

**Submission on Bill 8  
*Commitment to the Future of Medicare Act***

**Presented to the**

**Standing Committee on Justice and Social Policy**

**Submitted by the**

**Ontario Public Service Employees Union (OPSEU) Local 479**

**February 18, 2004**

OPSEU Local 479 represents the near 200 health professionals at the Royal Ottawa Hospital. We are among the 25,000 health care workers represented by OPSEU in this province. The facility in which we work is on track to become the site of the first P3 hospital in Ontario.

We are grateful for the opportunity to participate in this public consultation and applaud this effort to restore transparency and public confidence in the process of setting policy and direction within the health care system.

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

We have serious concerns with this bill as it is currently drafted and intend to offer our views on its major sections concentrating our remarks on privatization, in particular, the ROH P3 redevelopment and related issues of recruitment and retention within the health care professions. Throughout, we offer our recommendations as to how Bill 8 can be strengthened in order to truly fulfil its stated commitment to the future of medicare for all Ontarians.

## **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* (CHA).

While the enshrining of the principles of the CHA may be quite unnecessary it represents, nonetheless, a welcome statement of commitment on the part of the Government and should be broadened to provide for significant new initiatives with respect to these principles including the absolute and unequivocal prohibition of two-tier medicine, extra billing and user fees. It must also include provisions that concretely recognize that pharmacare for catastrophic drug costs and primary health care based on assessed needs are central to the future of the health care system.

## **2. Ontario Health Quality Council**

The Ontario Health Quality Council, as outlined in Part 1, Sections 1 to 6, of Bill 8 is intended 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.

To the above we would add that the Ontario Health Quality Council be required to report on the extent or otherwise that the Ontario health care system complies with the CHA principles of public administration, comprehensiveness, universality and portability and 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.

During the tenure of the previous Government we witnessed a serious erosion of the ability of the people of Ontario to exercise democratic control over the health care system through democratically elected boards reflecting and inclusive of various community constituencies, service users, patient advocates and health care staff.

In light of the aforesaid we strongly recommend that the Council should not simply be appointed by Cabinet but should be assembled through an inclusive, representative process exclusive of for-profit providers, given their obvious conflict of interest.

In addition to the requirement that the Council deliver a report on the health care system on an annual basis to the public and to the Minister, we would also empower the Council to make recommendations as to the future course of actions to be undertaken.

### **3. Opting Out / Extra Billing**

We support the explicitness with which 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 as provided for in Section 9(2) but are concerned that Section 9(4) contains language that may well open up the possibility of the Government itself, through regulation, allowing extra billing and opting out.

We support a ban on extra billing and opting out. However, the *Act* must be amended in order to assure that it is absolutely unequivocal in this regard.

#### 4. Queue Jumping

We commend the inclusion of section (s. 15) the intent of which is to limit the ability of individuals to jump the queue, prohibiting the payment of a fee so as to receive a particular test or procedure in advance of another person.

However, we maintain that this section must not be limited to insured services. As the list of medically listed services is restricted, this provision would not protect those seeking delisted or as yet unlisted services from queue jumping.

The major threat, however, is not the occasional queue jumping abuse, but rather the systemic shift from public to private for-profit health care services. 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, in Brampton and Ottawa along with seven others in various stages of planning, continue to be advanced despite promises made by the new Liberal Government during the election and must be immediately halted along with the delisting of services. The consensus seems to be that minor contractual changes announced by the Government in November 2003 do not substantively change the character of these P3 projects.

Despite claims by P3 proponents that such projects are cheaper a five member panel of economists including former TD Bank Chief Economist Doug Peters and a former Director, Audit Operations for the Auditor General of Canada Lewis Auerbach, the Royal Ottawa Hospital redevelopment will cost the public at least 10% more than a hospital built in the traditional manner (Funding Hospital Infrastructure: Why P3s Don't Work, and What Will, November 2003, ISBN: 0-88627-337-4). The ROH admits it has already spent \$8 million planning and negotiating the P3 deal, far in excess of traditional hospital procurement costs. The estimated cost has already risen from \$100 to \$132 million. The hospital's projected operating cost savings, if any are actually realized, will not be the result of the private sector's greater efficiency but will result from the planned 30% reduction in beds. Typically, P3 projects which claim to cost less, achieve these savings by building smaller hospitals and reducing services!

More recently, another member of the panel, Canadian Centre for Policy Alternatives Research Associate Armine Yalnizyan, in a February 11, 2004 report to

the Ontario Pre-Budget Consultations (on behalf of the Toronto Health Coalition) estimated that if the P3 approach is adopted the additional costs to taxpayers to finance the infrastructure needs identified by the Ontario Hospitals Association could reach \$1.8 billion over a typical 30 year amortization period. The additional cost of private financing to the taxpayer for the two P3 projects that are reportedly set to go in Brampton and Ottawa is estimated to be in excess of \$7 million annually (personal communication, see forthcoming erratum)

Surely such vast sums of money are better spent in the delivery of health care services. These unnecessary costs will necessitate either higher taxes or further reductions in services. For every \$1 million of taxpayer money spent unnecessarily on the added costs of private sector financing the ROH could pay the salaries of 20 much needed health care workers for one year.

In her brief Ms. Yalnizyan presents very compelling arguments related to economies of size and the consequent ability of government to command the best interest rates without the need to raise equity as the rationale for public funding of infrastructure projects. With interest rates at 40-45 year lows it would appear prudent to seize this opportunity to make an investment in the renewal of hospital infrastructure.

Inasmuch as Bill 8 endeavours to assure greater accountability in Ontario's health care system it is important to take note of the many criticisms of P3 projects concerning their lack of transparency and accountability. It appears now that Ontario taxpayers will not see the contracts for the Brampton and Ottawa P3s despite promises to release this information in December 2003 until they are signed, sealed and delivered.

Despite accounts of failed P3 experiments both domestically and abroad (public audits in New Brunswick, Nova Scotia, PEI, the UK and Australia have been highly critical) proponents continue to extol the virtues of the model inviting Ontarians to go down a road other jurisdictions have already abandoned. British companies like Carillion (member of the successful P3 bidder Healthcare Infrastructure Company of Canada both in Ottawa and Brampton) are eager to import the P3 model (termed PFI in Britain where it was originated) and are bidding on projects across Canada. However, in addition to the extra financing costs associated with P3s, reductions in beds and declines in services have also been reported; among such reports the

review by researcher Alyson Pollock published as a series of five articles in the prestigious British Medical Journal.

So if P3s are associated with increased costs, bed reductions and a decline in service quality what is the attraction? It is not difficult to discern the interest of the private sector which perceives health care as a huge untapped source of profit. For governments P3s are a seductive means of hiding government debt in a deficit phobic political climate. Under current accounting practices governments are not required to include the P3 debts associated with privately financed projects in the calculation of its debt making such arrangements irresistibly attractive to governments anxious to appear fiscally responsible. The irony is that in this effort to appear fiscally responsible governments are anything but!

As a result of the policies of the previous government, private stand alone clinics such as MRIs and CTs operate outside the public medicare system and drain money from it through third party billings (WSIB, third party insurance) and thereby deprive hospitals of lucrative revenue. More importantly perhaps, such private clinics poach scarce reserves of skilled staff from the public system. They further enable queue jumping for so-called medically unnecessary services.

An unfortunate example of just this occurred in our region at the Kingston General Hospital following the opening of a private MRI-CT clinic. There is a critical shortage in many of the health care professions in Ontario including that of Registered Technologists and despite advertising across the country the private clinic was unable to attract a candidate. Ultimately, the private clinic poached a technologist from the acute care hospital. As a result the waiting list for critically ill patients in the hospital grew while those seeking medically unnecessary services could simply jump the queue at the private clinic. Private clinic work is far less challenging than dealing with critically ill hospital patients and can be very attractive to overworked, underpaid, stressed out health care professionals who may be unable to resist the lure of the private sector further undermining our public health care system.

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 ballooning administrative costs, and this despite sending labour costs into a nose dive.

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.

The drift towards American style health care which favours those whose wealth guarantees the ability to jump the queue and receive blue ribbon service is alarming. Health care costs are a leading cause of personal bankruptcy south of the border. A recent New York Times article states that 43 million Americans are uninsured, more than the entire population of Canada. The same article explodes the myth of private sector efficiency reporting that health spending has climbed to 14.9% of US gross domestic product (GDP). In striking contrast, according to Sheila Block, health care spending as a proportion of Ontario's GDP has ranged between 5.3 and 6.3 per cent since 1993 (Health Spending in Ontario: Bleeding our Hospitals, Technical Paper #4, The Ontario Association of Registered Nurses (ARN), Budget. Canadian Centre for Policy Alternatives, May 2002). Ontario simply cannot afford a private health care system.

## **5. Block Fees**

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 important, controversial and concerning sections of Bill 8 are contained in Part 111 (sections 19 to 32) which appear to confer unprecedented power upon the Minister of Health to require individuals and organizations to comply with whatever accountability agreements and compliance directives the Minister determines to be appropriate, potentially including the overriding of legal collective agreements and other negotiated agreements. This constitutes a fundamental affront to the people's rights in a democratic society.

Further, according to s. 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 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 unionized health professionals, 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. Of particular concern is Section 27 which appears to enable the Minister to unilaterally change a person's terms of employment and to deem the change to have been mutually agreed upon and deprives the person of entitlement 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.

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.

Admittedly there are counter-arguments to the misuse and unfairness of such a sweeping exercise of Ministerial fiat, but why does the Bill take us down this road when it is so obviously as undemocratic as it is unnecessary and wrongheaded? Why should the vast majority of Ontarians who value public medicare have to resort to counter-arguments to address the potential threat to free collective bargaining?

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, far less anything approaching transparency. Despite the comforting words of the preamble, Bill 8 is more reminiscent of the Conservative's Omnibus Bill 26 than it is of the five principles of the *Canada Health Act*. It even takes the further step in s. 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.

We have been at a crisis point in recruitment and retention of health professionals in our public health care system for many years. Such draconian legislative measures can only serve to drive increasing numbers of health professionals from the public system if they find in addition to the high levels of stress they endure on a daily basis that they cannot rely upon the security of the terms and conditions of their employment into which they have entered in good faith.

## CONCLUSION

This brief attempts to speak both to the strengths and weaknesses of Bill 8 and makes recommendations for its improvement. It seeks to dispel the myth that privatization is the panacea for our health care system woes and demonstrates how in reality privatization has exacerbated the problems in the system. Privatization is neither an effective nor desirable remedy to Ontario's budgetary problems

Admittedly 2003 was not a good year for Ontario's economy. Despite this corporate profits are up 11.5% and the corporate tax rate will be 36% for 2004 compared to 40% in the US. We do not have an expenditure problem in Ontario we have a revenue problem brought about by the Tory tax cuts that will take \$13.3 billion out of government coffers this year alone more than the combined cost of running all of Ontario's hospitals. What is required is a return to fair and equitable taxation.

The Tories have left us not only with an economic deficit but also a democratic one and this consultation is an important step towards remedying it. This brief raises objections to aspects of Bill 8 which will surely add to this democratic deficit. It recommends that the Ontario Health Quality Council not be appointed by Cabinet but rather that it be assembled through an inclusive, representative process exclusive of for-profit providers, given their obvious conflict of interest.

Part 111 which appears to confer unprecedented power upon the Minister of Health with respect to accountability agreements and compliance directives is of greatest concern in terms of inflating the existing democratic deficit. These sections must be repealed in their entirety.

Public sector wages have dropped 10% after inflation and many health care jobs sit vacant. The draconian legislative measures of Part III can only serve to exacerbate recruitment and retention problems driving increasing numbers of health professionals from the public system. If health care workers find that in addition to the high levels of stress they endure on a daily basis they cannot rely upon the security of the terms and conditions of the employment into which they have entered in good faith they will have little reason to resist the siren call of more lucrative work elsewhere.

The privatization of health care, particularly in the form of P3 hospitals, was soundly rejected by the voters of Ontario. There is a preponderance of evidence both in terms of the economic analysis and outcomes from other jurisdictions demonstrating the superiority of publicly built, owned and delivered health care services.

We urge the Government of Ontario, in light of our comments, to reconsider this Bill. Further, we ask that this Government hold fast to its campaign promises to restore our public health care system and to halt its erosion through creeping privatization.

Thank you for instituting this dialogue with the people of Ontario and for allowing me the opportunity to participate in this important discussion concerning the future of our public health care system.

Respectfully submitted,

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