ISSN 1488-9080

Legislative Assembly
of Ontario

First Session, 38th Parliament

Official Report of Debates (Hansard)

Monday 10 May 2004

Standing committee on justice and social policy

Commitment to the Future of Medicare Act, 2004

Chair: Jim Brownell
Clerk: Susan Sourial

Assemblée législative
de l'Ontario

Première session, 38e législature

Journal des débats (Hansard)

Lundi 10 mai 2004

Comité permanent de la justice et des affaires sociales

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

Président : Jim Brownell
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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 10 May 2004

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE ET DES AFFAIRES SOCIALES

Lundi 10 mai 2004

The committee met at 1603 in room 151.

COMMITMENT TO THE FUTURE OF MEDICARE ACT, 2004

LOI DE 2004 SUR L'ENGAGEMENT D'ASSURER L'AVENIR DE L'ASSURANCE-SANTÉ

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

CATHOLIC HEALTH CORP OF ONTARIO

The Chair (Mr Jim Brownell): I would like to call the meeting to order and welcome the committee and those making deputations this afternoon.

We have for the first deputation the Catholic Health Corp of Ontario. I'd like to welcome you to the table. You will have 15 minutes for your presentation. Should you not use the time, we will split the remainder of the time between the three parties for questions and answers. Welcome. Please state your names when you present, so we can get them recorded for Hansard.

Mr Mark O'Regan: Thank you very much. My name is Mark O'Regan. I'm the vice-chair of the Catholic Health Corp of Ontario. To my left is fellow director Mimi Marrocco. To my right is Don McDermott, the president and CEO of the Catholic Health Corp of Ontario. Thank you for this opportunity to meet with you today—especially for going first—to consider further the amendments to Bill 8.

We represent the sponsoring organization for 13 Catholic health institutions in the province. We represent a total of 929 acute beds, 2,600 long-term-care rehab and psychiatric beds, governed by over 180 directors in eight Ontario communities. Mimi and I are going to share the presentation today. It's less than 10 minutes. Don McDermott will get the tough part, and he'll handle all your questions.

The Catholic Health Corp of Ontario was incorporated under the Canada Corporations Act in 1998 by the Sisters of St Joseph of Toronto, the Sisters of St Joseph of Sault Ste Marie, the Grey Sisters of the Immaculate Conception of Pembroke and the Catholic Health Association of Ontario. We have recently been joined by the Sisters of Charity of Ottawa.

As an organization to carry on its work in the name of the Catholic church, it is subject to canon law. Canon law requires it to have a sponsor to ensure its work is done within the values of the church. CHCO is such a sponsor for our 13-member institutions.

Previously, the congregations of sisters who founded the institutions acted as sponsors. Now the sisters are moving to other works and the Catholic Health Corp of Ontario has taken up the responsibility of sponsorship. In every case, the sisters retain ownership of the institutional property.

As sponsors, we delegate the operational governance of these institutions to voluntary institutional boards of directors. These directors, having the expertise required to govern a health care institution, are drawn from the communities where the institutions are located and represent the diverse nature of the communities, including ethnicity and religion. All the directors of our institutions support the mission and values of the faith-based approach to the provision of health care, within canon law and the laws and standards set out by the Ontario and Canadian governments. Faith-based institutions such as ours provide our mission-based services through the actions of these voluntary boards and the CEOs who work for and report directly to the governing boards.

We were privileged to meet with this committee on February 23, when it was considering amendments to the bill at first reading. As always, we recognize and agree with the intent of Bill 8: to ensure accountability within the health care system in Ontario and to preserve and ensure quality health care for the patients and clients requiring these services. We are fully in accord with the tenets of the Canada Health Act, including public administration that is accountable to the public. We are pleased that the standing committee recommended significant revisions to the bill at that time.

It is a step forward that early amendments have deleted any requirements to have the CEO contract

directly with the ministry, ensuring that the CEO remains accountable only to the governing board. We are also heartened by the provision of a due process for disagreements, and we welcome the inclusion of the public interest clause and other changes that were requested. Thank you for listening to our collective concerns.

Two major concerns remain with us. First, we fear that the wording of the legislation or its regulations will be used in future to minimize the role of the governing body or to compromise the values of the faith-based mission. For example, an institutional board could be obliged to sign an agreement that requires the provision of services contrary to our faith, or to partner directly with an organization that provides services that are contrary to our values. Therefore we support the proposal by the Catholic Health Association of Ontario and other faith-based institutions that you will hear tomorrow, May 11, for an amendment to the bill to state unequivocally that nothing within the legislation or within its regulations is intended to compromise the faith-based missions, ethics and values of the institutions or their owner-sponsors.

At this point, I would ask Mimi to conclude the formal part of our presentation.

Dr Mimi Marrocco: Thanks, Mark. My name is Mimi Marrocco and I'm a director of the Catholic Health Corp of Ontario.

We believe that this amendment would ensure that the legislation retains its original intent, namely that institutions are accountable to the public for their services and for the delivery of these services within their values and ethics. Such an amendment would be a simple confirmation of the assurances previously made by the provincial governments to us and to the owners and sponsors of religious institutions.

In a letter written to the Catholic Health Association of Ontario on August 27, 2003, the Honourable Dalton McGuinty, Premier of Ontario, wrote that "the Ontario Liberals are committed to preserving the Catholic health ministry in our province. We appreciate that governance issues are of the utmost importance if Catholic hospitals, long-term facilities and home care providers are to preserve their ministry."

Currently, as you're no doubt aware, other provincial agreements with their faith-based health care providers recognize and affirm their long-standing and valuable role within the system and their need to maintain their religious mission. We cite the following as examples:

Saskatchewan's district health board and affiliates agreement states in section E:

"It is recognized that the affiliated agency, a Christian institution in the Catholic tradition,

"1. is an integral part of the health system and has an evolving role to play in the health reform initiatives in the district and Saskatchewan;

"2. shall remain a privately owned corporation governed by its own board of directors or in some publicly recognized manner;

"3. has a stewardship role in maintaining its Catholic mission, values, ethics;

"(4) shall carry out its mission, programs and services according to the principles and guidelines of the Health Care Ethics Guide, as approved from time to time by the Canadian Conference of Catholic Bishops."

1610

British Columbia's master agreement of March 1995 states in section 1:

"The minister acknowledges that ownership and title to the facilities set out in schedule A and those additional facilities as may be added from time to time by the owners in furtherance of their religious mission belongs to the respective owners set opposite their names and they shall continue to enjoy the powers and privileges of ownership including, without limiting the generality thereof, the right to determine the context of their respective values and traditions, the mission and values of the owner so as to preserve the spiritual nature of the facility, to establish such medical staff bylaws as they deem necessary to safeguard the mission and values aforesaid and the right to govern the facility, appoint a chief executive officer and approve and implement a staffing plan."

Alberta's agreement with the Catholic Health Association of Alberta, May 1996, states in article 3:

"The co-operation agreements shall recognize that the ownership and operation of voluntary health facilities shall be retained by the owner/operators (or such other entities as the religious group or society they represent shall appoint in their stead from time to time) who shall continue to have the ability to:

"(a) determine the mission, values, ethical principles and guidelines of the voluntary health facility;

"(b) direct, regulate and appoint a governing board for the voluntary health facility," referred to as the facility board;

"(c) participate with the facility board in the selection and employment of a chief executive officer for the voluntary health facility."

The letter of understanding between the province of New Brunswick and the New Brunswick Catholic Health Association of April 1993 states in section 1:

"The mission statements that have been associated, or will be established, with respect to the delivery of services at the religious hospitals will be adhered to and this will be reflected in the regional hospital corporations' bylaws. Only services consistent with the above will be provided in the religious hospitals."

As noted by Mark earlier, in February we recommended that if a dispute is centred on the application of the religious mission, ethics or values of a Catholic institution, the bishop of the diocese within which the institution is located should determine the ability of the institution to comply within church law.

We'd like to conclude by expressing our major concern, and then leave you with two recommendations. Our concern is that the contracts, or the accountability agreements, between institutional boards and government could potentially interfere with the voluntary governance process, especially with faith-based institutions, where

this governance process is the way that we carry out our religious mission.

So we'd like to recommend two things: first, that a clause be inserted into the legislation to ensure that current and future interpretation of the legislation will not interfere with the mission, ethics or values of the faith-based institution or its services; secondly, that a third-party resolution process, mutually agreeable to both parties, be developed for any disputes which arise during the negotiation process and after, when interpreting the agreement. We recommend consulting the local bishop where Catholic ethics and values are in question.

We thank you again for hearing us. We'd be pleased to answer any questions that you may have.

The Chair: Thank you very much. We have about four minutes remaining, so we'll have to have quick questions and answers. We'll start with the official opposition.

Mrs Elizabeth Witmer (Kitchener-Waterloo): Thank you very much for your presentation. The first one is of course your concern about the interference with faith-based institutions. Do you have a clause that you would recommend to be inserted? Do we have a copy of that?

Mr Don McDermott: Don McDermott speaking. The Catholic Health Association of Ontario, when they present tomorrow, will have specific wording that we have reviewed and agree to. So they have identified a clause that they're recommending.

Mrs Witmer: Which would address that concern that you have.

Mr McDermott: That addresses our concerns. That's right.

Mrs Witmer: OK. Thank you very much.

Mr McDermott: It parallels the other provinces' wording in their agreements.

Mrs Witmer: Good. I'll look forward to seeing that.

Ms Shelley Martel (Nickel Belt): Thank you for being here today. The three agreements and the fourth letter of understanding that you referenced between various provinces: Were those agreements around funding, or were they broader than that?

Mr McDermott: No. It's an agreement that includes broad wording around funding. Yearly, there are budgets that are worked out with these provinces and their regional authorities. But it is a master agreement, essentially, that identifies services and funding around those services, and then specifics of funding come on a yearly basis.

Ms Martel: They're worked out annually after that?

Mr McDermott: To my understanding.

Ms Monique M. Smith (Nipissing): Thank you very much for coming today; we really appreciate your input. In the agreements the long-term-care facilities sign with the government right now, is there any language similar to what you reflected from the other provinces?

Mr McDermott: Not to my understanding, and we certainly would appreciate it if there were the opportunity to have some mission protection in those agreements.

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

REGISTERED PRACTICAL NURSES ASSOCIATION OF ONTARIO

The Chair: Next we have the Registered Practical Nurses Association of Ontario. Step up to the table and make yourself comfortable. There is water and juice at the side, if you like.

You have 15 minutes for your presentation, just as with the last deputation. If there's time remaining, we'll have questions starting with the third party. Welcome.

Ms Joanne Young Evans: Thank you very much. My name is Joanne Young Evans, and I'm the executive director of the Registered Practical Nurses Association of Ontario, generally known as RPNAO. With me today is Beth McCracken. As the deputy executive director, Beth is the most recent member of our team and is also a registered practical nurse.

The RPNAO is a voluntary professional association that has represented registered practical nurses, or RPNs, since 1958. Our association represents nearly 5,000, or 14%, of the 32,000 RPNs registered to practise in Ontario by the College of Nurses of Ontario. Our members work in a variety of settings, including acute care facilities, long-term-care facilities, community health, occupational health and many other venues within our health care system.

It is a great pleasure to appear before you today on a bill that is of great importance to the future of the health care delivery system in our province. As you may recall, we provided our comments and recommendations to you during the first round of public hearings, prior to second reading. We are pleased to be back to provide further comments on Bill 8.

Bill 8, the Commitment to the Future of Medicare Act, 2003, was introduced early in the mandate of the new government. It is viewed by many as a signature piece of health care legislation that was to define the new government and to distance it from the previous one. This legislation was portrayed as a clear commitment to make universal, public medicare the law in Ontario. It was said that this bill would outlaw two-tier health care in Ontario. This legislation, we were told, would enshrine into law that every citizen in Ontario would have access to timely, quality and affordable health care.

After a thorough public hearing process prior to second reading, several amendments were made to the bill. We were told that these amendments would make the bill clearer and transparent, and truer to its purpose: to preserve and strengthen medicare in Ontario. We were also told that the bill would provide enduring protection for publicly funded, universal health care in this province, now and for generations to come.

As the association representing RPNs in this province, we have a great interest in the future of health care in Ontario. RPNAO's members support the public health system. We want our patients to be able to rely on it and

to be able to access the necessary services they need in a timely manner. However, in order to do this efficiently and effectively, RPNs and other health care professionals require human, physical and financial resources.

With respect to nursing in particular, this government has already taken some steps to address some of the problems within the system. We welcomed the recent announcement of funding to hire 400 more nurses in small and rural hospitals. I would caution the government, however, that RPNAO trusts this funding will be used to hire both categories of nurses, RPNs and RNs alike. As well, we also hope this funding will not be used to hire one category of nurse at the expense of another.

1620

RPNs play an important role on the health care team. Yet there are hospitals that continue to prevent RPNs from practising to their full scope of practice. In fact, some hospitals have laid off RPNs or displaced them into non-nursing roles because of the myth that RPNs are unable to handle complex and acute cases. This, of course, is occurring at a time when a supposed nursing shortage is occurring in Ontario.

The preamble to Bill 8 states that the bill endorses the Canada Health Act and primary health care, that two-tier health care would be prohibited and that our health care system would be a consumer-centred system that ensures access and is based on need and not on an individual's ability to pay. The preamble also states that the bill will promote accountability in our health care system "that reflects the public interest" and that promotes efficient delivery of high-quality health care services.

You'll have to excuse us. We've been up since 7 this morning at a nursing career fair, so it's been a long day, as I'm sure it has been for you.

RPNAO supports all these objectives. We are concerned, however, that the content of Bill 8 does not contain the necessary elements necessary to fulfill these objectives.

Bill 8 is supposed to be about improving accessibility in the health care system. It was to reduce the wait times for such things as MRIs and CT scans, and it was also to prohibit queue-jumping for essential health care services. Unfortunately, Bill 8 fails to do so. In fact, it makes no mention of prohibiting private hospitals or MRI and CT scan clinics. Bill 8 also does not indicate how wait times will be reduced.

As we indicated to you in our previous submission, we support the establishment of the Ontario Health Quality Council. We are pleased that further changes have been made to this section of the bill that will ensure a more effective and productive council. The council will be an important step in supporting the Health Council of Canada. RPNAO suggests to you, however, that this council be an independent council reporting directly to the Legislative Assembly rather than the Minister of Health and Long-Term Care or to any other member of the executive council.

Ms Beth McCracken: Part II of the bill deals with accessibility. In principle, we support this part. We are pleased that amendments have been made with respect to the protection of personal health information, specifically as outlined in section 13. Our concern prior to the amendments was that this section of the bill would create another stream of access to, and disclosure of, health information. We were concerned that Bill 8 would prevail over Bill 31, the Personal Health Information Protection Act, 2004. We are pleased that Bill 8 has now been amended to provide a single regime for the protection of health information falling under the jurisdiction of Bill 31, on the condition that Bill 31 is proclaimed.

Part III of the bill deals with accountability. Despite numerous amendments that have been made to this part, it still causes great division between the health care sector and the government. What is set out in part III continues to be a heavy-handed and one-sided approach to enforcing health resource providers.

We suggested to you in our previous submission that without substantial revisions to Part II, one outcome of the bill would be a hostile relationship between the government and health service providers. We believe the changes that have been made do not entirely quell those fears.

Let me say that there have been changes to this part of the bill that we applaud the government for making. The bill has been amended to explicitly exclude individual practitioners and trade unions from accountability agreements and compliance directives. Amendments have also been made to exclude collective agreements from being overridden by compliance orders. Again, this is a concern we brought to you in our previous submission, and we are pleased it has been addressed.

RPNAO is still concerned, however, about the extraordinary amount of power that is granted to the minister. The minister of the day will still have the authority to direct health service providers to enter into an accountability agreement or issue compliance directives. The difference now is that the health service provider and the government can negotiate such an agreement or directive for 60 and 30 days, respectively, but if negotiations fail to reach an agreement, the minister may move unilaterally. Aside from this delayed unilateralism, if I can call it that, what is the incentive for the ministry to negotiate in good faith it if knows it can ultimately have its way?

The minister also has the authority to implement onerous fines on the board of our health care facilities, many of whom are volunteers. RPNAO recommends that the power of the minister be subdued significantly by appointing a supervisor for those cases where accountability agreements or directives can be negotiated within a designated timeline. This supervisor would ensure that both government and the facility negotiate in good faith. The supervisor will review the situation and the supervisor will make recommendations on how best to achieve the agreement.

With this approach, an agreeable solution will be sought and an accountability agreement will be developed through co-operation rather than coercion. It will also diminish any hostility created in the health care

system as a result of implementation of this legislation as it is currently written, and increase the facility's commitment to the agreement.

RPNAO also recommends that for part of the accountability agreements there should be a provision that an employment environment be conducive to all nurses working to their full scope of practice, utilizing tax dollars much more effectively and efficiently than at present. We would like to see included in the agreements proof that all publicly funded facilities hire both categories of nurses. This will ensure that new funding, for example, given to hospitals to hire more nurses will be used for just that purpose and not for salary increases for hospital executives or senior staff, as has occurred with the funding that has just been announced a short while ago.

As well, other hospitals are hiring only one category of nurse. This is slowly phasing out another category. In fact, we were just informed that the University Health Network in Toronto is moving toward an all-RN staffing arrangement. Any new funding that is received for hiring nurses will only be used to hire registered nurses. Furthermore, as registered practical nurses leave or retire, an RN will be hired to replace them.

Given that RNs receive a higher salary than RPNs, the amount of money that will be spent for hiring more nurses will be used to pay nurses more, rather than paying for more nursing. This, despite RPNs being just as capable and equipped to fulfill the role. I stress to you that RPNs are more than qualified to work in acute care, as well as in other areas within hospitals. They are a necessary and an integral part of the overall health team, and we need to ensure that they remain included. In fact, we can give you dozens of examples of award-winning collaborative nursing teams in health care facilities across this province.

In closing, I would like to thank you for the opportunity to appear before you again. We appreciate the open dialogue that Bill 8 has been receiving, and RPNAO truly hopes that, based on the suggestions and recommendations that you're receiving from various stakeholders, amendments will be made to the bill to truly protect medicare in Ontario.

We would be pleased to address any questions.

The Chair: Thank you very much. We have four minutes remaining. Ms Martel, a very quick question and answer.

Ms Martel: The question has to do with your solution around dealing with the agreements. There are literally thousands of agreements that will have to be dealt with. I don't think they're going to be dealt with in 30 or 60 days. You've got a suggestion for a supervisor at the front end, which we appreciate. There has also been some suggestion that we should have, at the back end of the process, an independent dispute mechanism in some way, shape or form, to deal with disputes that are ongoing. I'm assuming you agree with that proposal as well?

Ms Young Evans: Yes.

Ms Martel: OK. One other question. You talked about the contradiction—I mean, that's what it is. You didn't say it in your words. I'll say it, and you can either tell me if I'm right or wrong, but there is a contradiction between the preamble, which talks in glowing terms about medicare, and a bill where the contents do not shut down the private hospitals or the private MRIs. Do you see that as a contradiction? Do you remain concerned?

Ms Young Evans: We remain concerned.

Ms Kathleen O. Wynne (Don Valley West): Just a quick question about the supervisor mechanism. By the way, thank you for coming today. On page 4, you talk about the supervisor who would make recommendations on how best to achieve an agreement in the event that an agreement couldn't be reached. What is the accountability of that supervisor? Have you talked or thought about that? How would that work?

Ms Young Evans: We haven't looked at that in detail, but we think that a supervisor would be much more capable of dealing with this situation than handing it over to the minister. In the end, it wouldn't be the minister who deals with it anyway, so if you have someone who can walk into a hospital situation, who is familiar with how hospitals work, how the contracts work, they would be much more capable and knowledgeable in skill and judgment, to use nursing terms, to actually deal with the situation.

1630

Ms Wynne: We have to talk more about the accountability. Mr Leal had a question.

The Chair: It has to be quick.

Mr Jeff Leal (Peterborough): It is very quick. Thank for sharing. Thank you very much for arriving.

You talk about the accountability agreement and 60 days to reach a conclusion. It seems to me from when I was in municipal politics, when we had collective agreements pending with our unions, we used to start a year in advance—

The Chair: Fifteen seconds.

Mr Leal: —to get an agreement. Wouldn't that be commonplace, knowing that this legislation is coming in, to say, "A year in advance we're going to start to get these accountability agreements discussed and signed," rather than just waiting for the last 60 days?

Ms Young Evans: But that doesn't even happen with our contracts today.

The Chair: Thank you.

Ms Young Evans: And they would be accountable to the minister, so—

Mr Leal: I was just speaking from my experience.

The Chair: Thank you. Mr Klees.

Mr Frank Klees (Oak Ridges): Thank you for your presentation. Actually, Mr Leal makes the point that I want to zero in on. You've, rightfully so, pointed out the fact that in spite of all of the amendments, there is still one major problem—and it's not just you; it's really all the stakeholders who continue to point to this extraordinary power and authority that's still left with the minister. Whether you start negotiating a year ahead of time or within the 30- or 60-day period, the fact of the matter is, in this legislation, regardless of what happens,

if the minister feels that it's not the deal he or she wants, it's over, and he or she will make that deal.

I'd like to know what the implications are to your profession under this kind of authority given the Minister of Health.

Ms Young Evans: As we indicated to Ms Martel the last time we spoke, because she asked a very similar question, they can go in and change those particular contracts. They can change hours, they can change pay, they can change a number of things. That is extremely detrimental to us, particularly with RPNs being represented by about 20 different unions, unlike the registered nurses, who are basically represented by one union in the hospital situation.

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

ONTARIO COUNCIL OF TEACHING HOSPITALS

The Chair: Next we have the Ontario Council of Teaching Hospitals. Please make yourself comfortable. Should you need water or juice or anything, we do have them. Welcome.

Mr Murray Martin: Thank you very much. First, I apologize for the copies of our presentation. It will be handed out in a few moments as it was late arriving.

My name is Murray Martin. I'm the chair of the board of the Ontario Council of Teaching Hospitals and I'm the president and CEO of Hamilton Health Sciences Centre. I'm joined by Barbara Sullivan, who is a member of our board of directors at Hamilton Health Sciences Centre.

We believe this is an opportunity to reiterate our commitment to enhance accountability in the health care sector, to underline our joint role with government in developing appropriate funding formulae for Ontario's hospitals, to mutually determine expected outcomes of the services we provide, and to promote a rational piece of legislation that will become the accountability mechanism for many years to come.

We want to recognize and commend the minister and the standing committee for the significant amendments that have been made to the original bill. A number of important issues have been clarified and some of our initial concerns have been addressed. We want to emphasize, however, that the proposed accountability agreements must be negotiated using the best information available to provide care that meets the needs in each community that a hospital serves and that there is a recognition of the transition costs—monetary, professional health resources and technology—and timelines required to integrate services where that is agreed to be the appropriate direction in meeting regional health care needs.

Given the substantial revisions that have been made to the bill, we believe these hearings provide not only the opportunity to propose further amendments, but also to confirm expectations with respect to the execution and implementation of the accountability agreements in the real world.

Today we want to propose specific suggestions to further improve the legislation. OCOTH believes that additional amendments to Bill 8 are needed in the following specific areas:

Part I, Ontario Health Quality Council: We recommend that the role of the Ontario health council be expanded to allow it to make recommendations based on the information it has collected and reviewed.

Part II, section 9, under physician payments: We recommend that section 9 be amended to allow for a narrow range of payments to physicians. As originally drafted, section 9 prohibited any payments to physicians whatsoever.

In our first presentation, OCOTH proposed that this section be amended to allow a narrow range of necessary payments to physicians, such as hospitalists, lab physicians and those working under an alternative payment plan. At the standing committee, the government proposed amendments which effectively permit payments by hospitals to any and all physicians. Indeed, the ministry confirmed that the intent of this change will allow for top-up payments. As a consequence of these amendments, the bill will allow physicians to have, in effect, two mechanisms for payments: one charged to the hospital, the second to the provincial insurance plan. OCOTH members are strongly opposed to this amendment and propose the suggestion that we have.

Just by way of discussions with hospitals already, I've had other CEOs tell me that their physicians have already said to them, "Now this has been changed in Bill 8, we want to begin negotiations with you about our top-up." The reality is, with a shortage situation, this will simply create a bidding war among hospitals, upping the price, and add no more medical manpower to the province. This is a very serious issue.

Accountability agreements: For many years, Ontario hospitals and the Ministry of Health and Long-Term Care have worked on a made-in-Ontario, service-based funding formula. This formula would respond to a number of key policy objectives, including equitable access to care, efficient hospital operations, efficacy and high quality of care and stability and predictability in hospital operations.

At its base is accountability, since it's a truly rate-times-volume approach, where individual hospitals are reimbursed for the services they provide under terms and conditions specified in a mutually negotiated agreement between the government and the hospital. This is a new approach in Ontario and the proposed formulae have yet to be fully tested.

The question of possible service gaps in some communities is a large one and one of concern. The availability of appropriate data to determine the rate and the planned volumes is also a significant challenge. Issues that are of particular concern to teaching hospitals include patient acuity and the cost of teaching and research, which will require special attention.

Throughout the work of the JPPC, it has been clear that the accountability agreements that result from a move to service-based funding should be mutually agreed upon and should be phased in gradually. This bill makes the assumption that suitable service rates have been categorically established, and that volume projections are not only actuarially based but speak accurately to disease and condition incidence in a wide variety of communities across the province—and there is wide variation. It also presumes that service integration will always reduce costs and ensure a higher standard of patient care. The truth is that there is far from any evidence of this assumption.

Work is proceeding, and reference hospitals have been involved in the examination of many details that will lead to competent templates. In this context, therefore, we propose that additional amendments be made to sections 21, 26.1 and 27.

One of the further concerns we have is the ministry infrastructure to, in actual fact, effect these agreements. We need to see more evidence that that infrastructure is being put in place, because this is going to be a complicated exercise and it's going to require change.

We're pleased that the ministry recognizes through amendments the importance of negotiated accountability agreements. However, section 21 still permits these agreements to be imposed by the minister after a period of 60 days without appeal or necessarily taking into account a hospital's realistic view of whether the agreements can be successfully carried out or achieved in what time frames.

The provision that allows the minister to unilaterally alter/impose agreements should be deleted. As an alternative, OCOTH proposes that in the event that an accountability agreement cannot be reached at the conclusion of 60 days, a third party chosen from an agreed-upon roster of highly skilled individuals with strong knowledge of the hospital/health care sector would review the matters under consideration or in dispute and make recommendations within 30 days to the minister and the hospital board for resolution of the issues outstanding so that a satisfactory agreement can be entered into. The results of the third-party review should be made public. We consider that this will be an unusual situation, but sober thought may lead to a workable mutual agreement that might otherwise be unattainable.

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Ms Barbara Sullivan: We also recommend that paragraphs 1/2 of subsection 26.1(6), subsections (11), (12), (13) and (14) of subsection 26.1 and section 27 be deleted. In our view, it's important that a board be accountable for the CEO's execution of the accountability agreement, and this is explicitly addressed in section 21(5) of the bill, as amended, which we recommend could be made even stronger by changing the words "may provide" to "shall provide". We believe that this combination of changes will ensure that the board's responsibility to the minister under the accountability agreement is clearly spelled out in its CEO contracts and eliminates the untidy and controversial intervention of the minister in employment contracts between boards and CEOs. We further recommend that performance agreement guidelines—and I say guidelines—be jointly developed by the ministry, OCOTH and the OHA with clear reference to the board's accountability agreement with the minister, along with penalties and incentives specified.

These proposed amendments are consistent with the minister's recent public statements with respect to his desire to hold boards accountable and would avoid the need for the draconian control mechanisms in sections 26 and 27 of the bill. We think they're simple and workable.

Our final message has to do with implementation of the bill when passed. There's a critical need to ensure that there continues to be strong collaboration between health care providers and the government during the implementation of this legislation. Murray has already spoken of that. At present, there is a lack of clarity concerning how the agreements will be implemented, including the timelines for implementation. We need to work together to make the development of these agreements manageable and useful from a systems management and planning perspective.

Accordingly, our recommendations are as follows:

That the Minister of Health and Long-Term Care ensure that the development of accountability agreements will be based on principles of transparency and flexibility;

That the minister consult with health resource providers impacted by Bill 8 to develop a clear plan on how execution of the accountability agreements will unfold. This will ensure that processes and timelines are clear, and that there is equal treatment across boards;

That the minister re-confirm the commitment to involve health resource providers in the development of the regulations supporting this bill. We know that the minister committed to that in his statement to the committee. We want to underline the importance of that commitment.

We also believe that the minister should verify the linkage between the work that has been undertaken to date by the joint policy and planning committee, JPPC, to develop an accountability framework, and the proposed accountability agreements which are contained in this bill. More information is required by all participants on proposals for the agreement templates and how they will be fully developed.

The further amendments to the bill which we propose, along with a clarification of implementation measures, will, we're convinced, ensure a viable hospital funding mechanism, publicly measurable accountability vehicles and co-operative, coordinated provision of health services in this province. We share your commitment to these goals, and we thank you for having us back today.

The Chair: Thank you for your presentation. We have four minutes remaining. We'll start with the government side.

Ms Smith: Thank you, Mrs Sullivan and Mr Martin. I appreciate your being here today. We really appreciate

your input. I want to ask a little bit about the JPPC accountability framework. How do you see that linking up with the accountability agreements in the future? My understanding was that was going to form the basis of the accountability agreements. Do you see that working?

Mr Murray Martin: That is our understanding, but, to be frank, we're not sure. We want to make sure that the significant effort that's been put in through JPPC, which involves hundreds of people from the health care system, in actual fact is what results in the agreement. With the legislation and still-to-be-drafted regulations, it could go in a different direction, and we are concerned about that.

Ms Smith: Are you involved in the JPPC discussions?

Mr Murray Martin: Yes, I'm on several of the committees myself. At JPPC, there is an overriding understanding that this is the process, but there is always the uncertainty as to whether that will continue to be the case.

Ms Smith: But the understanding right now is that this will form the framework for the accountability agreements.

Mr Murray Martin: Yes.

Ms Sullivan: That's the understanding of the JPPC, but that may not be broadly understood through the hospital and other sectors.

Mrs Witmer: Actually, I had some questions around the JPPC as well. A lot of work has been undertaken, and I don't think anybody quite understands for certain how it's going to be used as we develop the agreements for individual hospitals.

You've talked about the fact that the implementation of the agreements is going to be critical to the success of the implementation of Bill 8. What would you recommend that the ministry do in particular to ensure a smooth implementation?

Mr Murray Martin: I think what is most important is that it actually be phased in, that there be real pilots and that there not be an attempt to fast-track it so that it's actually ahead of where the data is. This is going to be very complicated and there are some aspects of it that may not work as they were intended. There's new ground to be broken in terms of understanding the impact, particularly of the volumes part of the formula. What we would hate to see is that we rush into it and hold organizations accountable to something that is unrealistic and unreasonable.

Ms Martel: Thank you for being here. I have to say that even the timing of putting those in place is completely unrealistic. Setting aside the power that the minister has to impose, which I disagree with, and we have from the start, are the questions of (a) the ministry's human resources to manage this and (b) just the timelines. We're talking about hundreds of hospitals, hundreds of long-term-care facilities, thousands, I would think, independent health facilities and 56 or 57 community health centres. I believe you expressed a concern about resources, generally, at the ministry. How is this ever going to unfold in the timeline that's actually listed in the bill?

Mr Murray Martin: There certainly will need to be a major gearing up within the ministry. There's going to be the need, frankly, to recruit some additional infrastructure to support this. There is skepticism out there. The ministry in past decades has not had a good track record of overseeing contracts. They've been allowed to lapse, with long timelines between renegotiations. You have an industry that's very skeptical about the ministry's ability to take this on without significant work being done.

Ms Martel: Or significant human resources, would be the other issue.

Ms Sullivan: I think it's fair to say too that, for the hospital sector, the work of the JPPC in developing the accountability frameworks enables the hospital sector to be significantly ahead of some of the other sectors that are going to have to be involved in developed accountability agreements as well.

The Chair: We have about 20 seconds.

Ms Sullivan: OK. Just to go back to those JPPC frameworks, they include policy consideration, performance requirements, a performance indication ladder and a process for remediation. None of those things, frankly, have been spelled out in full so that they can be totally implemented today.

The Chair: Thank you very much. We appreciate your attendance here today and we wish you a good evening.

ROUGE VALLEY HEALTH SYSTEM

The Chair: Next we have the Rouge Valley Health System. Welcome. As in the past, you have 15 minutes, and any time remaining is split between the parties. Make yourself comfortable. You have the floor.

Ms Kathryn Ramsay: Thank you very much. My name is Kathryn Ramsay and I'm chair of the Rouge Valley Health System board of directors. With me here this afternoon is Mr Hume Martin, CEO and president.

The Rouge Valley Health System was formed in 1998 following the Health Services Restructuring Commission directive to merge Ajax Pickering General Hospital in Durham and Centenary Health Centre in Scarborough. The vision of Rouge Valley is to be a leader in the delivery of family-centred care for the 500,000 residents we serve.

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Since 1998, Rouge Valley has made a large number of improvements at both sites, which are detailed in your brief and I won't go into them specifically.

The ministry supported Rouge Valley in the achievement of many of these improvements, but the financial investment made by Rouge Valley to implement Health Services Restructuring Commission recommendations ultimately resulted in a deficit of over $16 million and a working capital shortfall that exceeded $31 million.

Over the past six years, the two previously separate hospital foundations merged and launched a $34-million capital campaign to support necessary expansion and redevelopment at both Rouge Valley sites. Rouge Valley

put in place cross-site management and appointed common medical staff leadership for eight of our 10 medical services.

We also played a remarkable, if unheralded, role during SARS. At the epicentre of the outbreak, we cared for 49 SARS inpatients and, through a combination of rigorous infection control practices, dedicated frontline staff and good fortune, avoided transmission of the disease to other patients and staff.

In 2002, the board made a proposal to the Ministry of Health and Long-Term Care to negotiate a financial and service agreement to maintain and enhance safe, family-centred care, eliminate our deficit and begin to pay down our debt. The Ministry of Health responded by saying that a policy framework for such an agreement was not in place. Despite this, Rouge Valley persisted and by March of this year our deficit was eliminated. Given this history, we believe we have a somewhat unique perspective on Bill 8.

Let me be clear. Rouge Valley welcomes Bill 8 and the concept of entering into an accountability agreement with the Ministry of Health. We do, however, have some concerns with the way Bill 8 is being implemented, and we have outlined three suggested improvements to the legislation: (1) strengthen the process by which the Ministry of Health can impose accountability agreements; (2) move away from siloed accountability agreements with hospitals, community care access centres and long-term-care facilities and begin to embrace sector-wide accountability agreements that support the minister's vision of more integrated service delivery across sectors; (3) assist the OHA in its commitment to strengthen hospital and health system governance to prepare boards for the new world of performance agreements and competitive service-based funding allocations.

With regard to the first point, Rouge Valley Health System has specific concerns that relate to sections 22 and 26 of the act that allow the minister to issue compliance directives and compliance orders to Ontario hospitals. Rouge Valley understands the Ministry of Health is ultimately accountable for the quality, volume and price it pays for services provided by hospitals across Ontario. Given the wide variation in hospital capacities and historic levels of base funding, checks and balances must be in place to ensure that both hospitals and the Ministry of Health work in good faith to address disagreements which will arise when the Ministry of Health imposes an agreement under section 26.

Rouge Valley believes a commissioner or commissioners should be appointed under section 26 of the act when a hospital and the Ministry of Health fail to reach an accountability agreement following a compliance directive. We propose that a commissioner or commissioners investigate those circumstances and report back to both the Ministry of Health and the hospital board on the results of their review. Cabinet could then consider the commissioners' report and impose or modify the compliance order. Commissioners' reports must be public documents.

Minister Smitherman has made it clear, and rightly so, that he expects hospitals to focus on strengthening community understanding and support for necessary changes in health service delivery. As currently drafted, Bill 8 may well lead to compliance directives being imposed on hospitals behind closed doors without the opportunity for public involvement.

This dispute resolution process Rouge Valley proposes could also be put in place for community care access centres and long-term-care organizations to the extent that performance agreements are implemented in a variety of health sectors.

Those provisions in the act which allow the ministry to modify employment arrangements of CEOs must be removed. They violate the most basic principles of voluntary governance.

With regard to siloed agreements, last February Minister Smitherman said, "What's needed is better integration and planning at the local level so that we can deliver better results in each part of the province. Not a regionalized model, but a made-in-Ontario solution that builds on the strength of our community-based organizations, large and small."

Rouge Valley is an active member of several local groups committed to health service integration. In Durham, we participate in the Durham Region Health Care Group, chaired by the medical officer of health. Over the past few years, this group has worked diligently to improve palliative care and care for the frail elderly. We have also put in place joint approaches to encourage young people to choose health careers and coordinated our disaster and emergency response planning.

In the east GTA, Rouge Valley is an active member of the Toronto East Emergency Network. We are proud of the role we play in reducing emergency department bottlenecks and identifying ways that hospitals and other health care organizations can work effectively together.

The Ministry of Health should declare its intention to develop a policy and legislative framework to support accountability agreements with local health partnerships focused on improving services to defined populations. These agreements could supplement, and eventually replace, annual agreements with individual hospitals. This will lead to accountability plans with measurable targets for meeting health service delivery needs in local areas. In turn, this will encourage greater cooperation between health organizations and provide a mechanism to constructively involve the public in the design and monitoring of these agreements.

Rouge Valley Health System is working hard to engage the Scarborough and Durham communities in a process to determine how we can best respond to the growth, aging and extraordinary diversity of the communities we serve. We must develop better ways of delivering services with a focus on safe, family-centred care.

As currently drafted, Bill 8 is all about accountability up to the ministry, with insufficient attention to our accountability out to the communities we serve. As

previously suggested, making the commissioners' reports public will go a long way to correct this deficiency.

With respect to strengthening governance, no doubt committee members understand that significant disparities exist across Ontario and the GTA in hospital base budgets and in the ability of hospitals to access capital funding. Newer hospitals, built at a time when the provincial economy was strong, benefited from relatively generous base budgets. These facilities are further down the road to such things as electronic patient records and to achieving lower facility and energy management costs. Their cost per case is lower and they disproportionately benefit from the funding allocation formula developed by the joint policy and planning committee.

When it comes to capital funds, some high-growth municipalities, through previously collected development charges, are able to provide much more generous support for their local hospitals than others. For example, municipal hospital capital support in Durham lags far behind levels of support in Peel, York and Halton. Ministry of Health policy must change if we are to avoid the growing inequity in capital and operating funding between hospitals in municipalities that choose to support their hospitals and in those that are unwilling or unable to provide reasonable capital support in the absence of a change in government policy relating to development charges.

Rouge Valley anticipates that service-based funding will be the cornerstone of the new accountability agreements. While Rouge Valley is not proposing a delay in implementing Bill 8, we are asking the Ministry of Health to work with the Ontario Hospital Association to begin to correct these funding inequities before imposing accountability directives on individual hospitals.

It is also important to strengthen voluntary hospital governance. Hospitals like Rouge Valley are the meat in the sandwich between growing communities demanding improved access, often without regard to the need to live within our financial means, and the ministry's insistence—rightly so—on balanced budgets.

How can hospitals populate their boards with directors who bring strongly held stakeholder views to the table while ensuring board members understand the breach of their fiduciary duty of loyalty if they are to serve exclusively as an advocate of a particular community?

This is the kind of question that requires serious thought and action across Ontario. The Ministry of Health must move quickly to support the Ontario Hospital Association efforts to strengthen governance as we move forward with budgets allocated through service-based performance agreements rather than incremental adjustments to increasingly arbitrary base budgets.

Thank you for this opportunity to express our views on this landmark piece of legislation. We look forward to your questions.

The Chair: Thank you very much. We will have Mr Klees from the official opposition. We have five minutes remaining.

Mr Klees: You indicate that you don't propose delaying implementing Bill 8, yet you make some fairly strong arguments that there should be some significant amendments made. So I'm assuming that you don't mind the bill being implemented as long as they incorporate these amendments that you're proposing. Is that correct?

Ms Ramsay: That's correct.

Mr Klees: I'd like to just focus on the issue of accountability agreements.

You're used to dealing with the Ministry of Health; you know what kind of rapid response there is to the concerns that your hospital may have from time to time. With 150 hospitals, 43 CCACs and more than 500 nursing homes in the province, tell me, how practical is it that these accountability agreements can in fact actually be negotiated, signed off on, within the period of time that the Ministry of Health is proposing? And how many of those institutions do you think will immediately, the minute the gun goes off on this, actually be out of compliance?

1700

Ms Ramsay: I would agree with you in terms of the struggles the ministry has before it in negotiating agreements that are balanced from both sides with the resources they have, and I was interested in the remarks earlier. I think it will be a challenge, but perhaps if there are ranges or something that allows some flexibility in the agreements so that there is some flexibility from the hospital's point of view to operate within ranges and then from the ministry's point of view in terms of their guidelines, that would provide some room to not be out of compliance immediately.

Ms Martel: Thank you for being here. I'm interested in a bit of the background that you talked about on page 2, when you said that in 2002 you made a proposal to the ministry and the ministry responded by saying there was not such an agreement in place, and despite this you persisted. What was the experience and, given that experience, if you look at the wide range of agreements that now have to be negotiated, do you think the ministry has any capacity, or the appropriate capacity, to actually manage what's contained in the bill?

Ms Ramsay: I'm not sure I can comment on whether they have the appropriate capacity, but I'll give you a little insight into what we did. Hume Martin joined us in July 2002, when we were in a very difficult position. We were fortunate to hire Hay, which helped us with those benchmarking standards to create that service agreement. It did take a lot of work and effort, and I would suggest it will be a difficult task for every hospital to undertake the same sort of thing. But we did work through all of our programs, program by program, and looked at benchmark levels, how we related to those benchmark levels and where there were instances where we could save significant dollars. So there were areas where there were smaller differences, but we tackled the larger ones first, and that allowed us the great success.

It probably didn't take a lot of work for Hay—I mean, Hay's not in the room—to create the document. I think

what takes the work is getting the buy-in from your staff and from your physicians.

The Chair: We move to the government.

Ms Smith: Thank you both for being here today. I had a question about a comment you make under your accountability agreement section. At the very end of the third paragraph you say, "As currently drafted, Bill 8 may well lead to compliance directives being imposed on hospitals behind closed doors without the opportunity for public involvement." I just wondered if you had reviewed section 21.1 of the revised bill, because it provides for notice of non-compliance. It provides for a process of dispute resolution where the minister and the health resource providers discuss the circumstances that resulted in the non-compliance. There is an opportunity to exchange information and there's also an opportunity to post that information, to advise the public as to why a compliance directive is being issued. I just wonder why you would state that you think it could be imposed behind closed doors.

Mr Hume Martin: Our sense from reading the legislation is that if an agreement cannot be reached following all the steps that you just enunciated, it still could be imposed without any public explanation that would help to address the real issues that we face serving two very different communities, with expectations that may not be in line with the funding levels that are available. We want to make sure that if an agreement is imposed, it is public, so that the public is fully aware.

Ms Smith: How would the use of a commissioner in any way make this more public?

Mr Hume Martin: It would get around the issue that I think we've just spoken about, which is that there may not be the capacity in the Ministry of Health as currently structured to have as independent and objective a view as required in terms of these situations.

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

COTA COMPREHENSIVE REHABILITATION AND MENTAL HEALTH SERVICES

The Chair: Next we have COTA, Comprehensive Rehabilitation and Mental Health Services. Welcome. You have 15 minutes for the presentation, and we will use any time remaining for question.

Ms Sandra Hanmer: Good afternoon, everyone. My name is Sandra Hanmer. I'm the president and CEO of COTA Comprehensive Rehabilitation and Mental Health Services. I'd like to thank you again for this opportunity to share our perspectives on Bill 8.

As many of you know, COTA is a leading not-for-profit community health and social service organization. We interact with all other parts of the health care system in Ontario. Our rehabilitation services are delivered through contracted partnerships with nine community care access centres across Ontario. We also deliver cost-effective site support, court support, hostel outreach, case management and aftercare programs to individuals living with mental illnesses. These are all funded through the Ministries of Health and Long-Term Care, Community and Social Services, and Children and Youth Services.

We are pleased to see that numerous improvements have been made to Bill 8 since first reading. However, before I address some of our key points pertaining to each section, I'd like to highlight COTA's overriding concern with this particular piece of legislation. In its current state, we are still unclear as to how Bill 8 will impact our governance as a not-for-profit, community-based health provider.

COTA, in collaboration with our partners, performs a unique role in our health care system. As such, it is still not clear what definitions, as outlined in Bill 8, pertain to us. For example, are we to be considered a health systems organization? This is defined in section 1 as "any corporation ... that represents the interests of persons who are part of the health sector and whose main purpose is advocacy for the interests of those persons." Likewise, are we to be considered a designated practitioner? This is defined in section 7 as someone "who may not charge an amount for the provision of insured services rendered to an insured person other than the amount payable by the plan." Each of these definitions—either alone or in combination—could have significant implications for community-based organizations such as COTA. The most obvious one, clearly, is whether we are subject to accountability agreements with the ministry. We therefore urge the government to use clearly defined, consistent terminology to remove such ambiguities and ensure legislative compliance.

With respect to the preamble, CODA supports the inclusion of "community" as an integral component for collaboration within a strong health care system. We are also delighted to see the preamble now include a reference that our health system is to be governed and managed in a way "that reflects the public interest." However, we would like to see this expanded to include "timely access to care." It is in the best interests of the public to have access to health services and the system as a whole. However, if that access is not timely, it may not reflect what's in the best interests for the public.

While Bill 8 recognizes the recommendations put forth by the Romanow report—we commented on this before—it makes no mention of how these will be addressed. In order for our health system to remain relevant and function as a true system, it must encompass a full continuum of care, including community-based services. We therefore recommend that the preamble be amended to acknowledge the public's right to access home care and pharmacare within a publicly funded health system.

With respect to part I, the Ontario Health Quality Council, COTA fully supports the creation of a health quality council for Ontario. We are encouraged to see that our initial concern with restricted membership has been amended to allow participation by senior staff. Ideally, we would like to see this council comprised of all

key players in the health care system, such as patients, advocates, and health care providers, including the often-overlooked community health and support sector.

In his address to this committee, the minister highlighted the need for significant system-wide change to make medicare more responsive and focused on quality outcomes. The Ontario Health Quality Council, whose purpose is to track continuous quality improvement, is an important step in this direction. However, we would like to see the scope and function of the council expanded to enhance accessibility and accountability within our health care system.

For example, the council could report on the cost-effectiveness of programs, highlighting the cost-benefit of for-profit and not-for-profit delivery. In particular, we recommend a dedicated focus on the mental health sector.

COTA has over 30 years' experience delivering community-based care to individuals living with mental illnesses and evaluating the outcomes of our services. Organizations like ours could therefore offer a unique and necessary perspective on monitoring our health care system and recommending cost-effective solutions.

With respect to part II, health services accessibility, COTA is pleased that its concerns with privacy rights have been addressed in the amendments to section 13. We applaud the government for ensuring adherence to the proposed Bill 31 and removing the minister's authority to directly collect, use and disclose personal information.

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The government has recently reiterated its commitment for providing help to society's most vulnerable citizens. Indeed, the health minister claims that Bill 8 protects and promotes accessibility—the health care issue of most concern to Ontarians. However, there is currently no mention in Bill 8 of "access to care in the community," as outlined in the Public Hospitals Act. We recommend including this provision to underscore the government's commitment to health services accessibility throughout the entire health care system continuum.

We understand that the government may be considering reducing OHIP coverage to physiotherapy services. This would not only negatively impact our most vulnerable community members, such as seniors and people with disabilities, but it would reduce accessibility to a proven cost-effective service. Early physiotherapy intervention prevents chronic disabilities and will play an increasingly important role in health prevention as the baby boomer population ages. The ability to access rehabilitation services can make the difference between living independently in the community and becoming increasingly reliant on costly health care interventions. If the government is serious about enshrining accessibility through Bill 8, we respectfully urge the government to avoid considering such shortsighted cost-saving measures.

With respect to Part III, accountability, COTA supports the government's intent to strengthen the principle of accountability within our health care system. We favour many of the changes that have already been made, particularly those amendments that ensure consideration of the "public interest" when enacting accountability provisions. We are also pleased with the amendments that will result in accountability agreements being made between the minister and board and not the CEO. Finally, COTA welcomes the proposed process for public involvement with regulations and requests that community-based stakeholders are included in these consultations.

The minister contends that accountability is a two-way street and that this legislation brings the notion of shared accountability to life. However, Bill 8 still appears to be largely a one-way street. There are numerous provisions to make health care providers more accountable to the government, but none that speak to how the government will meet its obligations of ensuring the provision of health care, particularly through stable, multi-year funding.

This point is particularly relevant for COTA. For the last several years, as an example, funding for the community health support sector has not been stable nor adequate and certainly not predictable. National research studies continue to provide evidence that home and community care is a cost-effective alternative to hospitals, nursing homes and emergency rooms. We therefore urge the government to revise the legislation to address the sustainability of the community support sector through stable, multi-year funding.

COTA also requests further clarification on how Bill 8 impacts governance. For example, the relationships that contracted service providers like COTA have with the various CCAC partners remain unclear. The bill is clear that the CCACs will be entering into accountability agreements. However, as a contracted partner, we would expect that our service agreements with the CCAC will reflect this accountability agreement and that we would not be entering into separate agreements with the ministry as a result. As I mentioned earlier, it is still unclear how that will play out.

Furthermore, COTA is also a transfer payment recipient. As mentioned earlier, will COTA be expected to enter into accountability agreements directly with the minister or will our current service agreements suffice? We urgently request the government to clarify explicitly how these contractual partnerships may be affected to ensure compliance.

In order to strengthen CEO accountability without undermining the role of voluntary boards, we also request clarification on the proposed lines of accountability between the minister and the board and the board and the CEO.

In conclusion, COTA fundamentally endorses the intent of Bill 8 to protect the defining values of medicare and to sustain its future for future generations. Significant improvements have already been made, but more remain if this legislation is to achieve its far-reaching objectives. We continue to seek amendments that ensure that both providers and the government are held accountable by Ontarians for the health care they receive.

Ontario is well positioned to include new ideas and models for health care whereby primary care, institutional care and community care all work together in a fully integrated, cost-effective system. We look forward to working collaboratively with the government to begin repositioning our health care system for the future.

Thank you for your time today.

The Chair: Thank you very much. We have about five and a half minutes remaining.

Ms Martel: Thank you for being here. On page 5 you say, "We … urge the government to revise this legislation to address the sustainability … through … multi-year funding." Is that something you want to see directly in the bill, that the government is committed and there is an amendment that reflects that?

Ms Hanmer: That would certainly go a long way to ensuring that we do have that two-way accountability with the funding being in place.

Ms Martel: With respect to physiotherapy—I'm sorry, I should know this; I'm forgetting—does COTA also provide, through your rehabilitation, physiotherapy services directly or do you contract those?

Ms Hanmer: We provide physiotherapy services directly. We are not, however, an OHIP provider. We're not a schedule 5 provider, but we do have therapists who work in schedule 5.

Ms Martel: I know schedule 5 providers are lobbying the government very strongly, but is there anything you've heard outside of the schedule 5 that would lead you to believe there's going to be an impact on your direct services?

Ms Hanmer: Again, it's unclear. Depending on what happens with the schedule 5 therapy clinics, what's the impact on the rest of the community sector, what's the impact on CCACs in the provision of services in the home, as our therapists do provide services in individuals' homes, many of whom would be accessing or may be accessing the schedule 5.

Ms Martel: And then would have to look to you for that service?

Ms Hanmer: Yes, that's right.

Ms Martel: Is there a cost for your service now? Do you have a fee?

Ms Hanmer: We do have a fee for our service. Most of our services are provided through the community care access centres. We have a very small portion that's provided on a private pay basis. We do work with insurance companies as well, so whatever the fee for insurance companies is is what's paid to our providers.

The Chair: Thank you very much. Ms Smith?

Ms Smith: Ms Wynne has a question.

Ms Wynne: Thanks for coming in. I just wanted to clarify. You had some questions on the first page of your presentation in terms of how COTA would be affected. On whether you're a health system organization: You're not, because the main purpose of your organization, as we understand it, is the provision of service. So you wouldn't be considered a health service organization.

You asked about designated practitioners. They're defined in the Health Insurance Act and you're not covered by that. The scenario you outlined whereby you have an agreement with the CCAC and the CCAC has the agreement with the ministry, that actually is accurate.

Ms Hanmer: Accurate.

Ms Wynne: Yes. OK?

Ms Hanmer: That's one example. But as Ms Martel was just asking me, we do have service providers who could be providing service directly to individuals outside of the CCAC environment. That's where we're not sure how we're fitting into the legislation. But I'm taking from your response that we probably don't.

Ms Wynne: You're not a health system organization, you're not a designated practitioner and you don't fall into the definition of a health resource provider in part III. OK?

Ms Hanmer: Thank you.

The Chair: Ms Witmer.

Mrs Witmer: Thank you very much. That's an excellent presentation. I guess now you know you're not covered by Bill 8—

Ms Hanmer: We're not covered by it.

Mrs Witmer: —according to Ms Wynne, so you won't need to be concerned about developing accountability agreements with the government.

But you do make some excellent points. You stressed the fact that despite what the government says, this bill really does not address the issue of providing timely access to care. You point out here the fact that the public should have the right to access home care and pharmacare within the system. How would you propose that would be included? You mentioned the preamble. Is there somewhere else where you would want to see that included?

Ms Hanmer: To me, that is an accountability portion as well, so in the appropriate sections within the accountability section of the act, so that again there is a two-way communication. The presentation prior to mine talked about the hospitals being integral components of their communities. We too have to be working with all sectors. The legislation has to reflect not only the institutions but also the community portion. The preamble would be a portion of that, as well as the accountability.

Mrs Witmer: You mention the fact that Bill 8 makes no mention of access to care in the community, as outlined in the Public Hospitals Act. I would certainly agree with you. I think that's a real deficit in this legislation. Any claims that have been made that this is going to protect and promote accessibility, we don't see that as the bill is currently written. I trust the government will hear the voices of concern.

Thank you very much. As I say, I think you've reiterated the main issues of concern that we've heard from all of the presenters, but a great presentation.

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RÉSEAU DES SERVICES DE SANTÉ EN FRANÇAIS DE L'EST DE L'ONTARIO

The Chair: Next we have the Réseau des services de santé en français de l'Est de l'Ontario. Bienvenue.

Welcome. You have 15 minutes for the presentation and there will be questions, should there be time remaining.

M. Normand Fortier: Je me présente. Mon nom est Normand Fortier. Je suis le président du Réseau des services de santé en français de l'Est de l'Ontario. Je suis accompagné de M^me^ Nicole Robert, qui est la vice-présidente du Réseau, mais elle est aussi membre du conseil d'administration de l'Hôpital Montfort.

Monsieur le Président, permettez-moi d'abord de vous remercier d'avoir accordé au Réseau des services de santé en français de l'Est de l'Ontario l'occasion de faire une intervention devant vous aujourd'hui sur la question de la Loi 8. Nous savons fort bien que votre temps est précieux et que votre tâche est pressante. Vous comprendrez qu'il en est de même pour nous.

Notre réseau oeuvre au service du mieux-être du quart de million de francophones de l'est de l'Ontario. Il est composé d'une soixantaine de membres, dont les établissements hospitaliers de la région.

Nous avons suivi avec intérêt le débat entourant la Loi 8. Nous tenons à féliciter le ministère de la Santé et des Soins de longue durée et les membres du comité qui ont proposé et accepté d'inclure les amendements au texte de la loi. Deux de ces amendements sont extrêmement importants pour la communauté franco-ontarienne.

D'abord, l'abolition de toute amende envers les bénévoles qui acceptent d'être membres des conseils d'administration d'hôpitaux. Il s'agit là d'une sage décision.

Le deuxième changement porte sur la décision du ministre d'inclure dans la Loi 8 qu'il agirait « dans l'intérêt public ». C'était une question capitale pour la francophonie ontarienne. Nous n'avons jamais douté que le ministre Smitherman n'oserait jamais agir contre l'intérêt public. Mais pour tout dire, nous avons été intrigués par le fait que cet aspect soit exclu de la loi.

Le Réseau et les établissements et organismes francophones de santé qu'il regroupe sont tout à fait d'accord avec la notion d'imputabilité qui, de toute évidence, est au coeur de la Loi 8.

Le Réseau et ses membres se doivent d'être imputables. Nous n'avons aucune marge de manoeuvre pour utiliser des fonds gouvernementaux à mauvais escient. Nous sommes redevables à notre communauté et les attentes de celle-ci sont, à juste titre, élevées. Nous sommes des gens responsables.

En Ontario français, nous avons eu à assumer nos responsabilités et, plus souvent qu'à notre tour, à demeurer vigilant afin de préserver nos acquis.

Vous n'êtes pas sans connaître les circonstances entourant l'épisode de l'Hôpital Montfort. Bien qu'il ait été concluant pour les services de santé en français dans la région de l'est ontarien et pour la communauté franco-ontarienne, c'est un scénario que nous voulons éviter à tout prix.

Monsieur le Président, membres du comité, c'est de cette vigilance que nous faisons preuve aujourd'hui.

La communauté franco-ontarienne est plus que prête à participer au développement de notre système de santé. Elle le fait déjà dans l'est ontarien, grâce aux centaines de professionnels de la santé qui travaillent activement à l'offre des services de santé en français et grâce aux gestionnaires des établissements pour qui l'amélioration de l'accès aux services de santé de qualité en français à la population francophone est une priorité.

Dans cette perspective, nous sommes ici aujourd'hui pour vous faire part de sérieuses préoccupations avec le contenu de la loi tel que présenté en deuxième lecture.

Our serious preoccupations with Bill 8 have to do with the new powers of intervention the minister seems to be giving himself over hospital CEOs.

First, let us signify that we fail to understand how certain individuals can be singled out and targeted in such a way within the entire government system to take the blame for failed policy. Let us also say that it is perceived as a non-confidence vote against every board of trustees of every hospital in Ontario.

We are not here as legal experts. But as francophones we have, sadly, had to go through more court cases than we can count. And there is one thing we did learn from our justice system: No government is above the law. You can't pass any law you want simply because it appears convenient at the time.

In this sense we deem that Bill 8's singling out of CEOs is a question of fundamental justice. And it is not right. But from our Franco-Ontarian point of view, there are greater concerns that go to the very heart of continuing fostering and survival as the most populous linguistic minority and one of the founding peoples of this country.

In our world, as a minority, institutions are something we consider sacred, because they are our only chance of survival. It is true of our schools, of our community colleges, of our justice system where lawyers represent us in our language, and it is certainly true of our health care institutions.

As a community, we're keeping a close eye on the development of our system. In that sense, we are greatly concerned that as Bill 8 still stands, our board of trustees' authority could be suddenly undercut and the CEO of our only francophone teaching hospital would be the chosen target of the minister, on the advice of his bureaucrats.

The fear of retribution is something we find extremely hard to accept, because the CEO of Montfort is in a unique position, as are other administrators tending to the health needs of the francophone population. On a daily basis they have to make decisions that are not only based on health care formulas but also on the assurance that the linguistic, the cultural and, in the case of Montfort, the French academic mandate of the hospital will be respected. This is a responsibility that makes the CEO an integral part of the governance of the establishment, and should he not assume it, he would not be there.

Negotiating for Franco-Ontarian rights with the government of this province has at times proven arduous. Yes, we will sometimes find a sympathetic ear at the political level, but it is quite different when you are confronted with the bureaucratic formulas that do not

factor in francophones and that impose accountability that we are ready to provide and have always provided, but is rarely asked from other organizations.

When you elevate that problem to that of the Montfort governance, which has too often come up against departmental incomprehension when all it is doing is pleading for basically essential service of the Franco-Ontarian community, then perhaps you can understand that we feel we are, as a minority linguistic community, being put in an extremely vulnerable position.

The Réseau does not represent Montfort Hospital only. Its many stakeholders all seek to improve their services to the francophone population, but the truth is that without Montfort's strong example and leadership, a lot of these efforts will be lost. Montfort is an excellent example of what is possible in terms of an extremely well-performing institution that is perfectly adapted to its community.

Mr Chairman, members of the committee, we sincerely believe that the members of our numerous boards of trustees can achieve in terms of accountability what the minister wants to achieve. It is now a matter of mutual trust, not of confrontation.

In the case of francophone rights, we are greatly concerned that the CEOs of our hospitals could be exposed to severe penalties as Bill 8 stands today.

À notre humble avis, une telle intervention du gouvernement dans notre système de gouvernance irait à l'encontre de tous les principes que les cours de justice du Canada ont énoncés maintenant depuis deux décennies. La majorité de ces jugements touchent le domaine de l'éducation, ainsi que l'article 23 de la Charte canadienne des droits et libertés. Toutefois, ils ont été cités abondamment dans l'argumentation qu'a présentée la Cour d'appel de l'Ontario pour rendre sa décision historique envers Montfort, centre de formation national pour les professionnels de la santé en français.

Il est aussi utile de se rappeler les dispositions de la Loi sur les services en français de l'Ontario, l'autre Loi 8. Dans le jugement de Montfort, la Loi sur les services en français, associée au principe constitutionnel de la protection et du respect des minorités, a pleine force de loi. Il s'agit en fait d'une loi quasi-constitutionnelle. Même les procureurs de la Couronne étaient d'accord avec la Cour d'appel sur ce point. Permettez-moi donc de vous citer un extrait du paragraphe 162 du jugement de la Cour d'appel que nous croyons très pertinent au débat actuel:

« La désignation de Montfort en vertu de la Loi sur les services en français inclut non seulement le droit aux services de santé en français, mais aussi le droit à toute structure nécessaire assurant la prestation de ces services en français. Cela comprend la formation des professionnels de la santé en français. Interpréter la loi de toute autre manière, c'est lui donner une interprétation étroite, littérale, limitée, par opposition à une interprétation qui reconnaît et traduit l'intention du législateur. »

Mr Chairman, when the French Language Services Act, as quoted by the Ontario Court of Appeal, speaks of all the necessary structures to render a francophone institution truly francophone, it necessarily includes governance, and that governance is not just limited to the board of trustees but to all those within the administration who are entrusted to exceed, to go beyond the standards of excellence simply to prove they have a right to exist. It is our understanding that when it comes to minority rights, Bill 8 as it stands could contravene successive court judgments in the last two decades.

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We come here as friends of the government of Ontario, of the members of this committee and of this Legislature. The Réseau's presence today serves one purpose, and that is to further the understanding of the impact that Bill 8 could have on our community. In the name of the responsible governance within the community and with respect to the rights of French-speaking Ontarians in Ontario, we trust you will consider our submission. Merci.

The Chair: Merci. We have four minutes remaining.

M^me^ Smith: Merci, monsieur Fortier et madame Robert. On apprécie bien votre présentation aujourd'hui. Au sujet de votre composition: vous avez une soixantaine de membres dans votre Réseau, et je me demandais, avez-vous d'autres fournisseurs de ressources en santé? Est-ce que vous représentez d'autres fournisseurs de ressources en santé?

M^me^ Nicole Robert: Tous les membres de l'organisme, du Réseau, sont des fournisseurs de services en santé. Les membres du Réseau dont vous comptez 60 comprennent tous les hôpitaux d'Ottawa et dans les régions de l'est. Vous avez les hôpitaux de Renfrew, de Cornwall, et dans la région de Hawkesbury et toute la région d'Ottawa. Nous comptons également toutes les institutions éducatives qui donnent des services d'éducation pour les professionnels de la santé, donc pour les infirmières, pour les orthophonistes, cervothérapeutes et physiothérapeutes, et tous les organismes de santé communautaire, dont mon organisme également en santé mentale, donc les organismes qui offrent des services de santé dans la région.

Nous comptons aussi des représentants du CASC d'Ottawa et de la région de l'est ainsi que de la région de Renfrew. Donc ça rencontre tous les organismes de santé que nous pouvons rencontrer et qui offrent des services en français.

Mr Klees: Thank you very much for your presentation. I recall when we met in Ottawa, where our former colleague M. Grandmaître made quite a passionate speech. In fact, he went to the extent of saying, if I recall his words, "This is not the Liberal Party that I signed on to." He was very strong in his condemnation of this bill. You are no less passionate in terms of your condemnation. In fact, if I read between the lines, and it doesn't have to be too much between the lines, I hear you saying that this bill effectively, when it comes to minority rights, is an unconstitutional piece of legislation.

Have you had legal advice? Do you have a legal opinion relating to this particular piece of legislation and

that issue in the context of the successive court judgments to which you refer?

Mr Fortier: Nicole will answer, but in the case of le Réseau, we don't have that many dollars to invest. We're going to wait until the legislation is passed and then we'll react. There's no way we can afford to look at the document unless it's complete.

Mr Klees: But I assume if it is passed without amendment, that is your position, that you will challenge it on a legal basis.

Mr Fortier: We'll certainly ask for legal advice, yes.

Ms Robert: As the board of the Montfort Hospital, as you've seen, we've been through many court cases. I was part of the board at that time also.

Definitely the document as it stands needs amendment, and I think the government is listening to all our sessions because the amendments are important for all the hospitals of Ontario. So I think we'll have to wait until the amendments and the law are passed to determine that, but there are many amendments that have been looked at and this is another important one that we're bringing forward.

M^me^ Martel: Merci d'être venus cet après-midi. J'ai une question pour vous, madame Robert, dans votre capacité de membre du conseil de Montfort. Durant la deuxième lecture, j'ai rencontré une partie des présentations de M. Grandmaître et de M^me^ de Courville Nicol. Après mon discours en deuxième lecture, M. le ministre Smitherman a dit qu'il avait parlé avec M. Grandmaître et qu'il n'existait plus de « concerns » de sa part.

Mais vous êtes ici en tant que membre du conseil de Montfort. J'ai lu la présentation, et à mon avis il existe encore des concerns de la part du conseil de Montfort. Est-ce que vous pouvez dire oui ou non, des concerns existent encore avec la deuxième présentation du projet de loi 8, et est-ce que vous pouvez exprimer clairement les concerns?

M^me^ Robert: Selon le document que nous avons présenté aujourd'hui, l'importance ici est celle d'un président et directeur d'un hôpital d'avoir quand même la possibilité de prendre les décisions de jour à jour de la fonction et de la gestion d'un hôpital grâce à son mandat et suite aussi aux responsabilités et l'imputabilité qu'il reçoit de son conseil d'administration. C'est ça notre souci aujourd'hui. C'est que le président-directeur général d'une institution, pas seulement Montfort, puisse pouvoir prendre des décisions de gestion comme un gestionnaire doit le faire. C'est ça notre souci aujourd'hui.

The Chair: Thank you very much. Merci beaucoup pour la présentation, et bonsoir.

M^me^ Robert: Merci beaucoup pour nous avoir reçus.

GREY AND BRUCE COUNTIES

The Chair: Next we have the Grey and Bruce counties community presentation. I'd like to welcome you. You will have 15 minutes for your presentation. Once again we'll split questions and answers for any remaining time between the parties. Welcome.

Ms Sonya Mount: My name is Sonya Mount. I'm the past president of the Grey Bruce Regional Health Centre Foundation. With me tonight is Ernie Morel, who is the current chair of the Walkerton and District Health Services Foundation.

What we want to do this evening is to take you someplace different. We want to take you to Grey and Bruce counties, and we want to give you a virtual tour of Grey and Bruce counties and health care in rural Ontario. I know some of the members of this committee are quite familiar with rural Ontario and some of you are not, so let's go for a quick tour. That's what we're going to try to do.

We're also going to try to point out to you the impact of Bill 8 as it sits with us today and what will happen to Ernie and me and our foundations if this bill is passed as it currently sits.

Grey and Bruce counties are very sparsely populated. We have the highest seniors population in Ontario. We have heart disease and incidence of stroke higher than all of the provincial averages. We have access to tertiary care which is a challenge. You should try getting to London in the middle of a snowstorm in January.

Rural Ontarians have a poorer health status than their urban counterparts. That was pointed out a number of times within the Romanow report. Recruitment and retention of health professionals is a top priority and a very significant challenge. Grey Bruce Health Services, which is supposed to be the regional centre for two counties as well as outside areas, has the second-lowest number of specialists in Canada servicing that community.

Right now in Grey and Bruce counties there are 10 foundations. There are over 100 members of the foundation boards and the directors, and they commit thousands of hours to their board work and to actual fundraising events.

When we have a special fundraising campaign, we use huge numbers of volunteers. With the recent CT scan campaign in Walkerton and the current MRI campaign that is underway in Owen Sound, we're sitting at about 350 volunteers as it sits today. Those numbers, as the MRI progresses, will increase, as well as the other regional asks that are out there right now. Those are huge numbers of volunteers. Right now, volunteers within the two counties are committed to raise $48 million in capital campaigns in Grey and Bruce counties.

What happens when you are a CEO in Grey or Bruce county? Our current CEOs are very accountable. The formal accountability structure sits between the CEO and their local board. In Grey and Bruce counties, the CEO is the face of rural health care. When you're a CEO in the GTA and the numbers are produced on what your income is over $100,000, for most of the people in this area it's not even on the radar. If you're a CEO in Grey and Bruce counties, chances are you're going to hear about it in the grocery store, you're going to hear about it at church and

you're going to hear about it at your kid's hockey game, because everybody knows your face, everybody knows who you are and everybody knows exactly how much money you make. There is no place for a CEO in rural Ontario to hide. When they make a recommendation to a board about beds, about facilities, or about anything else that exists within their facility, they will have to bear the brunt of that, and they will bear it face to face as they go through their community.

1740

The way we sit today, most rural Ontarians have no idea what Bill 8 is about. They have no idea of how it will impact them. Most rural Ontarians want accountability from their hospitals and from their government on how their health care is delivered. There is a lot more to accountability than dollars and cents. There's an expectation that their boards and their CEOs will make those decisions on moral and social responsibilities, and those decisions are made to their neighbours, their staff and their communities.

Rural Ontarians are fiercely loyal to their hospitals—if any of you can remember what it was like when there were some discussions about closing rural hospitals. We generally have poor access to health care, but our people are generous supporters of our foundations. They support the campaigns because they know who to hold accountable when the care and equipment they need is not there.

After Bill 8, what we're envisioning is hospital boards forced to sign accountability agreements. Given the number of hospital corporations within the province, it is virtually certain that the content of these agreements will not be sensitive to the needs of rural Ontario. The common buzzword is "legislation south of 7." It used to be "south of 2," but they've moved it up to "south of 7."

Rural Ontarians will hold their government, not their local boards or their CEOs, accountable for the programs and services that rural hospitals can no longer provide. In this environment, it will be impossible for rural hospitals to recruit board members for their hospital or for the foundations. Further, the joint initiatives that rural communities undertake collectively are discouraged under this legislation. We raise money based on trust. The trust is that the money is used wisely, that the dollars for the equipment and programs will go to programs whose future is secure. Rural Ontarians have little trust in remote bureaucrats to make the right decisions about the health care they currently need.

With hospital boards losing their ability to determine and respond to local health care needs, the generosity of rural communities to support their local hospitals and the volunteers who raise those funds will evaporate. The current financial impact of modernization and capacity expansion in Ontario is set between $7 billion and $9 billion. Right now, within Grey and Bruce county, we have substantial needs for major building redevelopment. If the 50% share that the rural community is expected to raise evaporates, the long-term implication on the taxpayer will be huge.

So what do we want you to remember? This committee is subject to a number of presentations. What we would like you to do by not addressing a specific paragraph or clause is that, when you're reviewing this Bill 8 and all of the components that it contains, remember that rural Ontarians are entitled to equal access to health care. Remember that the responsibility for local determination of health care needs remains with local volunteer hospital boards. Remember that hospital foundations can maintain the trust of their donors in the sustainability of rural health care, if we can have the bill worded that way. Thank you very much.

The Chair: Thank you for your presentation. We have seven minutes remaining. We will start with the official opposition.

Mrs Witmer: Thank you very much for your presentation. I think you have been able to accurately describe what health care and hospital boards in rural Ontario see as important. They do play a very critical role. I think you've also been able to successfully point out that, without some preliminary steps to be taken by the Ministry of Health such as ensuring equal funding for all hospitals across the province of Ontario, ensuring that there's equal access to care across the province, it really would be premature to move forward with these accountability agreements about which we don't know a lot. In fact, we don't know how they're going to relate to the accountability frameworks that have been developed, or are in the process of being developed, by the JPPC.

One of the suggestions that's been made is that because of so many unknowns and because of the uneven playing field in the province today, it would be wise to put in place some pilot accountability agreements. Would you be supportive, for example, of perhaps taking a hospital in rural Ontario, taking a long-term-care facility, to see if indeed these new agreements are going to be responsive and meet the needs of people throughout the province? Have you thought about how these would be implemented?

Ms Mount: The pilot project?

Mrs Witmer: A pilot project, which means you don't negotiate accountability agreements for every one of the providers—all the hospitals, all the long-term-care facilities and anything else that comes under it—but you would begin, perhaps in year one, to negotiate accountability agreements that would reflect a cross-section of those that are going to be part of the accountability agreement so you can determine whether the framework the ministry is thinking about is appropriate to meet the unique needs of, for example, rural hospitals or long-term-care facilities or city hospitals.

Mr Ernie Morel: Sure. We'd be happy to be part of a test, provided it was clearly understood that that's exactly what it is, a test.

Ms Martel: Thank you for being here this afternoon. Ms Mount, you've spoken very passionately of your concerns about how the bill will impact rural Ontario. Tell me, what would need to be done to this bill so we would not see CEOs put at risk by the minister being able

to claw back compensation and take other action against them, and also so we would not be in a position where volunteer board members would just make a decision not to be part of their local board because they weren't interested in being party to something essentially being run out of Queen's Park? What changes have to be made to this bill to stop those things from happening?

Ms Mount: From my reading of the bill, with the way it is currently worded the accountability contracts have very little flexibility. You can't have responsibility without accountability. The CEOs and the boards would have to know it was a one-on-one, a specific accountability contract that met their need and their community's. We're talking Grey and Bruce counties. Let's go to North Bay, to Little Current—no different in those communities than where we are. Their CEOs have the same issues that ours do, and they would have to be made aware, as would the boards, that they could deal with those contracts, that there was a mechanism by which they could appeal them and could appeal the final results.

Ms Wynne: Thank you very much for coming and for your presentation. I just want to challenge a couple of the assumptions and ask you where they come from.

You make the statement that "the joint initiatives that rural communities undertake collectively are discouraged under this legislation." How are they discouraged? You're saying that they're actively discouraged, and I don't understand where you're getting that.

Ms Mount: The bill makes reference to payment from hospitals to outside groups and outside suppliers. In our community we currently run a rehab program, a pilot program, in conjunction with the local Y. My read of the bill does not allow for that kind of payment, out of funding, to the local Y to help with that program.

Ms Wynne: I will have to check that.

Ms Mount: When I read it, that's the way I read it.

Ms Wynne: OK. That links back to the other issue about the virtual certainty that the content of the agreements will not be sensitive to the needs of rural Ontario. The negotiated nature of the agreements—to my mind, the reason the negotiation has to happen is that each hospital and each organization is different, so there has to be a conversation between the ministry and the organization to make sure the accountability agreement fits the situation. I would guarantee that people in my riding in Toronto don't know about Bill 8 either and people in the hospitals in Toronto think they have unique situations too. That's my understanding of why they have to be negotiated, so why the certainty?

1750

Mr Morel: My reading of the proposed legislation is that it doesn't provide for much negotiation. It appears that it's going to be mandated to the boards.

Ms Wynne: Sixty days of negotiation, OK? It's only after those 60 days that there's then a 30-day period where there's a process, and at the end of that, there could be the imposition of an agreement. But there are 60 days of negotiation. That's why that's there.

The Chair: Thank you. We'll have to stop there. Unfortunately, time has run out. Thank you very much for your presentation. Have a good evening.

INSTITUTE FOR CLINICAL EVALUATIVE SCIENCES

The Chair: Next we have the Institute for Clinical Evaluative Sciences. Welcome.

Dr Andreas Laupacis: Thank you. I think I'm the last person.

The Chair: Yes. You have 15 minutes. Should you not require the 15, we'll use it for questions.

Dr Laupacis: Great.

Good afternoon. I'm Andreas Laupacis, the president and CEO of the Institute for Clinical Evaluative Sciences, more commonly known as ICES. On behalf of our board of directors, I'd like to thank you for giving us the opportunity to be here.

ICES is an independent, non-profit organization that produces unbiased knowledge on a broad range of health care issues to enhance the effectiveness of health care for Ontarians. Our information is used by governments and providers to support health policy development and changes to the organization and delivery of health services.

My remarks today will be restricted to part I of Bill 8, the Ontario Health Quality Council. Let me begin by congratulating Minister Smitherman and the McGuinty government for tabling a bill that would see the creation of a health quality council in Ontario. A body of this nature has been discussed repeatedly in Ontario over the years but has never come to fruition. It is much needed and long overdue. With health care expenditures now accounting for 46% of the provincial budget, Ontarians are entitled to know what they are getting for their investment. The creation of a body composed of independent, objective individuals to monitor and report on health system performance is a positive step toward public accountability, improved quality and better management of a more coordinated health care system.

I'd like to focus my remarks on three aspects important to the quality council, first, the current lack of readily accessible, high-quality information needed for the council to fulfill its mandate; second, the need for the council to actively support the development and use of evidence-based guidelines and standards; and third, the importance of local and regional quality improvement initiatives, which I think is what we heard in the presentation preceding mine.

Bill 8 identifies the functions of the council as monitoring and reporting on access to services, health human resources, population health status and outcomes, and supporting continuous quality improvement. Regarding section 4(a) and its components, the critical challenge for the council will be to fulfill its responsibilities in the current absence of the necessary information or data.

In my opinion, Ontario has fallen well behind other jurisdictions in terms of the data available to monitor

health system performance. For example, the public is concerned about access to MRI scans, but the data needed to accurately determine wait times is not currently available. As well, the information required to answer the question, "Why are Ontarians waiting for MRIs and other key services?" is not being collected systematically.

Last year, ICES released one of the most comprehensive reports available on the management and outcome of diabetes, a chronic disorder of epidemic proportion in North America. One of the cornerstones of high-quality management of people with diabetes is good blood sugar control with diet and medications. However, we were unable to report on the quality of blood sugar control in Ontario because the results of lab tests are not being captured in a central repository.

Veterans Affairs in the United States recently described their impressive quality improvement initiatives in the New England Journal of Medicine. They reported on 17 important indicators of quality. Right now in Ontario, we can only report on six of these. Currently, Ontario simply does not have the information necessary to effectively monitor and report to the public on how the health system is performing. A concerted effort is urgently needed to correct this deficiency.

In most cases, the data is being collected but not brought together. Centrally housing much of this information would not be a difficult undertaking but rather would entail changes to existing processes. The benefits in terms of health system monitoring and reporting would be worth the time and investment.

With regard to section 4(b), the council's function in supporting continuous quality improvement, ICES agrees that this is a critical role, a role that could be strengthened by articulating the manner in which this responsibility will be fulfilled.

Stating that the quality improvement will be supported by council, without identifying the specifics regarding the manner in which this will occur, is too vague and runs the risk that substantive and necessary changes will not be made broadly or consistently.

We suggest adding the following items under clause 4(b), so that it reads:

"The functions of the council are ... to support continuous quality improvement, including,

"(i) ensuring the development of evidence-based guidelines and standards in health care delivery that provide information on the use of new and existing treatment options and identify outdated or ineffective treatments,

"(ii) promoting the practice of evidence-based guidelines and standards to professionals across the province through broad and effective methods of communication."

The inclusion of these items under clause 4(b) is critically important in arming clinicians with the necessary information to maximize the effectiveness and consistency of health care delivery across Ontario.

In Canada, we are seeing the creation of a variety of quality councils, including a national council, and one in Ontario focused on cancer. It is important that the work of these councils not be duplicative or contradictory. In general, it is local information that has the most impact upon the delivery of care. Thus, our provincial quality council must not be seen as replicating the quality initiatives of hospitals, local area networks or others. The data needed to monitor health at the provincial level, currently lacking, must also be provided at the local level to enable improvements.

In summary, the creation of a health quality council in Ontario is a significant and positive step forward. For this body to be successful in discharging its responsibilities, immediate action needs to be taken to address the current data deficit, evidence-based practices need to be identified, profiled and promoted province-wide, and the council must be supportive of local quality improvement initiatives.

We look forward to working with the government and council in making the necessary progress. With over 50 investigators, many of whom are practising clinicians, ICES has expertise in all areas of health care delivery, has a distinguished track record of producing usable knowledge out of raw health care data, and is eager to help the council fulfill its mandate. Thanks for your time.

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

Ms Martel: Thank you for being here today. I've taken the position that we may have great people on the council, but given their limited capacity to make recommendations, they won't be able to hold the government accountable.

In the section right now with respect to what they're able to do, the most they're able to do is make recommendations about a future area of reporting. They may well go out and get great information regarding access to MRI scans, but if they can't make recommendations about funding to improve that, then you have a great deal of information and a ministry doing nothing with it.

I have consistently made the point that the council should have the ability to make recommendations to the minister about what they gather, specifically recommendations on funding, on changes to health policy, and even on changes to health legislation. I'm wondering if you can comment on that.

Dr Laupacis: There is obviously a line between an independent group that may not have all the information the minister has at his disposal and a group that actually has to make decisions. But I certainly agree with you that the quality council should be able to clearly identify where there are areas of deficiency and perhaps provide policy options. That might be one way I would go, where one could say, "On the basis of the information we have seen, here are some reasonable policy options for the government to consider in order to improve the quality of care."

Ms Martel: And those should be public.

Dr Laupacis: I would agree.

Ms Smith: We appreciate your being here today and your input. I was wondering of you could tell us, do you see a role for district health councils in providing that

local information that you spoke about in the latter part of your presentation?

Dr Laupacis: I sure do. I see a role for all sorts of individuals throughout the health care system. I happen to have the pleasure of sitting on the quality council for cancer in Ontario, and the way that council operates is to broadly solicit information from all individuals—patients, practitioners, hospitals etc—to identify what they think the most important quality indicators are. I would have thought that district health councils would have a very active role to play in that.

Obviously, you don't want to collect so many indicators that it becomes overwhelming, and at some point a quality council like this will have to decide they want some indicators that look at prevention, at acute care and at palliative care etc. But absolutely, I think DHCs would have an important role in feeding suggestions and information up to that quality council.

My comment about data and information, though, is that I think it's important that those data are available province-wide.

Mrs Witmer: Thank you very much for your presentation. As Minister of Health, I certainly appreciated the tremendous data that ICES was able to collect and, hopefully, we were able to put to some good use.

I share the concerns of Ms Martel. Number one, this council is not going to be independent—I do believe that—and it was promised it would be. Secondly, it will not be in a position where it can make recommendations. I agree that, using the data that has been collected, they should be in a position where they can make recommendations on policy and funding, whether it be options or what. I believe the main deficit in the council is the fact that it's not independent and it has no capacity to make any recommendations as to where we go in the future. You've got all this data, but you can't recommend as to how it could be used to help better the quality of care in the province.

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

For the committee, thank you for your patience in this heat today. We will adjourn until tomorrow, May 11, at 4 pm.

The committee adjourned at 1802.

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