Submission on Bill 8
Commitment to the Future of Medicare Act

by the
Ontario Federation of Labour

to the
Standing Committee on Justice and Social Policy

February 17, 2004

Introduction

The Ontario Federation of Labour (OFL) is a province-wide federation of unions representing approximately 650,000 affiliated members. Our members include people from every sector of the workforce from public sector employees to construction workers, from health care workers to industrial and educational workers. Together we have long been interested and involved in economic and social issues in our community, such as health care, and welcome the opportunity to speak to you today.

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

We have serious concerns with this Bill as it is currently drafted and intend to proceed through its major sections, pointing out its weaknesses and offering our views for change.

1. The Preamble to Bill 8

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

Unfortunately, there is little in the actual legislation that provides any significant new initiative of these principles. Although the preamble commits the Government to support the prohibition of two-tier medicine, extra billing and user fees, a closer examination of the legislation shows it

fails to entirely close such options. While the preamble recognizes that pharmacare for catastrophic drug costs and primary health care based on assessed needs are central to the future of the health care system, there is nothing in the draft legislation which directly addresses either of these concerns.

2. Ontario Health Quality Councils

The Ontario Health Quality Council, outlined in Part 1, Sections 1 to 6, of Bill 8 is supposed to monitor and report to the public on:

1. Access to publicly-funded health care services;

2. Health human resources in publicly funded health services;

3. Consumer and population health status; and

4. Health service outcomes and to support continuous quality improvement.

It is our belief that this Section needs to be amended if it is to meet the purpose of the legislation. Given the preamble's commitment to the principles of the *Canada Health Act*, it is disturbing to find that the Ontario Health Quality Council does not include reporting on the extent to which the Ontario health care system complies with the principles of public administration, comprehensiveness, universality and portability contained in the *Canada Health Act*. Further, it is not required to report on issues relating to two-tiered medicine, extra billing and user fees. Each one of these issues is fundamental to the health care system and of primary importance to the public.

The Council is to be composed of between nine and twelve members, all of whom are to be appointed by Cabinet. We are compelled to ask:

Where is the democracy in this process? Where is the transparency? For all the public knows representatives from the private for-profit sector could be appointed as a major step towards eroding our public not-for-profit system. It is our strong view that for-profit providers, given their blatant conflict of interest, should be excluded from the Council and that this exclusion needs to be enshrined in the legislation.

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

Further, while the Council is required to deliver a report on the health care system on an annual basis to the public and to the Minister, it is specifically prohibited from making recommendations as to the future course of actions to be undertaken. A good deal of the value of such a Council is thereby thwarted by its inability to make recommendations.

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

3. Opting Out / Extra Billing

This Section of Bill 8 extends the prohibition against extra billing by eliminating the right of physicians and other designated practitioners to opt out of the *Health Insurance Act* and receive direct payments from patients for insured services up to the OHIP maximum.

These provisions [Section 9(2)] seem to strengthen the prohibition on extra billing and opting out, yet a further section of the Bill [Section 9(4)] contains

language that may well open up the possibility of the Government itself, through regulation, to allow extra billing and opting out.

We support a ban on extra billing and opting out and the *Act* should specify such.

4. Queue Jumping

Here Bill 8 proposes a new Section [Section 15] to limit the ability of individuals to jump the queue. An insured person cannot pay or confer a benefit in order to receive a preference in having access to insured services, nor can a practitioner charge or accept money for granting any such preference. In other words, a person cannot be charged money so as to receive a particular test or procedure in advance of another person.

The main problem with this Section is that it prevents queue jumping for insured services only. Yet, more and more pressure seems to be forthcoming due to financial considerations and private interests to delist services. As the list of medically listed services is restricted, this provision would not be applicable and those seeking delisted services would not be protected from queue jumping.

The major threat therefore is not the occasional queue jumping abuse, but rather from the ongoing shift from public to private for-profit health care services. It is our view that this shift must be stopped and reversed. The newly elected Liberal Government campaigned against privatization of health care and should follow through on their commitment to the people of Ontario. Currently, the most insidious form of this privatization is what is termed Public-Private-Partnerships or P3s. The P3 projects of the previous Conservative government, from Brampton to Ottawa and others in the planning stages, should be immediately halted along with the delisting of services.

It has been estimated that such private models can be expected to cost at least 10% more than their public sector equivalents. So, in addition to the evidence from other such experiments in Britain and Australia that suggests P3 hospitals would include a deterioration of hospital services and diminished accountability, Ontario simply cannot afford a private health care system. Making the operation of a hospital private, but keeping the ownership public through a mortgage, doesn't substantively change the private for-profit character of a P3 organization.

Another example are private, stand-alone clinics for MRI's and CT's which operate outside the public Medicare system. This work used to be done in our public hospitals. Further, such private clinics poach scarce reserves of skilled staff from the public system. It takes a whole team of health care workers to ensure good health. Privatization takes Ontario's finite resources out of the Medicare system which already suffers from under staffing. They further enable queue jumping for so-called "medically unnecessary" services.

Homecare provides a further example of the negative impacts of privatization. The privatized delivery of homecare through competitive bidding adopted by Ontario is redirecting precious health care monies out of patient care and into profits. As well, there are ballooning administrative costs while home care workers have had their wages and benefits lowered. Ontario's homecare system is rife with duplication, inability to utilize staff efficiently, additional expenses surrounding tendering requests for proposals, preparing bids, evaluating proposals, monitoring and, of course, profit-taking.

5. Block Fees

Many physicians across Ontario have charged patients for non-insured services by charging an annual or block fee. Typically, such services include telephone advice, renewal or prescriptions by telephone,

completion of various forms, etc. Such block fees have, to date, been largely unregulated although there are certain guidelines outlined by the College of Physicians & Surgeons of Ontario.

The proposals in Bill 8 specify that the Government, not the physician, will determine whether and under which circumstances block fees can be charged. It is our view that block fees should be banned. Block fees are but another mechanism to erode the publicly-funded health care system and should not be allowed in regulations or anywhere else.

6. Accountability Agreements and Compliance Directives

The most controversial sections of Bill 8 are contained in Part 111 (Sections 19 to 32). They cover the powers of the Minister of Health to compel persons to enter into accountability agreements or compliance directives. These provisions have been drafted in such a broad manner as to give the Minister unprecedented power to require individuals and organizations to comply with whatever the Minister desires, potentially including the overriding of legal collective agreements and other negotiated agreements. This constitutes a fundamental affront to democratic rights.

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

Not only is there little limitation on the Minister's power under such circumstances, but there is also little explanation in the proposed legislation as to what accountability actually consists of. As defined in Bill 8, Section19(a), an accountability agreement is an agreement establishing "performance goals and objective", "service quality", "accessibility of services", "shared and collective responsibilities for health system

outcomes", "value for money" and other "prescribed matters". In short, an accountability agreement can cover anything the government wants to cover.

We are opposed to sweeping powers being given to the Minister and such ill-defined accountability agreements. Indeed, throughout the Bill, the powers granted to the Minister are too broad, too open-ended. It is often unclear as to specifically what the directives are about, and to whom they will be directed. As a person proceeds through the Bill, one increasingly gains the impression that the directives of the Minister can be to anyone for virtually any reason.

Further, according to Section 20 of Bill 8, the Minister, in exercising his or her powers, is to be governed by the principle that "accountability is fundamental to a sound health care system" and is thereby to consider a list of matters such as fiscal responsibility, value for money "a focus on outcomes" and any other "prescribed matters". We are very much in favour of a high quality health care system and desire "value for money" and "fiscal responsibility" as much as anyone, but terms such as these, are all too often used as code words in the for-profit sector.

As representatives of the trade union movement we are committed to public Medicare and are opposed to such language if it is to mean advancing a privatization agenda.

The sweeping powers of the Minister and breadth of the directives is further revealed in Sections 26, 27 and 28 of the Bill. Section 27 enables the Minister to unilaterally change a person's "terms of employment" and "the change shall be deemed to have been mutually agreed upon" and "the change does not entitle the person to any sort of payment or compensation, despite any provision to the contrary in his or her contract or agreement of employment."

Section 28 gives additional unprecedented powers to the Minister enabling him or her to reduce funding, vary funding or discontinue any term of a contract or agreement of employment. Again, such dictated changes are deemed to have been mutually agreed upon.

These sections should be repealed in their entirety. We are concerned that the sections do not reflect democratic practices. The sections also do not give us transparency, such as public reporting on finances, or increased community control or any genuine accountability.

Under the provisions of Part 111 of Bill 8, there is a distinct possibility of severe repercussions for trade unions and collective agreements. Trade unions and employers could be directed to address certain cost saving measures, for example, through collective bargaining. Should they fail to do so, they could face an order requiring them to reduce wages or benefits or both. Alternatively, they could be confronted with an order to repeal their no contracting-out language or their successor rights clause.

In the name of "value for money" or "fiscal responsibility", hospitals and health care employees could be compelled to consolidate operations such as laundry or food services and change their collective agreements to facilitate such changes. An alternative avenue open to the Minister would be to simply order a compliance directive requiring collective agreement protections to be modified or overridden.

While the motivation of the Government is not entirely clear, Part 111 of the Bill can only be seen as an attempt to grant the Minister virtually unlimited power to unilaterally dictate fundamental changes in the health care system without procedural safeguards or democratic input. It takes the further step in Section 30 of seeking to insulate itself from legal liability arising from public opposition in the form of actions taken in connection with accountability agreements or compliance agreements. No one will be allowed to take legal action against the Minister or the Crown under the

provisions of this Bill upon its passage. At the same time, the Government is free to prosecute anyone not complying with an order by the Minister.

The powers and penalties in the Bill are all stacked on one side and it is not on the side of those that want democratic representation and transparency in a Medicare system supposedly designed for them. Unfortunately, we are left with little alternative but to call for a **complete withdrawal of this section of the Bill.**

CONCLUSION

One would have hoped that:

- this Bill would have explicitly prohibited two-tiering for so-called "medically unnecessary" procedures;

- accessibility would have been strengthened and assured with special attention paid to marginalised and equity seeking communities and those communities that are geographically remote; and

- there would have been some recognition that for-profit provision is a giant step back from accessibility as can be clearly seen in the American context, wherein millions of people have no medical coverage whatsoever and millions more are inadequately covered.

Given the preamble, one could have also reasonably expected to find provisions on pharmacare and homecare.

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

Privatization, in the form of P3 hospitals, or further delisting of OHIP items, is not “reinventing government”, it’s the path rejected by the voters of Ontario. Evidence from other jurisdictions tells us privatizing health care will lead to worse public services.

We urge the Government of Ontario, in light of our comments, to reconsider this Bill.

Thank you for the opportunity to participate in this important discussion.

Respectfully submitted,

Ontario Federation of Labour

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