

**Submission to the Standing Committee on Social Policy  
Regarding Bill 74**

**April 1, 2019**



## **Mission and Mandate**

Our primary goal is to protect and improve our public health care system. We work to honour and strengthen the principles of the Canada Health Act. We are led by our shared commitment to core values of equality, democracy, social inclusion and social justice; and by the five principles of the Act: universality; comprehensiveness; portability; accessibility and public administration. We are a non-partisan public interest activist coalition and network.

To this end, we empower the members of our constituent organizations to become actively engaged in the making of public policy on matters related to our public health care system and healthy communities. We seek to provide to member organizations and the broader public ongoing information about our health care system and its programs and services, and to protect our public health system from threats such as cuts, delisting and privatization. Through public education and support for public debate, we contribute to the maintenance and extension of a system of checks and balances that is essential to good decision-making. We are an extremely collaborative organization, actively working with others to share resources and information.

## **Who We Are**

The Ontario Health Coalition is comprised of a Board of Directors, committees of the Board as approved in the Coalition's annual Action Plan, Local Coalitions, member organizations and individual members. Currently the Ontario Health Coalition represents more than 400 member organizations, including more than 500,000 members, and a network of Local Health Coalitions and individual members. Our members include: seniors' groups; patients' organizations; unions; nurses and health professionals' organizations; physicians and physician organizations that support the public health system; non-profit community agencies; ethnic and cultural organizations; residents' and family councils; retirees; poverty and equality-seeking groups; women's organizations, and others.

## Undemocratic and Reckless Process

The process by which this legislation was introduced and has been moved through our provincial parliament is reckless and profoundly undemocratic. Major policy changes regarding vital health care services impacting more than 18 million Ontarians require proper public consultation, meaningful feedback and honest debate. This legislation was forged in secret without any public consultation. The Health Minister has never admitted publicly to the sweeping new powers she has given herself and the government's appointees in the Super Agency to order, direct, coerce and otherwise force the largest round of health services restructuring our province has ever witnessed. She has never admitted that there are more than 5 separate sections in this legislation in which the Minister has given herself and the government's appointees in the Super Agency extraordinary powers to force the transfer of services to for-profit companies. This legislation has been rushed through first and second reading in the Ontario Legislature at extraordinary speed so as to limit debate and reduce the time allowed for Ontarians to learn what the legislation means for them. Worse, Cabinet created the Super Agency and has even named most of its Board Members before the Legislation has even been passed in our provincial parliament. This makes a mockery of our system of parliamentary democracy and is nothing short of indefensible.

The public was given, at most, one-and-a-half days of notice to apply for standing to present before this Standing Committee on the new legislation. Even with the scant notice, more than 1,500 Ontarians applied for standing. There are only two part-days of hearings in Toronto and no hearings elsewhere in the province and only 30 spaces for presentations. Approximately 1,500 people and organizations that applied for standing will not be heard. We object in the strongest possible terms to what can only be described as an attempt to circumvent public scrutiny and debate. Ontario's health care system is understood to be a *public* system. Ontario residents fund it, we have contributed more than a hundred years in our local communities to building it, and we rely on it from birth to death. This legislation takes away all last vestiges of local control over our health care services. The process with which this legislation is being railroaded through our provincial parliament is high-handed and grossly objectionable.

In context, the usual process for major changes in public policy is that the government would issue a "White Paper", a discussion paper, and provide widespread public notice and distribution of the paper outlining key questions and intentions for public input. This input would be gathered over a period of months and it would be used in the framing of the legislation. That has not happened. Once written, such major legislation usually takes months to go through the Ontario Legislature. Usually there is notice for public hearings and those hearings are held in every geographic region of the province. There is usually a reasonable time (a matter of weeks or months) for organizations and individuals to apply for standing, and there is usually enough time in the hearings to hear from most or all of those who apply for standing. This has not happened. Usually, the input from the hearings is considered by all political parties for a period of time and amendments are drafted to reflect the input. These amendments are duly voted on in the Standing Committee. All of this process allows time for thoughtful consideration, public discussion and debate, informed responses and meaningful democratic input. None of this has happened with Bill 74.

Here is a summary comparison of this current process with the previous two rounds health care restructuring legislation in Ontario:

- The Local Health System Integration Act (LHSIA 2006) was introduced in 2005. Notice of public hearings was given in November of that year with a deadline to apply for standing on January 13

2006. There were hearings held in Toronto, London, Ottawa and Thunder Bay. These hearings were extremely limited and many organizations objected to this at the time. Nonetheless there was still a process with timelines that enabled Ontarians to have some input. The legislation was amended to improve the goals of the LHINs, to require public Board Meetings, and other improvements in the public interest. Faulty as it was, that process was measurably better than the current one.

- The Savings and Restructuring Act (1996) which launched hospital restructuring under the Harris Conservative government was introduced in November 1995. At the time, it was considered extremely undemocratic as it was a massive omnibus bill, it gave sweeping new powers to the Minister of Health to order the closures of local hospitals by fiat without going back to the Legislature for debate, and it was subject to “time allocation” by the majority Harris Conservative government to limit debate and move it through provincial parliament more quickly. (The same criticisms apply to the current legislation.) Even so, that legislation was referred to a Standing Committee where it was opened for 15 days of public hearings across the province. Those hearings allowed presenters 15 minutes to present. Today the hearings allow 8 minutes. The undemocratic nature of the process for the Harris government’s restructuring bill (which is nonetheless clearly much better than the current process) was so controversial that it is the subject of university theses, public policy articles and studies and books that are available online still today. Even so, the powers in that legislation were nowhere near as far-reaching as the powers in the current health restructuring bill (Bill 74) that is being rushed through this Committee and the Ontario Legislature now. Further, the Health Services Restructuring Commission was required to conduct its restructuring transparently, with published plans and reports, public meetings, public consultations, appeals, public access to documents, and a timeline. These provisions were widely criticized at the time as inadequate. However inadequate, none of these procedural protections are in the current health restructuring bill. In addition, the Harris-era restructuring was not permanent. There was a sunset clause in the legislation that ended the restructuring commission’s work. In Bill 74 the current government has given itself and its appointees in the Super Agency sweeping new powers to order, coerce and otherwise force restructuring in perpetuity. It must be noted that the plan of the Harris government was to cut \$1 billion from public hospitals through restructuring. In the end, they cut \$800 million. According to Ontario’s Auditor General the cost of restructuring was \$3.9 billion. That is, \$3.9 billion in public money spent to lay off staff, close local hospitals, merge and amalgamate, renovate and rebuild buildings to transfer services out of local towns and so on. Many towns lost their services after amalgamations and some lost entire hospitals that had taken a century to build and support. In the end, the administrative “savings” did not materialize and the evidence from Ontario and across the country is that the merger-mania of the 1990s was never shown to find savings and was damaging and disruptive to health care services and the workforce.

Forgoing due public process is a recipe for poor public policy and an affront to democracy. Each round of health care restructuring has lowered the amount of proper consultation and public input in policy making that impact Ontarian’s health and health care system. The current process is a terrible precedent and an abuse of power. We insist that this government reconsider its approach and hold proper public consultations with due notice in every geographic region of Ontario on their plans.

## Repeals and Amendments

Our first position is that this legislation is so poorly conceived and written that it should be repealed.

Failing that, it must be amended to give principles to guide the health system including the principles of the Canada Health Act and a commitment to uphold the provisions of the Commitment to the Future of Medicare Act. It must include clear provisions stating that the Object clause of the legislation, the Minister and any such thing as a Super Agency must act to improve population health. It must include a clear provision that the first job of a public health care system is to plan to meet population need for health care. It should include provisions that require any health care planning to protect and promote equity and improve access to public and non-profit health care. All new capacity should be owned and operated as public and non-profit services. French language services and Indigenous people's rights must be meaningfully protected and improved. None of these are in this legislation as it now stands.

Further, if this legislation is not repealed, in each section in which the government has given the Minister, its appointees in the Super Agency and health providers powers to restructure (including the powers that are given to negotiate, order, direct, coerce through funding powers and otherwise force mergers, amalgamations, mega-mergers, transfers of services from local providers to others, closures of local and provincial services, and closures of entire health service providers) there must be amendments passed to:

1. Prohibit the transfer, closure, merger, amalgamation, or take-over of public and no-profit services by private for-profit companies.
2. Prohibit the reduction and closure of local public and non-profit health care services.
3. Prohibit the closure, cuts to, or reductions of services in local and rural hospitals.
4. Prohibit the lay-off of any health care staff and the reduction of positions.
5. Insert transparency and democracy for all planning and restructuring processes including public notice of plans, public consultations, meaningful input, rights to access documents, rights to be heard, appeals, clear rulings on the record and due notice of all of these.

We must take issue with the claim of the Minister of Health that this legislation will not impact the use of one's OHIP card to pay for health care. Firstly, an OHIP card is not a payment card, and the Ontario government has the duty to protect single-tier public Medicare under Canadian and Ontario law for all residents. More importantly, the evidence is clear that the transfer of public and non-profit health care services to for-profit companies does indeed undermine and endanger single-tier health care. The Ontario Health Coalition has done three repeated studies over the last decade in which we called every private clinic that we could find in our province and/or across the country. In each study we found that the majority of the private clinics charged patients extra user fees and engaged in extra-billing for health care services, and that the vast majority of these were in violation of the Canada Health Act. In British Columbia private for-profit clinics that have taken over surgeries and diagnostics from public hospitals are routinely charging hundreds or thousands of dollars for services that are supposed to be provided equally under public funding to patients without extra charges, in violation of provincial and federal law. The evidence shows that private clinics are also double-billing. In other services, such as long-term care homes, for-profit providers have lobbied intensively for deregulation against the public interest, including deregulation of inspections regimes that protect patients and staff from harm and they have opposed minimum care standards that would improve care and ensure funding goes to care. In British

Columbia, Ontario and elsewhere for-profit cleaning companies have reduced the number of cleaners, reduced time to clean and skimmed on cleaning products to make room to take more profit, contributing to deaths from hospital acquired infections. The evidence shows that for-profit privatization of health care costs more and compromises safety and quality of care.

The government has no mandate to force privatization, mega-mergers, amalgamations, transfers, closures or reductions of our health care services. We must be clear that we see this legislation as extremely dangerous and damaging. We fear, based on the evidence, that it will result in high costs that take money away from care, upheaval and instability, loss of local services, inability for the public to have meaningful input, for-profit privatization, and profound risks to the quality and accessibility of our health care. We are asking you to repeal this legislation. We will fight any attempt to cut, reduce, transfer, merge, close or privatize our health care services.

-----

*Specifically, we propose the following repeals and amendments:*

**I. This Bill should be repealed.**

Failing that, the following are proposed amendments:

**II. PREAMBLE**

Amend this section to add the following to the list provided under the clause “The people of Ontario and their government:”

- a. Confirm their enduring commitment to the principles of public administration, comprehensiveness, accessibility, universality, portability and public funding for health care as provided in the Canada Health Act (Canada) and in the Commitment to the Future of Medicare Act (2004);
- b. Are committed to the promotion of the delivery of public health care services by public and not-for-profit organizations.
- c. Believe that the health system should be guided by principles of compassion and equity.
- d. Believe in public accountability and transparency.
- e. Recognize the role of the people of Ontario in the planning, design, delivery and evaluation of their health care services.

Repeal the sections in quotes from the following:

- “Are committed to a sustainable, digitally-enabled,” publicly-funded health care system “built to last”
- Remove “establishing a new model..” and “creating a single provincial agency...”

**III. INTERPRETATION**

- a) Repeal “integrate includes: (c) to transfer, merge or amalgamated services, operations, persons or entities (d) to start or cease providing services (e) to cease operations or to dissolve or wind up the operations of a person or person or entity”

- IV. Insert a section: “Objects of the Minister of Health” with regards to this legislation. Include the responsibility to uphold the principles of the Canada Health Act and the provisions of the Commitment to the Future of Medicare Act; include promotion of public

and non-profit delivery of health care; include requirement to plan to meet population need for health care; include requirement to be transparent; include requirement that funding for health care be transparent and that the Minister must provide to the public easily accessible information to the public about funding levels for all health care providers; include principles of equity and compassion. Include amendment to the Freedom of Information and Protection of Privacy Act (1990) Section 17 (1) legislation requiring that contracts between government/the agency and health service providers receiving government contracts for health care and support services be excluded from privacy provisions regarding commercial secrecy.

## **PART II THE AGENCY – REPEAL THIS SECTION**

If this section is not repealed completely, which it should be, then we recommend amendments as follows:

- Board Members of The Agency should be elected through a process set out in legislation and passed by the Ontario Legislature. This process must ensure that the Agency reflects the diversity of our province.
- There must be strong protections against conflict-of-interest. As it is, the Agency is not even covered by the provisions regarding conflict of interest in the Public Service of Ontario Act (2006). This section must be amended so that Board Members of The Agency must not have any financial or other interest in any entity that receives funding from or is contracted by the Ontario government or in any health service provider or other entity that receives contracts from or is funded by The Agency, and cannot have held any such financial interest or contract within five (5) years prior to being appointed to the Board. Board Members of the Agency may not apply for contracts with the Ontario government or any Health Service Provider or other entity that receives funding or contracts or any other financial gain through The Agency for five (5) years after holding a position on the Board. The strongest measures possible must be included to prevent a revolving door between for-profit interests and the Board.
- Board Meetings of the Agency should be open to the public with due notice for all meetings available publicly. The language here should be as strong as it was in the in the LHIN legislation. (See LHSIA(2006) Section 9 (5).

Objects of the Agency should be amended as follows:

- The first object of the Agency should be: to plan to meet Ontario's population need for health care services in a compassionate and equitable way under the principles of universality, accessibility, portability, comprehensiveness, and public administration, and under the criteria of public funding as embodied in the Canada Health Act and the Commitment to the Future of Medicare Act (2004).
- Add the following:
  - a. To improve population health.
  - b. To promote the public and non-profit delivery of health care services.
  - c. To promote equity in access to health care including appropriate and equitable access to care for our diverse populations; recognition of unique regional needs including the

uniqueness of Northern Ontario; and the need to enhance access to health care across the whole continuum of care in rural, northern and remote communities.

- d. French language and Indigenous Peoples' protections as two separate items.
  - e. To improve quality of care.
  - f. To promote the public interest in health care planning, design and evaluation, including protection of existing publicly funded health care services, addressing geographic inequities and inequity in access for marginalized and equity-seeking populations, continuity of care and care provider for patients, stability for the health care workforce.
  - g. To ensure timely access to public and non-profit health care services.
  - h. To ban the use of managed competition and competitive bidding.
  - i. Requirement to create and make public and consult upon a human resources plan for health care services to address shortages, stabilize the workforce, protect continuity of care and of caregiver.
- Repeal the following:
    - All references to "sustainability"
    - (e) to support or provide supply chain management services to health service providers and related organizations
    - (g) to promote health service integration ...
    - (h) any other prescribed objects

## **V. PART III. FUNDING AND ACCOUNTABILITY**

- Amend Section 18 (1) and repeal section(2) as follows: The Minister may provide funding to the Agency to meet population need for the publicly funded health care services covered by The Agency under the Principles of the Canada Health Act and the Commitment to the Future of Medicare Act (2004). This funding must be publicly accountable and transparent. Funding shall not be managed on a "market" basis of "efficiencies" and returning or retaining surpluses, but shall be guided by measured population need for care. There shall be no financial incentive to cut health care services for the people of Ontario.
- Section 19 (1) & (2) Amend these sections to say that the Minister will conduct broad public consultations on her/his strategic plan for Ontario's Health Care system. The plan, after consultation and subsequent amendment, shall be published publicly. Then the Accountability Agreement between the Minister and the Agency must be consistent with improving public health care under the Principles of the Canada Health Act and the Commitment to the Future of Medicare Act (2004) and it must be published publicly.
- Repeal 19 (2) (e) and (f)
- Repeal 19 (3)
- Amend 19 (4) to require the reports to be public
- Repeal Section 20 entirely. \*\*Note: this is one of the places where the Minister has given herself sweeping powers to order the contracting out any health care services covered in the legislation.
- If the government members vote down repeal of Section 20 then amend Section 20 to clearly state that such directives shall not result in: a) the loss, closure or



reduction of any health care service; b) such directives shall not result in the cut to or closure of any local, small or rural hospital; c) such directives shall not result in the lay off or termination of anyone or the elimination of any positions d) such directives shall not result in the transfer of any public non-profit health care service or any part of that service to a private for-profit provider, and; e) that any expansion of public health care services must be provided by public and non-profit health care providers.

- Repeal Section 20 (3) (4) (5)
- Amend Section 21 to clearly state that such funding decisions shall not result in: a) the loss, closure or reduction of any health care service; b) shall not result in the cut to or closure of any local, including small or rural hospital; c) shall not result in the lay off or termination of anyone or the elimination of any positions d) shall not result in the transfer of any public non-profit health care service or any part of that service to a private for-profit provider, and; e) that if any funding decisions that result in the expansion of public health care services, those services must be provided by public and non-profit health care providers.
- Repeal Section 21 (2)
- Amend Section 21 (3) to change it from “The funding that the Agency provides under this section shall be on the terms and conditions that the Agency considers appropriate and ...” to “The funding that the Agency provides under this section shall be in accordance with the principles of the Canada Health Act and the Commitment to the Future of Medicare Act (2004) and...”
- Repeal Section 21 (4)
- Section 23 (1) and (2) should apply to the Minister of Health and Cabinet also.

## **VI. PART IV INTEGRATION**

This entire part and every subsection of it should be repealed.

Failing that:

- Repeal Section 29.

Failing that:

- Section 29 (1) Add in a clause under this section that no integration -- by Minister’s designation; by negotiation, funding changes, facilitation decisions of the Super Agency; by Minister’s orders, decisions or directives; or integration by service providers themselves; or by any other method - shall result in the closure or reduction of any public and any non-profit health service or the closure of any public or non-profit health service provider that exists at the date of the passage of the legislation.
- In addition, this section should specify that no integration shall result in a cut to or closure of any local, small or rural hospital.

- In addition, this section should specify that no integration shall result in the transfer, merger or amalgamation of a public or non-profit health service provider or any part of its services to a for-profit health service provider.
- (Note: the amendment cannot simply use the language of health service provider since when they are amalgamated they are no longer a legal entity.)
- Repeal Section 30.
- Repeal Section 31.

Failing that:

- Amend Section 31 to add: no integration shall result in the closure or reduction of any public or any non-profit health service, or the closure of any public or non-profit health service provider.
- In addition, this section should specify that no integration shall result in a cut to or closure of any local, small or rural hospital.
- In addition, this section should specify that no integration shall result in the transfer, merger or amalgamation of a public or non-profit health service provider or any part of its services to a for-profit health service provider.
- Add in an entire process for appeals including public notice, public access to documents pertaining to integrations, the right to be heard, the requirement that the Super Agency has to respond in writing, the requirement that the Super Agency post a clear decision with proper public notice.
- Repeal Section 32. Failing that:
  - Amend Section 32 to add: no integration shall result in the closure or reduction of any public or any non-profit health service, or the closure of any public or non-profit health service provider.
  - In addition, this section should specify that no integration shall result in a cut to or closure of any local, small or rural hospital.
  - In addition, this section should specify that no integration shall result in the transfer, merger or amalgamation of a public or non-profit health service provider or any part of its services to a for-profit health service provider.
  - Add in an entire process for appeals including public notice, public access to documents pertaining to integrations, the right to be heard, the requirement that the Super Agency has to respond in writing, the requirement that the Super Agency post a clear decision with proper public notice.
- Repeal Section 33 (1). Failing that:
  - Amend Section 33 (2) to add in “issue an order under any part of subsection (1) to a health service provider or integrated care delivery system that carries on operations on a public or not-for-profit basis to transfer, merge or amalgamate any of its operations to one or more persons or entities that carry on operations on a for-profit basis.”
  - Add: no integration shall result in the closure or reduction of any public or any non-profit health service, or the closure of any public or non-profit health service provider.
  - In addition, this section should specify that no integration shall result in a cut to or closure of any local, small or rural hospital.

- Add in an entire process for appeals including public notice, public access to documents pertaining to integrations, the right to be heard, the requirement that the Super Agency has to respond in writing, the requirement that the Super Agency post a clear decision with proper public notice.

Failing that:

- Amend 33 (2) (g) and (h) to include public as well as non-profit in the exclusions of full transfers and full mergers
- Amend Section 33 (4) to add in the words “or appeals” and change the duration to 60 days. Expand appeal rights to cover facilitations that are not by order.
- Add in subsection (4) a – an entire process for appeals including public access to documents pertaining to facilitation orders, the right to be heard, the requirement that the Minister has to respond in writing, the requirement that the Minister post a clear decision with proper public notice.
- Add in subsection (4) a – requirement for a public referendum including all residents in the catchment area as defined by the health service provider in the case of any order to integrate a local public hospital.
- Replace subsection (5) with much enhanced appeals process with longer timelines and teeth and public access to documents/information needed.
- Repeal Section 34 (4)
- Repeal Section 35 (1) (3). Failing that:
  - Amend Section 35 to add: no integration shall result in the closure or reduction of any public or any non-profit health service, or the closure of any public or non-profit health service provider.
  - In addition, this section should specify that no integration shall result in a cut to or closure of any local, small or rural hospital.
  - In addition, this section should specify that no integration shall result in the transfer, merger or amalgamation of a public or non-profit health service provider or any part of its services to a for-profit health service provider.
  - Amend Section 35 (7) to be 60 days and make it a meaningful appeals process with public notice, access to documents, the right to be heard, a required response in writing from the Minister and including the public notice and clear decision requirements under this section. Amend Subsection (8) accordingly and make it 60 – 120 days. Amend Subsection (9) to say the Minister may consider the public interest and remove “any matter that the Minister considers relevant.”
  - Repeal Section 37 (1) and prohibit any transfer of property held for charitable purposes.

## **V. PART V. TRANSFERS**

This section should be repealed.

Failing that:

- Repeal Section 39.

- Repeal Section 40 in its entirety.

Failing that:

Amend Section 40 to add:

Such orders shall not result in: a) the loss, closure or reduction of any health care service; b) such orders shall not result in the cut to or closure of any local, small or rural hospital; c) such orders shall not result in the lay off or termination of anyone or the elimination of any positions d) such orders shall not result in the transfer of any public non-profit health care service or any part of that service to a private for-profit provider, and; e) that any expansion of health care service resulting from a transfer order must be provided by public and non-profit health care providers.

- Amend 41 (9) to amend FIPPA to exclude from Section 17 (1) any contracts with private for-profit and non-profit companies from provisions regarding commercial secrecy.
- Repeal Section 43.

## **VI. PART VI GENERAL**

- Amend Section 44 regarding public engagement to remove “in accordance with the regulations if any” and change the language to say that the people of Ontario have a right to be involved meaningfully in the decision-making regarding their health care system and require public notice of decisions, open meetings, access to information, real appeals, referendum etc. as per above. Get rid of all language of “engagement” and replace with democracy, meaningful public input, public hearings on the official record, appeals that are on-the-record also etc.
- Amend Section 45 to include only “the public interest” and repeal all other provisions.