and CT scan clinics, or put a stop to P3s.

The only concept to support the Canada Health Act that's included in the bill is enhanced accountability. RNAO very strongly supports the need for enhanced accountability. We also urge the government to deliver, though, on its promise to implement the Romanow report in Ontario through Bill 8. We would like Bill 8 to explicitly ensure that MRIs and CT scans are dedicated only for medically necessary services and that delivery is not for profit. It must also serve to prohibit the continuation of P3s until they prove that they provide better quality at a better price, which is not the case, as we know from all the studies at this point. A bill that does not include these key features can in fact serve to undermine the long-term sustainability of medicare. The bill must explicitly include the public's right to access primary health care, to access home health care, and to access catastrophic drug coverage. RNAO is eager to work with the government to address these vital gaps in Bill 8 as it currently stands.

Establishing the Ontario Health Quality Council: RNAO is pleased with the government's commitment to form an Ontario Health Quality Council. We see this as an important step forward in supporting the Health Council of Canada, a key recommendation of the Romanow commission and an essential element to protecting the Canada Health Act. RNAO strongly recommends that membership in the council be determined through a transparent and democratic process that would serve to build social cohesion and select the best representatives.

RNAO would like to see the scope and functions of the council expanded. Bill 8 proposes that the council

only report on access and quality issues, and support quality improvements. These are indeed essential functions but are not sufficient to support system accountability and the sustainability of medicare in the long run. We believe the council must also report on cost-effectiveness of programs. Specifically, we are asking that the key outcome indicator be cost-benefit of for-profit and not-for-profit delivery.

We ask that the council be truly independent, with the mandate to write recommendations to the Legislative Assembly. These recommendations should also be included in the council's public reporting.

1720

Part II, health services accessibility: Guaranteeing equal access to health is an absolute core value and a key component of Bill 8. Thus, RNAO applauds the continued ban on extra-billing. Regulating block fees is a step forward, but RNAO endorses the urgent call by the Medical Reform Group to fully ban block fees. Until the government is able to ban these fees, we recommend that doctors who continue to charge block fees be required to post government-designed posters specifying which services cannot be included in block fees, and the complaint procedure in the event of policy violation. While block fees will be regulated under Bill 8, the bill fails to regulate how much physicians can charge. We urge the government to correct this. RNAO appreciates the guarantee that patients cannot be denied services for refusing to pay the fee, as stated in Bill 8, and we ask that this guarantee be extended to total equality of access in terms of timeliness of service and quality.

Part III, accountability: Part I was a first step in enhancing accountability. Part III addresses this issue through accountability agreements between health resource providers and the minister. The bill has been amended to explicitly exclude individual practitioners and trade unions from accountability agreements and from direct sanctions under compliance orders. Amendments also exclude collective agreements from being overridden by compliance orders. We support both of these exclusions.

Accountability is essential to a sustainable health care system, and putting teeth into the accountability provision is to be commended. It would appear, however, that accountability is a one-way street, from provider organizations to government, with no clear accountability envisioned from government to providers and the public. In particular, we would like to see that providers can expect adequate and predictable multi-year funding.

RNAO also finds weaknesses within the provider accountability clause. For example, there is no mention of the crying need for transparency for commercial enterprises like P3s, which appear to be proceeding behind a veil of corporate secrecy.

The health council could provide the necessary accountability if it is adequately resourced, with a broad enough mandate, and if it is fully independent of government. An independent council should be given the power to collect the information needed to assess key performance issues in the health care system and to use that information to conduct key assessments such as value-for-money audits of P3 hospitals. RNAO wants to see these assessments publicly available so that all Ontarians can see what works, what doesn't, and what needs to change.

We also ask that accountability agreements and the council attend closely to two urgent nursing human resource matters: (1) monitoring progress on the government's commitment to 70% full-time employment for registered nurses, and we congratulate the government on the progress made to date; (2) monitoring progress on the government's commitment to hiring 8,000 additional nursing positions. The nursing human resources situation is dire, and accountability agreements that explicitly include these targets will ensure precious taxpayer dollars are properly used. The work of the health council could help guide the system toward a sustainable nursing workforce.

As we have stated before, we cannot speak from both sides of our mouth, saying on the one hand that we have a nursing shortage, and on the other denying full-time employment for most graduating RNs. The government took a good first step with targeted funds for full-time employment, and we expect that the May 18 budget will bring hope to the 3,090 registered nurses who have just graduated, most of whom cannot find full-time work, and many of whom are leaving the province as we speak. Government must provide funding and accountability mechanisms to ensure Ontario does not lose a single RN because of a lack of full-time employment.

Thank you. I believe we have plenty of time for questions.

The Chair: We have about five minutes left. I do want to remind all parties that we will recess in about five minutes—we have a vote we have to get to—and then we will come back. So a quick question from each, and we start with the opposition.

Mrs Witmer: Thank you very much, Ms Grinspun, for the presentation. It's really quite comprehensive and thorough. I see you've taken the time to point out where the government has done well and where there's a need for some further action.

I would agree with you; you've pointed out the need for the health council to be independent.

The other issue that I think is really critical is that this bill presently does not provide accountability for the government. How do you think the government should change the legislation to ensure that accountability goes both ways?

Ms Grinspun: I believe there should be clauses that exclusively point out the accountabilities of government, specifically in terms of stable and multi-year funding. Otherwise it will be impossible for employers, basically, to respond to the needs of Ontarians.

Ms Martel: Thank you, Doris, for being here today. You said, "We ask that the council be truly independent, with a mandate to write recommendations to the Legislative Assembly." You know that right now the only

recommendations they can make are about what else they should report on in future years. What do you foresee if we had a truly independent council that would hold government accountable? What are the kinds of recommendations this council should and could be making in that regard?

Ms Grinspun: One of the aspects that we included is that the scope of the council should be expanded to include not only quality improvement aspects and achievements but the ongoing debate, not only in this province but in this country, in relationship to the delivery mode, specifically the issue of for-profit versus not-for-profit. We believe that unless the Health Council of Canada and any other council in the country, including the one in Ontario, deal with this specific issue, we will never resolve it and we will deal more with rhetoric than with facts. We believe that if the mandate of the council is expanded, then recommendations as to what type of services we should have in Ontario to best protect the Canada Health Act and to best provide access in a timely fashion to the public within the taxpayer dollars we have available will be appropriate.

The Chair: Mr Duguid, a very quick question.

Mr Brad Duguid (Scarborough Centre): I appreciate your comments regarding the accountability section. My question is, recognizing the need to target funding to service providers for such things as reducing the number of part-time nurses, increasing the number of nurses and improving the quality of work life for our nurses, do you really want to see those kinds of accountability agreements in the hands of a third party arbitrator who's accountable to no one? Do you not think you are better off to have the minister, who is accountable to the people who elected him, accountable to the government and committed to bringing these things forward? Do you not feel safer with regard to getting these things through?

Ms Grinspun: You are referring to the comment of the OHA. Let me be straightforward in the answer. If the Minister of Health would always be the same person we have now, you are right, but that might not be the case, right? So to have a third party will allow us to bring issues of concern from anybody. It would be appropriate if the matter cannot be resolved at the minister's level. Today we have a minister whom we highly respect. In five years it might be a different situation.

Interjection.

Ms Grinspun: I said the same minister.

The Chair: Thank you for your presentation, and have a good evening.

We will recess now and be back right after the vote.

The committee recessed from 1730 to 1741.

COLLEEN FLOOD

The Chair: I call the committee to order. Next we have the University of Toronto faculty of law, Colleen Flood, professor. I'd like to welcome you. Again, we'll have another vote, but I think we can certainly work around your presentation. You will have 15 minutes; we'll divide the time at the end.

Ms Colleen Flood: First of all, I'd like to thank you for hearing my submission on this topic. Just in brief, I am a professor of health law at the University of Toronto and I'm cross-appointed into the department of health policy, management and evaluation. My work is in health law and policy, and I've written in particular about comparative health care reform, studying a number of different jurisdictions. I have written background papers for the Senate committee chaired by Senator Kirby and for the Romanow commission.

I wanted to speak today because I've seen some of the materials that have gone around in response to Bill 8, and I thought it might be helpful to have the perspective of an academic who has no particular interest in the outcome of this debate, apart from having an interest in health policy and being a taxpaying citizen and sometimes patient.

I think you've heard a great deal from those who feel threatened or concerned about Bill 8, but I just wanted to counsel you on the fact that that is to be expected: nobody likes change. But I do hope you'll agree that the surest way to suffocate medicare at the moment is not to change it at all, to deny it the oxygen of change. It's important to fix on the larger public interest that is at stake as opposed to the particular interests of stakeholders. So I want to just focus on the forest as opposed to the various trees.

There are obviously particular aspects of the bill that are of concern for different people depending on where you're coming from, but Bill 8 is primarily about injecting accountability as an operational principle into medicare. It's about other things as well, but it's to this issue of accountability and performance that I want to direct my comments.

Accountability for performance, as Romanow and Senator Kirby have told us, is what actually ails medicare. We have no idea about what we get for the billions of dollars we inject into health care. We do know, however, that we can't measure much in the returns by way of improved health outcomes. Do we know if things are really getting better or if they're getting worse? We all have opinions, but we don't have basic information, because no one in the system has the incentive to either collect or provide that information.

You might remember the famous lawn mowers case: After the Health Accord 2000 and the capital fund, the new money flowing, the only thing we know we got out of that was the purchase of some additional lawn mowers. Where did the rest of the money go? We know that it was spent on health care, but we have no idea where and for whom and on what basis of priorities that money was spent.

What do we know? We know that beyond the doors of hospitals there may be a pending crisis in safety and quality. We know that from evidence from the United States, where there are significant concerns about safety and quality within hospitals and evidence that more people die as a result of medical errors than they do in

car accidents, and there is no reason to actually think that the size of this problem is any less in Canada.

To be more specific, the crisis that we are going to face is not about more money, because obviously the US hospitals have cash beyond the wildest dreams of most Canadian hospitals; it's going to be about performance, about systems and about accountability. The crisis in health care, I submit, will not be a crisis in funding. It's not even going to be a crisis about timeliness, although timeliness is important. It's going to be a quiet crisis of quality and safety.

So we need to make sure that nurses, physicians, hospitals, long-term-care institutions, regional health authorities if we had them, and governments—decision-makers at all levels of the health care system—are accountable for what they do. We've seen tragic examples of what happens when there is no accountability or when accountability is fragmented, and then we can all point fingers at everybody else and say, "It was their responsibility, not mine." Shared accountability is just an opportunity for avoiding responsibility. We've seen it in Walkerton, we've seen it in the contamination of the blood system and we've seen it in SARS.

In publicly funded health care, there is always an assumption that the fact alone that it's public means everything is going to be hunky-dory. Most people will do the best they possibly can, but we all respond to the institutions and environments we work in, we all make mistakes and we know that with the right supports and the right vision we can do a lot better. No one in the private sector with an enterprise as large as publicly funded medicare would dream of not holding decision-makers to account for the decisions they make. Why should it be acceptable in something as valuable as medicare?

Bill 8 is a step in the right direction, even if it's just a small step. It calls for clear roles and responsibility in the management of health care. It will hold hospitals, long-term-care facilities, community care access centres and independent health facilities accountable for their performance in delivering care, and it will implement a quality council.

All these initiatives have been underway in other provinces for several years, and in other jurisdictions, like New Zealand—my original home—and the UK, for decades. The proposals in Bill 8 are hardly new and it shouldn't be controversial to ask those who receive precious public dollars to account for their performance. Accountability of, for example, hospital boards through local governance structures is good but it's not good enough. Hospitals and other institutions need to be accountable for what they do, directly to the government and through government to taxpayers, citizens and patients at large. Ontarians have a right to a system—I repeat the word "system"—of health care, not a collection of institutions and organizations forging their own paths. Bill 8 will not solve all the problems of medicare, but it's not a bad start.

To try to respond to this problem of accountability, in most jurisdictions—in fact all, apart from Ontario—there has been a move to regionalization. The goal is that governments should govern, regional health authorities should manage, and this is a forum to integrate spending, to bring together the silos of financing.

In a separate paper that I have submitted to your committee as well, my colleague and friend Duncan Sinclair—Duncan is from Queen's University—and I advocate that Ontario, as with all other provinces, should move to regionalization.

Undoubtedly all the stakeholders who have presented to you on Bill 8 would find this even more of a horrifying prospect than the relatively mild measures proposed in Bill 8. But as we and many others have argued, regionalization is an important first step to getting governments into the business of governing and out of micromanaging health care, and to providing the means to integrate the silos of financing across our current non-system, and thus to ultimately integrate care.

In Ontario, after several decades of medicare, the general public, as the taxpayer and the single biggest funder and consumer of services, considers the provincial government of the day to be directly responsible for every problem in health care, imagined or real. Public opinion in this regard is highly conditioned by two major factors: the providers of health care and the media.

The Minister of Health and Long-Term Care and the government as a whole—I'm not just speaking about this government but previous governments as well—are in the unenviable position of being held accountable for a health care "system" that does not really exist. Among the providers of health care services, none, or at most very few, would freely acknowledge that they contribute to the collective work of a system, much less that they are accountable to the minister for the quality and quantity of their performance.

1750

The minister and government assume the role of governance only with respect to providing the money and serving as the recipient of blame when things go wrong, or not right, in the so-called system. It's an example of responsibility without authority. It is neither effective nor sustainable.

The new Liberal government of Ontario has evidenced a strong commitment to the values and principles of publicly funded health care. Early in its mandate, there is a small window of opportunity to advance a real reform agenda. Ontario has the benefit of being able to review first-hand the experiences of other provinces with regionalization.

Real change, I think, is only possible if we rearrange the present players on the chessboard of medicare. Witness primary care reform in Ontario, a process so slow and hampered that we actually think the Maple Leafs are more likely to win the Stanley Cup than primary care reform is to actually happen in Ontario. I say that, but I've still got my little flag out.

Interjection.

Ms Flood: Yes, it's been a long wait.

If the government looks at reform more broadly, reform that embraced the accountability provisions of

Bill 8 and more, it would abandon its current proposals not to go down the regionalization path and embrace it.

In the absence of devolution and regionalization, then Bill 8 and its provisions for performance agreements is a second-best alternative. The clearer and more open the lines of responsibility and accountability, the less is the risk that stakeholder interests will prevail over more diffuse public interests. Let me just be clear: That is in the best interests of the government and of providers. It is better for the government to be transparent about its objectives, as it is for providers.

Transparency is key. I think there's ample transparency provided for in Bill 8, much more than the equivalent legislative provisions in other jurisdictions, where the many checks and balances of due process do not have to be gone through before a Minister of Health can fire a CEO, for example.

I believe that everyone who has presented before you has genuflected at the altar of accountability. However, it's one thing to talk the talk; it's another thing to walk the walk. If accountability were indeed such an obvious mom-and-apple-pie concept, why have previous governments not provided for it in legislation, with or without all the caveats asked for by stakeholders? Why have stakeholders not advocated for performance agreements, or for a quality council?

Usually everyone likes the idea of accountability, except when it comes to increased accountability on their own behalves. To this extent, hospitals and other institutions are right to ask, what about the accountability of the provincial government? However, it's not the accountability of the provincial government to the hospitals, long-term-care institutions and community care access centres that is at issue. The provincial government owes accountability to the people of Ontario for governance of health care, of the health care system as a whole.

It should commit through Bill 8, I believe, to notifying Ontarians on an annual basis of what its specific short-, medium- and long-term goals are for the health care system and how it plans to achieve them. It should, in turn, negotiate and enter into agreements with hospitals, long-term-care institutions, community care access centres and other groups for the realization of these objectives. The health quality council should report on the realization thereof, with, as is provided in Bill 8, the report being tabled in Parliament.

I agree with those who call upon the provincial government to address issues of timeliness in treatment, but I do not think it needs to happen through the auspices of Bill 8 at this time, for it cannot be done overnight. Instead, I think it should charge the health quality council to work toward setting appropriate maximum waiting times for a variety of disease indicators and then incrementally include realization of those waiting time guarantees and performance agreements with hospitals and other institutions.

Undoubtedly, this may take additional resources, but I am confident that those who are asked to achieve change will make their need for resources known.

Change is extremely hard to realize in publicly funded health care, but we most recognize the only way to save medicare is to change it. The enormous forces of resistance to any real change may well continue to prevail, arguing that change is not possible because we don't have enough money to fund the core—the core of hospital and physician services.

This is a vicious circle, because unless we begin to invest in other areas of care, like community care and primary care, the same old problems will continue on and on. We can placate with money, but the status quo will not change and real reform will not occur. Ontario now has the opportunity to convert its rhetoric about renewal into action through Bill 8. Let's seize it.

The Chair: Thank you very much. Perhaps one short question. Actually, when I look at my watch, we're down to the wire. Thank you very much.

Ms Flood: OK. Sorry I took so much time.

The Chair: We really appreciate your presentation, and I wish you a good evening.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Chair: Next we have the College of Physicians and Surgeons of Ontario. Please make yourselves comfortable at the table.

Interjection.

Dr Barry Adams: Do you want to adjourn and go to the vote, and we can present after the vote?

The Chair: We have about six minutes that we could get part of your presentation in, if you don't mind splitting your presentation.

Welcome. State your name when you present so we can have it on the record for Hansard.

Dr Adams: Thank you, Mr Chair and members of the committee. On behalf of the College of Physicians and Surgeons of Ontario, I want to thank you for this opportunity to present. I'm sure you're aware we were here before. We certainly have an interest in this issue and want to bring you up to date on our interests.

My name is Barry Adams. I'm president of the college. I have been a practising paediatrician in Ottawa for the last 39 years. I continue to practise because there are no new doctors out there to replace me. With me are Rocco Gerace, the registrar for the college, and Louise Verity, the director of communications and government relations.

The government maintains that the principles of accessibility and accountability are the key drivers behind the introduction of Bill 8. The college supports both of these principles.

Our presentation today is focused exclusively on section 16 of the bill, the section that deals with block fees. The college continues to have concerns with this section of the bill, as it allows for the transfer of block fee regulation from the college to the Ministry of Health. As the legislation is currently drafted, anyone who charges a block fee that is not in accordance with the

regulations will have contravened the legislation and committed an offence. That presumably would be prosecuted under the Provincial Offences Act. The college does not normally instigate proceedings under the Provincial Offences Act.

As it stands currently, the CPSO block fee policy is enforced by the college through a policy as opposed to a regulation. As with all college policies, this policy is reviewed every three years to ensure that, amongst other criteria, the policy meets its intended objectives and is in the public interest. The college does not have to contend with the volume and nature of policy issues that government faces and that sometimes prevent government from moving as quickly as it should. We believe that the college's mandatory review process ensures that changes and improvements are made in a timely manner.

At the very least, we recommend that any block fee policy or regulation should include a mandatory review component to ensure it remains current.

We have found, over the years, that the government has often either been very slow in implementing regulations that we have submitted, or been so extremely slow that our regulations are often so out of date that they require us to revise them before they can be implemented. Many other colleges have had similar experiences. This is in large part why we believe our policy development and review process to be more responsive to the public interest. Our processes provide for a mandatory review and consultation, as well as an expeditious approval process.

We heard shortly after the introduction of Bill 8 that the ministry has received some calls from the public about our current block fee policy. To date, the context of these calls and volume of these concerns have not been shared with us.

As we conveyed to the committee previously in our initial presentation, our block fee policy is currently undergoing a review. This review was initiated prior to the introduction of the bill. The college has persevered with this review despite the uncertainty about our future role with respect to block fees.

I'd like to take a few moments to explain our policy to you. The current block fee policy allows doctors to charge their patients for services that are not covered by OHIP. Uninsured services include telephone advice, requests for renewal of prescriptions by telephone, the completion of forms etc. The services covered by this fee must be clearly stated in writing and understood by the patient, and the patient must be given the option of paying individual charges for uninsured services as they are rendered or by paying an annual block fee.

The decision as to which payment option is chosen must be made by the patient and must not be a condition of the patient being accepted by the doctor or continuing under the care of that doctor. The patient must be given a copy of the block fee policy statement and indicate his or her acceptance of paying for uninsured services in this manner before being billed a block fee. A fee for the service of "being available to render a service" cannot be charged in advance and is not to be included in a block fee.

You should be aware that it is the Ontario Medical Association and not the college that is responsible for establishing guidelines for actual block fee charges. We have been in discussion with the association and they agree that block fee charges should be made available to the public when requested.

The college has identified key areas of improvement to the existing policy to ensure that it is transparent, accountable and clearly distinguished from extra-billing. A block fee is a charge for an uninsured service only; it is not a premium paid to a particular physician for any services rendered. In addition to our consultation process, the college is also reviewing policies from other jurisdictions such as Alberta, New Brunswick, British Columbia and Manitoba. These policies are in the process of being assessed as part of our block fee review.

The block fee policy has been available on the college's Web site since 1997, and the May-June issue of Members' Dialogue, which is a communication that goes out from the college to all physicians in the province, clarified the current block fee policy.

The college takes our role in educating the profession very seriously to ensure our policies are clear to Ontario physicians. We also take the necessary action to ensure our policies are effectively enforced.

In 2003 there was a prominent example of a physician inappropriately charging patients for services and disguising these as block fees. The college's discipline committee investigated the complaints and found the physician to be guilty of professional misconduct. In response, the physician's certificate of registration was suspended for a period of three months and he was required to reimburse all patients for any inappropriate charges.

The Chair: My apologies for interrupting at this moment, but we will have to recess. You have about six minutes, so we'll come back and continue for another six minutes.

Dr Adams: That's fine.

The Chair: We won't be long.

The committee recessed from 1804 to 1812.

The Chair: Ladies and gentlemen, I'd like to call our committee hearings to order. We'll have six more minutes from the College of Physicians and Surgeons.

Dr Adams: I was just saying that we take our responsibility quite seriously, and when we are aware of a breach in policy, we certainly do investigate it and, if necessary, take action. The college hopes this shared goal to protect the public can be achieved while respecting the autonomy of the college to administer this function.

The college would also like to ensure that the consultation process we have underway will continue. The college anticipates that our recommendations and the new policy developed as a result of our review will be incorporated in any regulation created by the government if a decision is made not to amend the legislation and leave it as it is, under the aegis of the college.

In conclusion, I'd like to thank you again for the opportunity to provide input to the drafting of this legislation. The college welcomes a continued open dialogue with the government as recommendations are considered and amendments are drafted and finalized.

It is our hope that the government will amend the bill in a way that will achieve the following: Regulation of block fees remains a responsibility of the College of Physicians and Surgeons and is within a statute that governs the activities of the college, like the Regulated Health Professions Act and the companion legislation, the Medicine Act. We also would like that block fees remain a policy as opposed to a regulation.

Finally, should the government decide not to amend the bill, it is our hope that the college's work in reviewing and improving the block fee policy will form the basis for a block fee regulation.

The Chair: Thank you for your presentation, and our apologies for the break in your presentation.

We have enough time for one quick question from each party. We'll start with Ms Martel.

Ms Martel: You said your review is ongoing and that if there's no change in the legislation, you would offer up the results of that to be part of the regulation. Can you share with the committee at this time any of the information coming out of that, which might be helpful to the process?

Dr Rocco Gerace: We're very early in the process, and we're trying to get feedback from all the stakeholders who are involved. This is a periodic review, and we're not at that stage. We're very anxious that we be able to continue the review and that we be able to get feedback from government, patient groups and others.

Louise may want to make a comment as well.

The Chair: Very quickly.

Ms Louise Verity: I think one of the reasons we're so eager to get feedback from the ministry is that we are culling any telephone calls, any type of inquiry we have received. We want to know about any that anyone else has received so we can put that into the mix, in terms of coming up with recommendations.

Ms Smith: I have a question with respect to the communication of your policy. I recently spoke to a family doctor—just a casual conversation—and asked about block fees. That doctor told me she was planning on implementing a block fee program—$100 a patient—and didn't even bat an eyelash that this could be unacceptable or against college policy. She just said, "Yeah, I'm looking at implementing a $100 fee, because I can't manage all these little nickel-and-dime fees everywhere." I said, "Are you going to do that for all your patients?" She said, "Yeah. I mean, I can't figure out who's in and who's out." I said, "Well, could I just recommend that that's not appropriate?"

That just smacked to me of exactly what we're trying to deal with in this legislation, which is ensuring accessibility. To her, a $100 block fee was nothing. To many members of our society, a $100 block fee is prohibitive. So I just wondered how the college communicates and then polices or enforces its policies with respect to block fees now.

The Chair: A very quick answer. We have about half a minute.

Dr Adams: Actually, as I said, last year we put an article in our Members' Dialogue about how to let your patients know about block fees and what they entail. We can't ensure that everybody reads the Dialogue, but hopefully they do. If a question came up from any of her patients about the way she implemented a block fee, we certainly would look into it through our complaints process.

Mrs Witmer: Thank you very much for your presentation. I'm pleased to see that you have initiated a review and a consultation yourself of the policies in other jurisdictions. It looks to me that you've given an example here where you did take action when you found there was inappropriate use, and I congratulate you on that.

What is it now that you want from the government? Do you simply want them to amend the bill to allow you to continue to do what you've been doing?

Dr Adams: That's what we would prefer, and if that doesn't come about, we certainly would like to have input into the regulation and how they expect it to be enforced—if not under the health protection act, under which act would it be?

The Chair: Thank you for your presentation this afternoon. I wish you all a good evening.

I would like to thank the committee for your patience with me. This committee stands adjourned until 4 o'clock tomorrow.

The committee adjourned at 1818.

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
Mr Ted Arnott (Waterloo-Wellington PC)
Mr Kevin Daniel Flynn (Oakville L)
Ms Shelley Martel (Nickel Belt ND)
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

Monday 3 May 2004