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Tuesday 2 October 2001

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Mardi 2 octobre 2001

Standing committee on estimates

Ministry of Health
and Long-Term Care

Comité permanent des budgets des dépenses

Ministère de la Santé et des Soins de longue durée

Chair: Gerard Kennedy
Clerk: Susan Sourial

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 2 October 2001

Mardi 2 octobre 2001

The committee met at 1538 in room 228.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr Gerard Kennedy): I think we have a quorum. With everybody's agreement, we will start the proceedings. I believe we are with the official opposition, Mrs McLeod. We have approximately 11 minutes in the initial discussion and questioning.

Mrs Lyn McLeod (Thunder Bay-Atikokan): Just to start off, at the last session, Minister, you may have been made aware that there were a number of questions asked for which the ministry did not have materials available and they had undertaken to table. I just want to put them on the record. There was to be tabled information as to how many full-time equivalent new nursing positions had been created in acute care hospitals. That's not hires, but actual new positions, and how many of those are permanent. Secondly, we had asked for the critical care bypass and redirect figures, the current figures. Thirdly, we had asked for the number of funded beds in acute care hospitals this year compared to last year.

The Chair: Mrs McLeod, there is a statement from the ministry that we are going to have copied for everyone. Perhaps you could compare that and, in the subsequent round, we could go back to whether or not there are any deficiencies from what the ministry provided.

Mrs McLeod: All right. I appreciate that. I just understood it was important to have the questions on the record.

The Chair: It is very important to have on the record so that we can easily transact the business of the committee with the ministry.

Mrs McLeod: I won't go into the questions, but just let me conclude. The fourth area was the actual advertising budget for door-to-door distribution of materials and, lastly, a question about the expenditures that were booked last year and are to flow this year. I'll certainly wait for the statement, but could I just for the record determine that the ministry has undertaken to provide that material? Could I just have your affirmation of that?

Hon Tony Clement (Minister of Health and Long-Term Care): I think we have undertaken to provide what we can. Some of the questions may not be within the purview of the ministry. To the extent that they are within the purview of the ministry, we'd ask for those.

Mrs McLeod: I would think they're all within the purview of the ministry.

The Chair: If I could just briefly interject, we'll provide copies to all members of the committee so they can assess for themselves for their own questions. You can pursue anything you like, Mrs McLeod, but that will be forthcoming within a few minutes.

Mrs McLeod: Yes, I will go on. Certainly the questions I've raised are definitely within the purview of the ministry's operations. They're all very directly related to the ministry policy decisions, as well as funding lines.

Just one very quick last question for the moment on acute care hospital funding. I had asked last week about how much of the $8.72 billion, which is now the figure—I understand it's increased because of the July announcement. I'd asked how much of that had already flowed. I was told that all of it had actually been allocated. My follow-up question to that is, how much of that $8.72 billion is actually allocated base funding and how much of it would still be one-time funding?

Mr John King: You didn't ask that question the last time.

Mrs McLeod: No, that's a new question.

Mr King: It sort of threw me that we didn't answer that. The majority of that funding now is base funding. We had some one-time funding at year-end. At year-end last year there were two pots of money that did flow as one-time money. There were $177-million and $120-million performance grants.

Mrs McLeod: Last year. I had asked last day whether or not—

Mr King: It's part of these estimates.

Mrs McLeod: It is part of this year's estimates?

Mr King: The $8.7 billion is the number.

Mrs McLeod: That's actually money that was one-time money that flowed last year but is shown in this year's estimates, in the $8.7 billion total?

Mr King: It's in the $8.7 billion interim actual.

Hon Mr Clement: What happens is that it gets added to the base in the subsequent year.

Mrs McLeod: Let me determine that then. Money that was actually flowed last year separately from the expenditure of $8.7 billion is shown in this year's estimates, so that money that flowed as the two pots of money that flowed on a one-time basis at the end of the last fiscal year is not part of the $8.7-billion allocation to hospitals this year?

Hon Mr Clement: No, it is.

Mrs McLeod: It is. So money that was actually for last year's deficits is part of the $8.7 billion?

Hon Mr Clement: Do you want to answer about the deficits?

Mr King: I just want to go by the estimate numbers. In the $8.7 billion that's shown as the interim actual, included in that would be two one-time pieces. The $177 million did flow at year-end to look at certain hospital operating deficit situations. There was $120 million that was announced also that was really a performance grant for hospitals. Although it was last year, many of the hospitals did flow it this year, but it wasn't one-time.

Mrs McLeod: That money then was one-time in terms of its impact on last year's hospital budgets, but is rolled into base for this year's estimates and is part of what has been allocated for this year as part of base funding, according to what the minister just said.

Hon Mr Clement: You're talking about the performance grant, the $120 million, Mrs McLeod?

Mrs McLeod: I'm attempting to find out what the $8.7 billion is doing. Mr Chair, it may be necessary to look at the statement and have the ministry address this question if it's not addressed in that statement.

As I understood what you've just put on the table today, the $8.7 billion, which is being shown as this year's expenditure, includes $177 million plus $120 million which was last year's money. The minister has said that money is now rolled into base for this year's money. Therefore, as I understand it, $177 million plus $120 million is actually counted twice in the $8.7 billion.

Hon Mr Clement: No.

Ms Maureen Adamson: If I could try to explain this—Maureen Adamson, assistant deputy minister, corporate services. Again, the $8.7 billion on the interim actual line in the estimates includes the two one-time tranches that Mr King mentioned. In the cash dollars, over in the year 2001-02, of the $8.4 billion, that included some annualized dollars that also showed in the estimates of the previous year that did get rolled over in base to the tune of about $400 million. But not to confuse the matter, it does come to the cash versus the actual dollars that were announced, which comes to about $8.7 billion if you look at it on a PSAAB basis. Again, you get into the confusion of cash versus versus PSAAB.

Mrs McLeod: I appreciate that. That's a very important clarification in terms of knowing how much money the hospitals actually have to work with. We may come back to that later. Mr Chair, do I have a few more minutes left?

The Chair: About six minutes.

Mrs McLeod: We are not going to have time to get answers to all of these questions, but I'm anxious to put the questions on the table. Let me turn to hospital capital and the restructuring projects. The first question is, of the projects that were approved by the ministry following the restructuring commission's report, how many of those projects have actually been started and/or completed? I think there were 81 projects.

Hon Mr Clement: I think I'll defer to Paul Clarry or Mr King.

Mr King: The director for capital will answer those questions, Paul Clarry.

Mr Paul Clarry: Paul Clarry, director, capital services. The commission, as you know, did go into 22 communities and issue directions for 92 hospitals. There is a multi-year allocation of about $2.4 billion as ministry share toward those projects. There is a list of approved functional programs for probably–I don't have the exact number; I've got the list here. It's about 35 hospital corporations that have approval on their full plans to respond to commission direction. The total approvals to date for the ministry share are in the range of about $1.6 billion to $1.7 billion. That has not all been cash-flowed. That's for the hospitals that have approval of their entire plans. Most of the other hospitals have what we have called "head start projects," which are at least to get them going on some of the pieces of their commission directions that can be implemented while they're doing their full planning. There's virtually construction going on at every hospital that has been directed. We have not yet given approval for the full scope of commission directions. We will be able to provide you with a list of what's been approved and not approved to date.

Mrs McLeod: So of the 35 that have been approved, that's $1.6 billion in approved ministry share of the cost for those 35 projects?

Mr Clarry: Yes, it is about $1.58 billion in total.

Mrs McLeod: How many projects are actually started, then?

Mr Clarry: I believe there is construction going on at virtually all of those sites. I will have to come back and confirm that for you, but they are either under construction or there will at least be parts of their projects under construction.

Mrs McLeod: Are the ones that have a head start–did you refer to it that way?–in any way in a construction stage or are they still just in the planning stage?

Mr Clarry: The head start projects may be in design stages through to approval to tender and actually under construction. I'm confident that we have activity going on at all of the projects but some of them may just be architectural and design work at this point.

Mrs McLeod: How many approvals, then? You said there were 90-some. That's up from the 81 that I think we had in the last auditor's report. How many actual projects have to have approval?

Mr Clarry: For the total actual projects, I'd have to go back to get a separate list because some of them are multiple approvals and I only have the rollup based on the entire corporation, rather than individual components of the projects.

Mrs McLeod: So we are somewhere in the order of 80 to 90 individual projects?

Mr Clarry: Yes. There have been recommended investments for the 92 sites. We have approvals for either redesign work or actual construction at virtually all of them, but not all of the commission directions have yet

been subjected to ministry approval. We are still working with the hospitals on scope and need. There are some issues related to other infrastructure investments that are slowing down our approvals on the commission's clinical directions.

Mrs McLeod: I'll put two questions very quickly on the table. Do you have a sense at this point of the cost overruns on the projects in comparison to what the commission had estimated them to be? My second question would be, are projects going ahead at this point even where municipalities have said they are not prepared to undertake any commitment to the cost?

Mr Clarry: Projects have gone ahead where the hospitals have been able to demonstrate they have a viable financing plan that may or may not include municipal contributions. We have in our multi-year plan anticipated 30% cost overruns from commission-directed numbers.

Some of the projects, based on their best planning, may have been approved at higher than that, but that's the current base on which we are asking all the hospitals to undertake their planning.

1550

Ms Shelley Martel (Nickel Belt): Welcome, Minister. I wanted to follow up on the line of hospital restructuring, so you might want to come back. I want to deal with what's going on in my own community first and then ask some general questions. I suspect that mine is a community where this has regrettably ground to a halt.

I was part of the Heart and Soul Campaign, the telethon that took place at the beginning of September. You were good enough to provide a video of that. I even have a transcript of your remarks. People in the community were curious as to what you actually meant, so just let me read into the record the two sentences that I'm particularly interested in: "The Mike Harris government is fully committed to providing hospital services that the people of Ontario can depend upon without fail. For the people of Sudbury and northeastern Ontario, the move to a single hospital site means they will receive the health care they need in a state-of-the-art facility."

Hon Mr Clement: I'm not sure I said it as well.

Ms Martel: This is how it was transcribed. The question I have for you has to do with the situation that has now regrettably occurred in the community. Construction has effectively ground to a halt at the site. This is because the cost overruns on the capital side are quite enormous: an $88-million estimated capital project—that was from the Health Services Restructuring Commission—we are now up to $209 million, and no change at all in the planning of the site itself to account for that. That's just sheer increase in construction costs. What do your comments mean to our community in that context? Are you prepared at this point to commit to funding the cost overruns that our hospital is experiencing?

Hon Mr Clement: When you ask it that way, the answer has got to be, not to the extent of just a blank cheque. So the direct answer is no. From our point of view, we entered into an arrangement with the Sudbury Regional Hospital Corp. At that time they said, "Look, we want to have an aggressive, alternative construction approach. We are quite willing and able to assume all financial risks from this alternative construction approach." We worked out terms and conditions for the funding of the project on May 5, 1999.

My predecessor agreed: for the Northeastern Ontario Regional Cancer Centre, $9.89 million. Then we approved, for the HSRC-directed development, $92.14 million. That was going towards a total cost of $143.5 million. Now we've got a situation where they've come back to us and said, "We know we said that we would take any of the risk associated with costs escalating beyond what we had anticipated. We know we said we would take 100% of that risk. But now that the cost is over $200 million, please take the risk yourself." I don't think, as a representative of the taxpayers' interests, I can do that automatically. I'm not saying we won't have discussions. Of course we will have discussions. I'm not saying that the project has ground to a halt. It shouldn't grind to halt. But we've got to decide what this project is, what the nature of it is, what the extent of it is, and build the project.

I would say the same thing in Mrs McLeod's area. I know we've been facing, because of all the building going on—all of the new long-term-care facilities, all of the new college facilities, all of the new university facilities. In the public construction in this province there's been a huge boom, plus we've got the Pearson airport, which is the largest construction project in Canada right now. All those things mean that there's an excess of demand over supply, if I can put it that way.

We know we have a problem that we have to work through together, but it doesn't mean I automatically say yes. I guess that's the way I would characterize it.

Ms Martel: In fairness, though, the ministry has been involved right from the beginning. The hospital has been upfront and has co-operated with the ministry in terms of whatever information was required. The two reasons that they have been very public about taking the approach they had were (1) it allowed us to have local control over who did the work, so that 90% of the people working on the site are local, which was terribly important to our community; and (2) because they were assured that if the project could be up and running by 2003, they could achieve significant savings on the operating side. Those are the two public reasons they have offered time and again for taking this approach. I think the ministry was well aware of that and agreed that that was a legitimate approach to take.

The concern I have at this point is that we have a significant cost overrun due to no fault of the hospital, because the plans haven't changed. There has been, as you said, a real problem around construction and getting both the materials and some of the specialty labour required. The community isn't sure how much more it can cope with in terms of the local share that we have to raise. We already have a $17-million share being raised through the Heart and Soul Campaign, the region is

probably in for another $25 million through property tax, and we are still waiting for what the additional estimate will be. I don't know if you've received the final cost estimate that the hospital thinks they're in for, and if you're working on that now–

Hon Mr Clement: Pardon me. Have we received the final cost estimate?

Mr Clarry: We have heard from the hospital that they're looking at a project somewhere in the neighbourhood of $209 million. The issue is, do they have the management structures and decision-making structures in place to even keep it at that price? That's one of the issues we're working with them on before we go further into the project. What they told us was that, yes, they wanted local bidders and local trades in and that the aggressive construction management approach would allow them to beat the market because of all the competition the minister has spoken to. They're coming back and telling us now that the reality has been quite different, that while there are local trades working on the site, the contractors who are winning the jobs are not local contractors, and some of the ones they thought they might get a better price from don't have the capacity to do the work for a variety of reasons.

The second thing they're telling us is that they're not beating the market curve in terms of the demand for certain speciality mechanical and electrical needs. We are working with them now to understand what has been driving the costs to where they are to ensure that it is not scope changes. Then we are also looking at what the alternatives are for how we can keep the project moving ahead that reflect not only our affordability, but the board's written commitment that they would manage costs above what was approved. We haven't got a strategy yet that works for them or for us but we are working with them on it.

Ms Martel: Do you have any reason to believe that the changes are from changes in scope of the project?

Mr Clarry: I think we are still under discussion on those points. We've asked for a variety of information from them. We are busy looking at it. But I could not answer the question definitively one way or the other based on the analysis we've done to date.

Hon Mr Clement: What you've got, Ms Martel—we are all looking at it as a snapshot in time. This is an ongoing dialogue we are having with the hospital and its trustees. I don't want my remarks to indicate in any way that we are not discussing these issues, that these issues are not on the table. But of course it is a dialogue; it's not a one-way discussion with them and their interpretation. We've got to analyze, we've got to interpret and come up with what we think is the best solution for the community, of course, and also for the taxpayer.

It has got to be a balance of the two. Because yours is a very important community; it's not the only community. If I can in some way have excellent quality health care that is not diminished one iota in your community and save a dollar that can be applied to another community, that's part of what my job is. That's the kind of dialogue we are having. Certainly we will keep you informed on the progress we make.

Mr King: The only other area I wanted to add, on top of what the minister has said, is that the Sudbury Regional Hospital is also going to be undergoing an operational review.

Ms Martel: Which they requested?

Mr King: They have worked with us on that. It has a lot to do with the escalation in their operating costs and it is also the length of the project. Some of the delays right now are also beneficial for us to really examine the impact on operations. I just wanted to highlight that.

Ms Martel: I was going to ask you about operations, but just one more on the capital side: the original Health Services Restructuring Commission estimate was $9 million for technology and new equipment. I understand that is now in the order of about $65 million or $70 million. What dialogue is going on with the ministry around assessing those needs?

1600

Mr Clarry: The ministry does have a separate process wherein we review the equipment requirements to support the program expansions to look at what the replacement needs are and to ensure that the plan is affordable from the depreciation allowances they receive for replacement equipment.

We build in the appropriate funding for the new equipment they have to acquire as part of the capital project. We are engaged in that process now and it was held back, separate from the construction side of the project, simply to facilitate the timely implementation of the construction work.

Ms Martel: How much money has been allocated for technology and equipment for the new site at this point?

Mr Clarry: I don't have the information here in front of me, but we can get that for you. Basically the commission provided an allowance and we held that number until such time as we got through the process with the hospital about the full range of equipment needs. That would be implicit in the $143-million approval. I'll get the number for you.

Ms Martel: Let me go back to the operating review. My understanding was that the hospital requested that the ministry come in last fall, if I'm correct about the timing of this, because they were concerned about the operating deficit as well. The first action was a representative from Management Board who was in to do audit work last fall. I stand to be corrected. I'm not sure what happened after he was in. Certainly he made some recommendations that provided some immediate funding so the hospital could meet payroll over some of the months last fall. But I'm not sure what adjustment has been made, if any, to the hospital's operating budget and what review is going on right now with respect to the $32-million deficit that they currently have, a deficit which they have clearly articulated to your staff has to do with their trying to operate not only a community hospital but a regional hospital servicing all of northeastern Ontario.

Hon Mr Clement: Some of that is beyond my institutional memory. I'll defer to Mr King.

Mr King: This did begin last year and, again, we were unaware of the extent of the problem. Actually, it was about this time last year that the Sudbury Regional notified us of their issue with respect to their deficit situation. We had slated them for an operational review. We do operational reviews on a scheduled basis every year and we cannot do every hospital, of course, because it is quite time-consuming, does consume resources. They were slated for this year, which we are working through the process.

We did assist them with their one-time funding, which we discussed earlier, at the end of last year to help them through last year. We are working through the process with them at this time. There was an auditor who did go in from the audit branch to do a review of their accounting practices and some of the issues related to that. That report has not been fully received yet. It did not at this point recommend any future funds, because that was not the purpose of the audit. The audit was really to look at some of the management practices. The operational review will do an in-depth review of the funding—the savings that the hospital should achieve. They will look at governance. They will look at management. All of those operations are taken into consideration.

Ms Martel: When is that due to start and when will it be completed, so we have some sense of what funding is required to continue to operate this hospital?

Hon Mr Clement: I was just going to say that discussions are ongoing right now on these very issues. We are in the midst of it right now.

Ms Martel: But it hasn't started at this point.

Mr King: No. We are just in the process of the RFP, which will go out. We hope to complete it by the end of March in this fiscal year.

Ms Martel: In time for the next fiscal year so that an adjustment could be made in the next fiscal year. You wouldn't foresee an adjustment before that time?

Mr King: If there is adjustment necessary, we have to look at some of the issues on savings of the organization.

Ms Martel: I'm just assuming there will be–

Hon Mr Clement: The other thing I'll say generally, because we are into this, apart from the special operational reviews, there are always reviews of plans, business plans and so on, and I'll just say this. Sometimes assumptions are made completely in good faith by the hospital corporation, and when they understand a little bit about how we budget for things, their assumptions prove to be a bit off. Therefore, the requirement for funding is less than they had assumed. That's why we always have to have this dialogue. It is pretty well constant, year-round dialogue about what the ministry policy is, what the funding arrangements are and how they impact on a particular hospital.

Ms Martel: I appreciate that, Minister, but I think it is fair to say that the hospital welcomes the review. They made it clear to me last fall, when someone was in from the audit branch, that they would be happy to have that happen, if only to try and demonstrate what they were trying to do at the regional level versus just the community level. I wanted to ask more general questions about the restructuring itself, because I understood that the OHA had provided some cost estimates on provincial restructuring in recent weeks that put the cost at about $7.1 billion. I was wondering if the ministry was aware of that, and does the ministry agree with that estimate that's been put out by the OHA?

Hon Mr Clement: We might want to call Paul back. Why are you on the last chair?

The Chair: We can probably bring that chair closer, if that would help.

Mr Clarry: The last that we had any official communication from the OHA on restructuring was several years ago. They did a survey of their members which suggested that the cost of restructuring would be somewhere in the order of about $3.2 billion. At that time the ministry's estimate was about $3.3 billion. We have not heard from them recently about the updated estimates.

I will say that the health reform implementation team in the ministry, which is working with all of the hospitals that are implementing restructuring, has been tracking what hospitals are planning or wanting to submit, those that don't have their approvals, and if we total that up it certainly comes into the range of $7 billion. The issue is whether or not it can all be justified in the context of the clinical directions of the commission, and that's the process that the HRIT, the implementation team, is working on with other parts of the ministry, to validate what the real cost to implement commission directions will be as we come forward and approve projects.

Ms Martel: Clearly what the $7.1 billion represents is strictly restructuring, which we believe flowed from the commission—not just ongoing capital that has been done by hospitals.

Hon Mr Clement: I'm not so sure. I think what sometimes it means is the hospital receives the HSRC direction and then, for whatever reason, and an entirely valid reason, there is a view that they have to move beyond what the HSRC directed. I'll give you one example in my local community where the push was on not to plan to 2003 but to plan to 2008. Now everybody wants to plan to 2008, and for valid reasons, I understand that. But by planning beyond the horizon of the HSRC, you can just imagine what impact that has, especially if you're in a growth area or a high-needs area or whatever, in terms of their budgeting and their submissions to the ministry. So I guess the answer to your question is, it might be beyond HSRC which militates this kind of number, which is a lot bigger than we had originally anticipated.

Ms Martel: You have a committee working on that now; I appreciate that. But what is the figure that the ministry uses currently as its best estimate?

Mr Clarry: Our current estimate is about $3.4 billion. Our current funding approvals are based on a total estimated cost of $3.4 billion. The reason the numbers are seemingly so high is because, as the minister pointed to, there are issues around the planning parameters that

hospitals are using beyond HSRC, but there are also perhaps some unrelated infrastructure and other things the hospitals are trying to get built and using HSRC direction as leverage. We're trying to separate those out, because there's a different funding—

Ms Martel: I apologize if I wasn't clear on this. The $3.4 billion right now you would recognize as what you would consider to be legitimate commission directives and the capital costs associated, or is that—

Hon Mr Clement: We've gone through a due diligence on all of those dollars and said those dollars are legitimate and flow from the HSRC directives.

Ms Martel: So what is the total? As I understand it, that's the ministry's share. So what is the total share? Because there's a local share in each of those, right?

Mr Clarry: The actual total project cost that the ministry's plan supports is $3.4 billion, and at 70% funding rounded, the ministry's share is $2.4 billion and a little bit of change. We can certainly give you the numbers on that. The hospitals have to come up with the remaining $1 billion.

Ms Martel: And you're saying about $1.6 billion of that has already been flowed?

Mr Clarry: Yes.

Ms Martel: And what is the timeline to flow the balance of those capital funds to meet just the $3.4 billion?

Mr Clarry: We flow the funds based on the actual work the hospitals are approved to do and they provide us with architects' certificates that the work has been completed. There was a tranche of unconditional grant provided totaling about $1.14 billion and there were obligations that those monies be used for the commission-directed projects. But otherwise, our cash flow will be driven by actual work undertaken.

1610

Ms Martel: Don't you have to estimate in any given fiscal year how much you might require to have the funds available?

Mr Clarry: We are asking hospitals, as they get project approvals, to give us cash flow numbers upon which we can do our multi-year cash flow plans.

Ms Martel: So your estimates for this year for the capital that will go—

Hon Mr Clement: Is that the $1.89-million number, Paul; $189,224,300.

Ms Martel: That is over 2001-02?

Hon Mr Clement: That's right.

Ms Martel: What I'm curious about is an explanation, if you have it, as to how some of the estimates that were provided by the commission could be so different from what some of the actual costs have turned out to be in so many of these construction projects. We've got a problem in my community; Lyn has a problem in hers; there's a problem in North Bay. There's a problem in a number of other communities as well where the original estimates by the commission are two, sometimes three times higher now in reality when the construction costs are being reviewed. How could it have happened that there could have been such an underestimation of what this whole thing would have cost?

Hon Mr Clement: I'll take the first shot at this and Paul can help me out on things I've missed. Part of it is just the huge demand that is created by all of the public sector projects that are going on simultaneously, as I said: long-term care facilities, colleges and universities, the transportation infrastructure, Pearson airport and other big projects. Supply is going to be only so elastic and therefore it creates a huge demand that drives up the price, quite frankly. So that's the first thing.

The second thing, as I mentioned, is the changes in parameters, whether you're projecting to 2008, rather than to 2003; or maybe Cancer Care Ontario has designated a site as a regional cancer centre. So how do you fit that into your plans? So changes in parameters also are part of the issue.

Those are the two big ones that I worry about at night. I don't know, Paul, if you've got some other insight in this.

Mr Clarry: There are a couple of other factors. The commission had to use rough square-foot construction costs, based on either new construction or renovation. They had to look at gross square footage in the hospitals. They had a very tight time frame in which to look at the need for clinical restructuring and translate that into what it might require in the way of renovation or new construction work at every hospital. So there were rough estimates of space that needed to be worked on and rough estimates of cost. They didn't have the benefit that hospitals get when they engage architects to actually go in and look at the full state of infrastructure and look to make sure there aren't issues of building code compliance and other things with the geometry of the building that have added to costs.

The actual planning process we use, wherein the hospital's architect submits plans of design that get reviewed by the ministry, has helped us to identify some of those other factors. But it's simply a matter of the time and the methodologies available to the commission to estimate.

I think it's also important to note that the commission's methodology was intended first and foremost to look at alternative options for how to implement restructuring and what those relative costs may be. Unfortunately, that was the best information that was broadly available to put a price tag on the total cost of restructuring.

Ms Martel: Does the ministry have a clear idea of what the shortfall is with respect to the commission's estimates on technology and equipment for the restructured projects and what the actual cost is now coming in? What is that deficit and how will you cope with that?

Mr Clarry: The medical equipment piece we are working through with the hospitals through submission of their full list of needs, then looking at what's replacement versus what's new, and marrying that into the funding streams available.

On the IT side, we are working with the OHA and others to come to some reasonable order of magnitude for what those needs are, albeit at this point the ministry does not provide direct funding for information technology either through capital or through operating budgets for hospitals.

Ms Martel: What you're saying to the committee is you don't have a clear idea what the equipment deficits are from the original estimates to what hospitals that are being restructured now will require?

Mr Clarry: The commission's equipment estimates, in total across the province, were in the order of about $225 million. The numbers that we're seeing, based on what hospitals have been submitting, could range from $600 million to $1 billion, and part of the challenge is that includes some replacement equipment that is funded through hospital operating grants. We are busy working with the hospitals to separate out those two needs so we can look at appropriate funding plans for the new equipment.

Mr King: I was just going to add that there are a number of factors involved in equipment also. The local foundations do a lot of fundraising for the hospitals as part of our partnership with them. We also have just issued two pieces of funding for medical equipment which are assisting the hospitals that are preparing for some of the replacement equipment. That has been announced recently.

A number of hospitals were not visited by the commission, so we're still working with those organizations also.

Ms Martel: Thank you for that information.

Minister, I wanted to now ask some questions about community care access centers. First, I think that probably the most important one would be if you can explain to me why the government would have frozen budgets for community care access centers this year, which in fact resulted in cuts to many of the budgets because their deficits had been funded last year. What was the rationale for the government decision to do that this year, in the face of what are increasing needs of seniors in so many communities?

Hon Mr Clement: I can go into the history of a little bit of that. Of course, home care in the province is not a new phenomenon and has always been an integral part of providing the proper care to the appropriate people as close to home as possible.

In the period from 1995 to the previous budget, the home care budget on average province-wide increased by about 72%. So that was a pretty firm indication of our province's commitment to home care services.

Of course, part of that was an equity component too. Underfunded parts of the province—because historically it was relatively uneven in terms of funding—were also given equity funding. I know in my region, for instance, that meant a 200% increase in the budget from 1995 to 2000.

This year we faced a situation which meant a convergence of various events, one of which was the third-party independent evaluation of CCACs. Our government thought it was appropriate, at a time when CCACs had been fully in operation and existence for a three-year period, to review the management and some of the issues, CCAC by CCAC, and come up with some general conclusions.

To encapsulate those, there are some resource issues; there is no question about it. There are also some management issues relating to how CCACs managed their client base and managed the demand within that client base. There were also some standards issues—

The Chair: Minister, approximately one minute.

Hon Mr Clement: —where CCACs in different parts of the province were applying different standards.

We want to work with the CCACs. Minister Johns is taking the lead on that and has made it certainly her top priority. We want to get to a viable sector that focuses in on what is important in terms of the delivery of the best home care and other services, community services, that CCACs offer. It will undoubtedly require some changes.

The Chair: Ms Martel, you've got about 30 seconds.

Ms Martel: If I might, Minister, I'm assuming the third party review you're talking about is the PricewaterhouseCoopers. Their recommendation, on page 145, was that the ministry should continue to move forward with its commitment to invest in CCACs, as indicated in the ministry's business plan; not to freeze or, in essence, cut the budgets. So I'm concerned about your reliance, if I might put it that way, on the third-party report to somehow legitimize the action that the government took with respect to funding.

Clearly, their recommendation to you was that there were ongoing needs, that you should recognize the cost implication of expanding the role of CCACs, and that you continue to increase your funding to them.

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Hon Mr Clement: As I mentioned in my remarks—

The Chair: Minister, I don't wish to restrict you in any way, but maybe in fairness for your answer, you could either address it if the government party chooses or wait until the next round.

Hon Mr Clement: That's fine.

The Chair: OK. Now to the government party. You have 30 minutes to use as you see fit.

Mr Frank Mazzilli (London-Fanshawe): I'll certainly start off by complimenting you and your ministry on some of the initiatives you've taken on this year, such as the flu shot and some others. I'm sure many parents appreciated the fact that they had to visit the doctor's office less through the winter months than they otherwise would have had to. For those of us who make those trips regularly, any reduction in visits helps out the schedule.

Just in talking about the restructuring, since it's come up, I think it was well addressed. Meeting with my local community in London, the restructuring has been an enormous issue, and they're successfully getting through it with the London Health Sciences Centre, St Joe's and the London Psychiatric Hospital. Certainly construction costs have gone up since 1995, there's no question about

that, whether it's commercial construction or residential construction. It's a supply-and-demand issue.

The other thing that many people did not take into account is that once you start taking out a building permit and you take something apart, the inspectors are not going to let you put it back without fixing everything else under there. Perhaps that's something that was overlooked, if you will, to some degree at first.

Then there's another component. The hospitals themselves, through their administrators and boards, added different components, and that's what has happened in London. If you're working on an old building and you're going this far to implement the construction, it would make sense to do C and D while you're at it, so that you don't have to rip the project apart later and it costs you twice as much. So they've added components to it. There is a logical explanation for why these costs have gone up, and they're real. Yes, it does make sense to do C and D, but it's also expensive to do C and D, and we all acknowledge that, and I know you have your hands full on that issue. It is the right direction. The vast majority of administrators know that, the boards know that and they know it's a difficult task to work through.

I want to talk about something else for a moment, if I could. It's something that I feel I need to get resolved for London. I've brought it up in the past and I will continue to bring it up. It's the issue of land ambulances. If you look at the common denominator of the land ambulance issue, the five operations that were run by the Ministry of Health have increased human resource hours more than any of the other services. That's a common denominator, if you look at it.

When the municipalities with the 50-50 funding formula—a lot of people try to blame it on the funding formula. That's an inequity that's been there all the time, the difference in human resource hours. So it's not the funding formula; it's none of those things. This problem was never fixed. Some municipalities had more service than others, I recognize that, and they continue to have that today. Some have kept the status quo and they have their 80 ambulances, and then others have lower resources.

In London's case they've put in a proposal through the upper tier for a few more ambulances and the county of Middlesex says they have their portion ready and they're ready to go on it. When can we expect some decisions to be made in relation to those approvals?

Hon Mr Clement: Thank you for the question. It's regrettable that Bart Maves departed just at the very moment when he would be the best expert in the room on this, so I'm going to have to defer to Mary Kardos Burton, who is perhaps the next-best expert.

Ms Mary Kardos Burton: Mary Kardos Burton, executive director of health care programs. In terms of the land ambulance file, there are a couple of things that I think are important to raise with you in terms of the funding of land ambulances. We have certainly done a lot in terms of ensuring that the delivery of service throughout the municipalities has some consistency and we're certainly still responsible for the standards. But last year we actually had an approved cost template. One of the things that was not completely decided was what in fact are approved costs. We went through a process with the municipalities where they told us what their costs were, and that resulted in an additional increase for the municipalities of roughly around $30 million. That was announced last fall.

We're also currently going through a process of getting information from municipalities in terms of the costs they would have to meet response time commitments. So I think shortly you can expect that certainly all municipalities will know where they stand. But we also last year, and again just recently, have given all municipalities $5 million in terms of the federal medical equipment fund and they were very pleased to receive that as well.

Mr Mazzilli: I understand that and I know you can't correct yesterday's problems all at once. The problem you have when you're distributing things equally is that there are the ones that had the increased service and they continue to increase their services, and the ones that were working at half capacity are not increasing as fast. So that inequity continues. I understand that you have to deal with that. But I'm urging you, if you look at a population base, that the ones that have been efficient in terms of comparison—when they put their proposals forward, that those be addressed first.

Ms Kardos Burton: I think some municipalities have been really creative about the methods they've used in terms of improving. I think we'd like to make sure there's an acknowledgement for those, not only in terms of getting their municipal councils to invest their own funding, regardless of what the government was going to do, or also different ideas in terms of looking at US or other jurisdictions' experiences and doing some things. We do want a system so that citizens in Ontario can expect similar service, but we have a geography that sometimes prevents that. In terms of a goal for the ambulance system in Ontario, that would be it, in terms of hoping that every citizen gets the same service.

Mr Mazzilli: I applaud that effort as long as the same standards are used throughout. I don't want to see one community, because it is efficient, being pushed off to use their own resources and another community that had higher numbers continue to get them and everything's fine. As long as you apply the same standards across the board, I would certainly welcome that and encourage that.

Ms Kardos Burton: We do have a land ambulance implementation steering committee which we've had in place to manage the transition. One of the subcommittees of that is a standards committee. So I think you'll find that through that process there will be oversight in terms of ensuring consistent standards throughout Ontario.

Mr Mazzilli: In London's case, when can I expect a decision to be made?

Ms Kardos Burton: That will be a decision made at some point within the next short while. I don't want to give you a date.

Hon Mr Clement: If I can undertake that, I'll check with Mr Maves and try to give you a better answer than that. No offence, Mary.

Mr Mazzilli: Thank you. Those are all my questions.

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Mr Norm Miller (Parry Sound-Muskoka): Minister, thank you for coming in today to the estimates. I have some specific questions to do with my riding of Parry Sound-Muskoka.

First of all, in our area there are some regions which are underserviced in terms of a shortage of physicians, particularly in south Muskoka; I think the Gravenhurst area is designated as an underserviced area. The Parry Sound area, I believe, is also designated as underserviced. The Huntsville area has done very well and is not underserviced. But in terms of those areas in my riding which are underserviced, what is the ministry doing to encourage more physicians and to solve that problem?

Hon Mr Clement: I'll take a first attempt at this and talk about some of our newer initiatives and then George Zegarac can give you more of a tour d'horizon of the underserviced area program. This is an issue that our government has identified as one that needs some aggressive action. As you're probably aware, when you look at the overall figures for the province of Ontario, of course, we're graduating more medical graduates, we're attracting more medical physicians, but there is a certain unevenness, if I can put it that way, that traditionally occurs as to where these physicians decide to practise their profession. My predecessor Elizabeth Witmer summoned together an expert panel to recommend to us as the government ways in which we could address that imbalance, if you will, when it comes to the practice of medicine. So we've really been focusing in on physician recruitment and retention over the last little while.

In response to the George report, there have been a number of recent initiatives over the last several months. In terms of medical school graduates here in Ontario, three significant initiatives were undertaken. The first one was to correct the number of medical doctors who graduate by expanding by 30% the intake into our medical schools. That's now 160 positions, and over the next two years the medical schools in Ontario will expand by that 160-position total. Of course, that's an ongoing number that will then start to graduate 160 more doctors in years in the future.

Second, with respect to rural and northern Ontario towns and cities that are underserviced, there have been a couple of initiatives. First of all, the northern medical school, the first new medical school in 30 years in Ontario, was announced, with significant components in both Thunder Bay and Sudbury, and also, incidentally, some outreach components for our aboriginal areas and peoples. That's an exciting development for the north, where northerners and others can be educated in the north and can have their clinical practice and their clinical training in the north. We have every confidence in Dr George's conclusion that this will help us with recruitment and retention in the north.

Yesterday I was able to announce another component of this, which was in Windsor, but involved both southwestern Ontario—which, incidentally, is our worst-hit area when it comes to the number of physicians per 100,000; southwestern Ontario is the absolute worst in the province, so it was in need of some correction—and central Ontario, including the Niagara region. In both of those areas there is going to be what are called clinical education campuses of UWO or McMaster. It's basically a satellite school campus for those already entrenched, highly regarded and credible institutions. That means an additional 34 medical graduates would get their clinical training as well as their higher education training of their third and fourth years in Windsor, Essex county and other counties surrounding Windsor and in central Ontario, as well as the Niagara region. Those are some specific areas which I think are very exciting.

The other thing that is occurring is quite a marked expansion of our international medical graduate program, a near tripling from 36 to 90 per year of international medical graduates whom we expect to have certified in this province, with a particular emphasis on those individuals practising their profession in underserviced areas, which might be of the most particular interest to the Parry Sound region of our province, Mr Miller. The new program that was announced this year was for, I believe, 50 positions. Basically, the deal there is that this involves international medical graduates who have already had not only training but have practised outside of this country. They've actually practised medicine somewhere else in the world. So it's not just getting a medical student, but a medical student who has actually practised medicine—a doctor who has practised medicine—in some other jurisdiction. We have offered those individuals an expedited six-month credentials' assessment program—or up to six months; six months being the maximum, but hopefully it's less than that—where we can judge very quickly their credentials and, in the cases where it's appropriate, approve their credentials and give them a licence to practise on the condition that they serve in an underserviced area. That will be part of their contractual arrangement with the College of Physicians and Surgeons.

I think this is very exciting news, and provides a very important and legitimate stop-gap. It will obviously be available in the future as well, but for the years before the new medical graduates graduate, it provides us with a more or less instantaneous way to get qualified medical practitioners into our province.

Those are some of the most recent initiatives. I beg your indulgence to ask George Zegarac to provide some more detail about the more entrenched underserviced area program.

Mr George Zegarac: I'm George Zegarac**,** executive director for the integrated policy and planning division.

As the minister has indicated, there are a number of measures that the government and the ministry have initiated to try to deal with the physician supply and distribution problems we're facing. These problems are not unique to Ontario. We're facing these problems throughout the nation, and actually internationally. So the solutions have to be quite creative, as the minister has indicated.

Back in 1993, provincial governments throughout the country took the step of reducing medical education enrolments by 10%, anticipating that we would have a surplus of physicians. That obviously has not been the case. We've taken a number of measures to try to deal with those pressures.

As the minister indicated, in 1999, then-Minister Witmer appointed Dr Robert McKendry from Ottawa as a fact finder to look at what the short-term measures would be to deal with these issues. There are a number of recommendations that Dr McKendry put forward, and the government responded immediately on many of the short-term measures. If I could, I'll just give you a quick highlight as to where we're at.

Dr McKendry recommended we add 15 additional post-grad positions and try to recruit back some of the medical school graduates we've had who have gone for post-graduate training to the United States and who, with a very short period of additional training, could get licensed here in Ontario. We proceeded to implement that recommendation. Dr McKendry also recommended that we expand a successful program we've had with international medical graduates from 24 positions to 36, so we increased that by a total of 50%. We immediately responded and filled those positions. We also doubled the number of community development officers who are assisting us to recruit into these communities that are underserviced. We had three in the province and we increased that to six.

We also increased the number of northern family medicine post-graduate positions to provide some additional expertise to those post-grad physicians who are getting training so they can serve in those communities with the additional training they get. We also expanded our re-entry program, which is geared to retrain some of our existing physicians in those specialties where we actually need them. We've increased our program for that initiative from 25 to 40. So there are a number of initiatives that we've responded to immediately.

The next step was to initiate the expert panel review that the minister has referenced already. There are a number of recommendations they've put forward. We've also proceeded on and exceeded some of the recommendations put forward by the expert panel. For example, the expert panel actually recommended two clinical education campuses for the north. The government has responded by establishing a clinical education campus in Thunder Bay and committing to a northern medical school in Sudbury that would work closely with the Thunder Bay campus.

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The government also recommended that we actually go beyond the recommendation of the expert panel around the international medical graduates. As the minister has indicated, we've initiated an additional 14 spots in our international medical graduate program and introduced 40 positions for early assessments to try to get international medical grads who were recently practising into the system quicker, because some of the enrolment increases that the minister highlighted will not actually provide some additional service for four or five years. So one of the things we want to do is to complement some of the long-term strategies with some short-term strategies.

One of the other recommendations put forward was also to deal with, as the minister indicated, our particular problem in southwestern Ontario. As the minister indicated yesterday, the government announced that it would be expanding its network. We have a very successful SWORM program in the southwest. We'll be adding additional post-grad positions and providing some infrastructure in those communities to try to address really service problems that they're confronting. By getting post-grads there as quickly as possible they'll actually be able to relieve some of the pressures that the existing physicians have in those communities.

The other investment that was announced yesterday was also for other underserviced communities in central Ontario, and that was to build on our successful program with McMaster and the ROMP program out of Collingwood to again introduce additional post-grad positions to support those communities by providing additional post-graduate trainees to provide services. In the end, hopefully, these will be preceptors for future medical grads who would want to train and practise in those communities.

The government also announced that we would expand our ability to do long-term planning and will be investing in the government capacity to do longer-term planning by hiring additional staff and providing some additional research funding. One of the problems we confront is that we deal with these issues as they arise in a crisis situation, and we want to ensure that we have long-term planning to deal with these issues.

Mr Miller: Thank you for that answer. Particularly the medical school in the north is great news and I'm happy to hear about the long-term planning. It sounds like a good strategy.

I met with the administrator of the West Parry Sound Health Centre a couple of weeks ago. Of course, that's an area where the HSRC ordered new hospitals to be built. There were questions about what work is being done. I believe they're just at the stage where they're doing site preparation for that hospital, and it's one that probably did greatly expand. It has now looked at long-term care beds in it and it has expanded to a $62-million project. We're certainly looking forward to that being built in our riding.

One of the questions the CEO had of me was—they have great ideas for information technology and trying to get connections with doctors, with nursing stations in our area, and as well to hospitals in the south. I know it was mentioned earlier that information technology is not something funded, and I'm just wondering how the hospitals go about funding information technology or if there's any other work going on to make sure that medical information is being used all the way through the system. That seems to me to be something that makes sense. If you come into a nursing station in Britton and are transferred to the Parry Sound hospital and end up in Toronto, it would make sense that your medical information goes along with you seamlessly.

Hon Mr Clement: Absolutely. I'll defer to some of the ministry staff in a minute, but the correct and successful use of information technology is a concern of this ministry from a policy point of view and from a funding point of view in specific cases. There's a whole range of issues that intersects with that: what does the practising physician have available to her or him, and how much of that can be networked; how can that be connected to the pharmacist and her or his database; and finally, how is that connected to the hospital and to CCACs and other providers of long-term care or home care or acute care? These are things that we are seized with. It's under the rubric of Smart Systems for Health. We are pursuing these things and it's certainly part of our agenda.

I'd say parenthetically as well that it was just a little over a year ago that we were able to announce the capital project for West Parry Sound hospital that was approved to about $38.3 million, which represents about 75% of the shareable hospital costs. That certainly is very tangible evidence of our commitment to the people of West Parry Sound and the Parry Sound-Muskoka area for their hospital needs.

Deputy, would you like to say a few words on the record?

Mr Dan Burns: Yes. Dan Burns, the deputy minister. The minister touched on a couple of the key components of our IT strategy in the health sector, so I just want to touch briefly again on the main components. Obviously, the people we fund, including hospitals, have IT now and are looking for ways to improve it. We do support that through our general funding of hospitals. But next to that, the hospital association itself has an IT council and a whole set of activities underway looking at what investments would make the most sense from the point of view of the performance of the whole system, not just inside an individual hospital's walls. That group works with the ministry's Smart Systems for Health program. The Ontario Medical Association also has an IT council whose mandate is almost identical, only looked at from the point of view of doctors and the use of IT in doctors' own offices.

The primary care reform initiative the government announced in the budget before last contained a fund which will be dedicated to IT investment to support the connection between doctors and, as the minister said, hospitals and pharmacies and other pieces of the system. The use of that dedicated fund will roll out as we build an operating relationship with the new family health networks as they develop around the province.

The next piece, our own part of Smart Systems for Health, is focused on building the components that connect people. Those of you who are dedicated readers of the government's electronic marketplace, MERX, will know that we issued a proposal call for the physical connections between health care providers in June and we're on the verge of issuing proposal calls for some of the other key connection pieces, which we believe are the key parts of our responsibility for this.

Next, the agreement, the memorandum that came out of the meeting between the Prime Minister and the Premiers a year ago which dealt with health issues contained within it a commitment to create a $500-million fund. The use of this fund is to enhance the development and use of IT in the health sector and some of the things that we've just discussed. That fund is being managed by a corporation. The provinces, territories and the government of Canada are the members of that corporation, and the business plan for the use of that fund is under development as we speak.

I think you're going to see over the course of the next two years not just good IT investment programs on the part of health providers, but connections we sponsor, investment by this new national program and investment in technology in the primary care health networks as well.

The Chair: We now turn to the Liberal Party.

Mrs Sandra Pupatello (Windsor West): Mr Burns, the deputy minister, this may be our last opportunity to be sure to have you at estimates before you go on to your next career. Just on that note, congratulations. I wanted to make a comment too that they've already hung your portrait in a very appropriate room here at Queen's Park.

Hon Mr Clement: He uses that sword a lot too.

The Chair: This is called loosening them up in estimates.

Mrs Pupatello: It's probably your favourite room in the building and it's appropriate it should be hung in a committee room.

With the small amount of time that we have today, if I could advance some questions, and tomorrow, when we get to come back to our session or list, whatever, perhaps the staff could have prepared some answers to them. If I could use a little bit of time to put some questions on the record, I'd appreciate it.

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Specifically regarding the community care access centres, if I could get some response on how the funding is listed in the estimates book so that we can do a fair comparison between last year's spending and this year's spending on home care. The way it's itemized is very different this year, so it looks as though the CCAC line has been added and it may comprise professional services, homemaking services and attendant outreach

services. Once we add those three up and compare that to last year's three separate lines, we see there's a deficit of $73 million. That would account for the shortfall. I'd like to know if that's accurate, and if that's the case, I need to know where the balance of those other services that are listed have gone. If there's $74 million lacking, has that money been assigned to some other line in that section? If I could get some clarification, that would be super.

I wanted to make a note of Duncan Sinclair's comments in the Kingston newspaper today. I recall his comments some time ago. I was always interested in his willingness to resign as the chair of the Health Services Restructuring Commission when the government refused to fund community services as a part of restructuring process. Of course he got canned, and so did the commission, before he had an opportunity to resign, but what he said today—I thought I had brought it here with me. He made several comments regarding the necessity to fund home care, and he acknowledged that the government was not funding appropriate levels of home care. I would like some kind of official response. The former chair of the Health Services Restructuring Commission on record now acknowledges a lack of investment into community services, such as home care, and making the obvious link between hospital cutbacks, the driving down of those patient days, the utilization levels of hospitals and how that's linked. Clearly that would have a huge impact on the home care requirements.

The government is on record as showing an increase in the area of home care, but what I would like to know is what data exist that indicate the documented increases of demand. The percentages have flipped. What used to be 30% as a demand for home care service for out-of-hospital patients has now become 70%. Of course, what's happened is that the demands for those services that are not hospital discharges, that may be for less than critical or less than acute areas like housekeeping items etc, are falling off the bottom and not considered a priority.

But I wonder what data exist that you're collecting that say the number of patients of the individual CCACs is now 5,000 families versus 2,000, so that if you compare that to the supposed increases the government claims to be making in the area, it's not, as a percentage, keeping up with what the demand increases have been. So I'd like any kind of documentation that exists around the demands now made on the community care access centres, including the type of client they now serve, compared to even three years ago when the percentage was still 30% out-of-hospital discharges. I don't know if there is any, but I'd like to see some.

I'd like to know too the explanation for the $7-million drop in amounts being allocated to community health services. I'm trying see what page that was on.

Mrs McLeod: Page 111.

Mrs Pupatello: We're showing that it's going from—well, it's $7 million less in any event, and I'd like to see if there's any relationship or correlation between the funding of community health services and the 109 communities that are designated as underserviced communities. Where community health services centres would have been used as some kind of a catch-all where there were families without services through their local doctors, which is certainly the case in my community, it seems to me that would be the ideal place to be funding community health services, and what we see overall is a decrease in funding. I just can't imagine the rationale for dropping what we're now spending in community health services when the number of communities without a sufficient level of doctors is going up, not down.

There are a couple of questions in the long-term-care area. I'd like to know the rationale for your announcement this past week of the 1.9% increase in the per diem for long-term-care facilities, the $2.60. I think it was just last week. How did you get that figure? The long-term-care industry was suggesting there was a requirement for some $25 more per diem per bed, so I don't know how you got from what the industry suggests they need to properly care for their patients in long-term-care facilities to the $2.60 that was announced. Whoever is working in that area, perhaps they could say that it was an inflationary figure or perhaps it was something that was meant to be targeted to a particular kind of service that should be available in these facilities? How was that $2.60 targeted? Why was it not all put toward nursing care, for example, where the regulation maybe would have been changed along with that to require a certain level of nursing services to each patient in a long-term-care facility?

I'd like to know where Ontario ranks in terms of the per diem across other provinces, even jurisdictions nearby, but particularly compared to other provinces. How do we fare in our long-term-care facilities?

I'm going to leave a little bit of time for Lyn to get some questions on record too.

Are there any questions about the information I'd like to have, if possible, so we could continue tomorrow?

Hon Mr Clement: I'm sorry, Mrs Pupatello, what was the last question?

Mrs Pupatello: Any questions on what I'd like to know in preparation for tomorrow?

Hon Mr Clement: No. Certainly some of them are—

Mrs Pupatello: I'm going across several topics here, I realize.

Hon Mr Clement: Are there any that you'd like us to try to focus in on? Some of them are factual numbers questions and others are policy questions, so is there a particular one you want to—

Mrs Pupatello: Yes. Well, I think you may even have a policy paper that drove you to do some of the things you did or there may be pieces of information—some of it is just a matter of data, for example.

Hon Mr Clement: Sure.

Mrs Pupatello: The CCAC question is probably the toughest, because it's a matter of what you know is happening on the ground, because your government has not set standards in place for what services should be in that basket to provide the patients in every region of Ontario. The CCAC boards really are on their own for

getting this lump sum of money and determining that in the basket in Sudbury will be these services, and in Windsor it will be these services. The Liberals have always maintained that when you started CCACs you should have set that out at the beginning so you wouldn't have the difficulties you have now where local volunteer boards are forced to make the decisions on your behalf for what they can no longer afford because that acute patient is now 70% versus 30% as a function of what's happening in the other parts of the health sector.

For the CCAC questions, I would specifically like to target certain regions: the Simcoe region, Kitchener-Waterloo, Sarnia-Lambton, Frontenac-Addington, Cambridge, York, Ottawa and Leeds-Grenville. Those regions in particular are struggling with meeting the demands of their community, and their local MPPs are well aware of those struggles and hopefully supportive of them.

Lyn, you wanted to get some questions in?

Mrs McLeod: Sure. I think the thinking was that Sandra had a number of questions that involved some data, so if you can come back with those tomorrow, we can deal with both the policy issues and the data that presumably you would have.

Hon Mr Clement: If I can return to the long-term-care issues, there were some issues that were more of a policy nature there that I can elaborate on here and that might help animate some further questions. Usually that's what happens in my case.

Can I just say a couple of words about that then. There are two branches to long-term-care funding, of course: capital and operating. Capital has been, I think, a remarkable success story after—

Mrs McLeod: Minister, we had a number of other areas we wanted to go into. One of the advantages of the opposition is we get to place some very specific questions, and I think Sandra's questions were asking for specific numerical data. We'd like to have that data as a basis then for having some further discussion. So if you're prepared to give some numerical data—otherwise, I'd like to put a couple of other areas on the table.

Hon Mr Clement: I guess, Mr Chair, I'm in your hands. There are some numerical data questions which I think we can either respond to now or respond to later, and there are also some public policy questions that were raised. I was merely attempting to—

1700

The Chair: In terms of the tradition of the committee, I think we try to keep it fairly even-handed. Each party basically controls how they would like to conduct each, and if the ministry is agreeable, then information that can be supplied on paper facilitates discussion.

What we from the committee need is, has the ministry agreed to provide the information that was asked for? Then it's up to the opposition if they want to move on to another line of questioning.

Mrs McLeod: We are going to come back and give that opportunity to respond to those questions.

The Chair: Just for the sake of the continuing discussion, for the whole committee's sake, is it an agreement on the part of the ministry that the information would be provided?

Mr Burns: Mr Chairman, I would just add the caveat that those dozen or 15 data sources in the request, some of which I know we have already collected on that basis, but others we may not—we'll do the best we can. Where we don't have an immediately available data source for the question, then we'll tell you what we do have.

Mrs McLeod: Fair enough. Our goal simply is to get as many areas—we've got more areas to cover than we have time, so we want to try to utilize our time as best as possible.

Mr King: Could I just have one clarification on one of your questions? You mentioned that one of the lines was the community health centre line.

Mrs McLeod: Yes.

Mr King: You're comparing the difference between the estimates and the interim actuals? I just wasn't sure of the number. You came up with a number of seven—

Mrs Pupatello: If you can refer me to the pages.

Mrs McLeod: It's 116 and 109.

Mr King: You referred to page 111.

Mrs Pupatello: It's 116 of the interim actuals and 109 of the estimates for this year. So it's a $7-million—

Mr King: So you're comparing the estimate to the interim actual?

Mrs Pupatello: Yes.

Mr King: And that's the clarification you would like?

Mrs Pupatello: Yes.

Mr King: OK. Thank you.

Mrs McLeod: This one may have a really straightforward answer right off the top, and then I can move into another more major area. I notice the Healthy Babies program is one area where the ministry shows a fairly significant increase in funding, albeit a large part of that, if not all of it, may be federal. It shows a $21-million planned increase in the Healthy Babies program.

There was an article in the Toronto Star yesterday that said Peel region's Healthy Babies program has been cut back because the province has frozen funding for this scheme. I just wonder which is accurate.

Hon Mr Clement: I have no idea why they said that, because it's not accurate.

Mrs McLeod: Is Peel labouring under a misunderstanding of the program's funding?

Hon Mr Clement: I believe they are. Have you talked to one of their MPPs?

Mrs McLeod: Can we get some information, then, to clarify the public record?

Hon Mr Clement: Certainly.

Mrs McLeod: There are a couple of major areas I'd like to get into, and I'm going to start with cancer care. Again, it may be one where some data would have to be tabled, but let me ask, first of all: there's a $245-million planned increase to Cancer Care Ontario in this estimate. Could you compare that to the budget request for me?

Hon Mr Clement: Are we answering these questions now?

Mrs McLeod: Yes, if there is an answer, otherwise I'll accept a commitment to bring—

Hon Mr Clement: I have a whole bunch of answers to Sandra's questions, but at some point I guess we'll have an opportunity to dialogue.

Mrs McLeod: We're going to go back to a major discussion of home care and long-term care.

Hon Mr Clement: I'm sorry, Mrs McLeod, but what was your question?

Mrs McLeod: It was about the budget request from Cancer Care Ontario in comparison to the planned increase.

Mr King: Dr Nuttal will answer the questions on Cancer Care Ontario.

Mrs McLeod: What was Cancer Care Ontario's request for a budget increase this year, compared to the $245 million?

Dr Sandy Nuttal: I'm Dr Sandy Nuttal, with health care programs. I'm the consultant for Cancer Care Ontario within the ministry as well. We have before us Cancer Care Ontario's 2001-02 operating plan, so we're just now doing an analysis of what their budget requirements are going to be. But we had forecast that perhaps they would need up to $245 million for all cancer services provided by CCO, and that's the number before you.

Mrs McLeod: So that's not necessarily based on either their request or the analysis of their operating plans?

Dr Nuttal: It's based on our projections and our discussions with Cancer Care Ontario as of last year when they were putting forward their budget requirements.

Mrs McLeod: Can you share with us what the totality of their request would have been prior to your analysis?

Dr Nuttal: We're expecting that Cancer Care Ontario is probably going to come in with a request that is very close to $245 million when we look at the costs for providing radiation treatment across the province as well as expansions to the new and emerging drugs program that Cancer Care Ontario manages for the province.

Mrs McLeod: I'll come back to that if there's time, because I know that in previous years the prevention budget that was requested wasn't funded and I'd be interested in knowing whether that's going to be the case this year. But I'm particularly interested in knowing the increased cost of funding radiation therapy on a per-case basis now. That was a change in policy by the government, and I'm wondering what the increased cost of radiation therapy has been as a result of that.

Dr Nuttal: We have been providing Cancer Care Ontario and Princess Margaret Hospital, who are the only providers of radiation service in the province, with a cost per case of $3,000. That was negotiated with both Cancer Care Ontario and Princess Margaret Hospital, based on the costs they incur to provide that service.

We have received in Cancer Care Ontario's operating budget, and from Princess Margaret as well, notification that $3,000 per case is perhaps not enough to cover some of the salary increases they've been experiencing over the past year. So we are in dialogue with Cancer Care Ontario to try to finalize that number. We're also in dialogue with Princess Margaret Hospital.

Mrs McLeod: What's the cost per case for radiation therapy in the private clinic?

Dr Nuttal: We're paying $3,000 per case for cases treated in the after-hours clinic. There is a performance bonus associated with that, as there is with Cancer Care Ontario as well. However, the performance bonus for the after-hours clinic reaches $500 per case in addition, should the clinic reach 1,000 treated cases. So that would average out to $3,500 per case for 1,000 cases treated.

Mrs McLeod: And in CCO?

Dr Nuttal: Cancer Care Ontario provides a performance bonus for their cases as well. If they reach a 7% increase in cases, the ministry has committed to provide up to $1.8 million.

Mrs McLeod: But it's not based on the number of cases?

Dr Nuttal: No, it's based on a 7% increase over last year's number of cases, so it would actually come in at less than 1,000 cases.

Mrs McLeod: Right. A thousand new cases?

Dr Nuttal: Yes.

Mrs McLeod: So the private clinic gets the performance bonus of $500 per case for any 1,000 cases, regardless of whether or not that's an increase?

Dr Nuttal: Once they reach 1,000 cases, their performance bonus would be averaged out at about $500 per case. That's an arrangement that was negotiated by Cancer Care Ontario with the independent service provider.

Mrs McLeod: Is that for every case over 1,000, or is it $500 for each of the 1,000 originally, if they in fact see 1,000 patients?

Dr Nuttal: If they see 1,000 patients, they will be remunerated at the level of $500 in addition to the $3,000 per case for each single case. So at the end of the day, if Cancer Care Ontario is able to satisfy the ministry that they have indeed treated 1,000 additional cases through the after-hours clinic, the ministry would provide $3.5 million to Cancer Care Ontario.

Mrs McLeod: I think I have that. It would be most helpful to see that in a written format.

There's a $3-million cost here for enhanced radiation access. Is that the anticipated cost of the travel program?

Dr Nuttal: That's the third year of funding that was provided in a multi-year funding approval the ministry went forward with back in 1999. Once Cancer Care Ontario made the ministry aware that they were actually facing a crisis of proportions that Cancer Care Ontario themselves felt was no longer manageable, the ministry and the minister then appointed a committee to review radiation services at Cancer Care Ontario and to bring forward recommendations that would assist Cancer Care Ontario in expanding capacity. So back in 1999, we went forward with a request for $15.5 million that will build to about $20.1 million this year. The $3 million you're seeing is the third-year instalment on that multi-year plan. That funding was to enhance and expand training

programs for radiation therapists and medical physicists and to increase salaries for radiation therapists and medical physicists in the Cancer Care Ontario system.

The Chair: You have 30 seconds

Mrs McLeod: Just one last question, then. Radiation therapy wait times: the goal of Cancer Care Ontario was to reach a target of 90% of patients being treated with radiation therapy within the accepted standard of four weeks. Do you know how close they are to meeting that standard, or even the 50%?

Dr Nuttal: At the moment, Cancer Care Ontario is able to treat about 40% of Ontario's patients within that four-week standard.

Mrs McLeod: And within eight weeks?

Dr Nuttal: They're getting pretty close to treating about 60% within eight weeks. That may fluctuate from time to time, depending on circumstances and availability of staff.

The Chair: We now turn to the third party for 20 minutes.

Ms Martel: I just return to the minister and look for an answer to my concern that you would be using the PricewaterhouseCoopers report to justify funding cuts to CCACs, when clearly the recommendation was to increase funding. I'd like to start there.

1710

Hon Mr Clement: I hope I made it clear, Ms Martel, that the report is pretty comprehensive. It deals with resource issues, and as I think I said in my earlier remarks, there is validity in that part of the report. The other parts of the report I was particularly interested in were the differentials in standards and the different quality and level of management ability in standards.

I'm sure you would want to look at the whole report, not cherry-pick out funding without looking at standards or management or standards of management without acknowledging funding. Our challenge, as represented via Minister Johns, is to come up with a viable, sustainable, excellent home care system which this province needs and certainly its citizens have a right to expect.

We have gone through a period of extremely rapid growth in our community care access centre and home care funding—as I mentioned, that 72% number comes to mind—over the last six years. I think our ongoing goal and aspiration is to make sure that the right home care or community care recipients receive the right service for their needs as close to home as possible. I must say it's an ongoing challenge, there's no question about it.

Ms Martel: With respect, Minister, the reason I am specifically referring to the funding issue is because, as I read it, the recommendation that came forward from PricewaterhouseCoopers with respect to increasing the funding was not dependent on having the other issues addressed. Clearly, their recommendation number four said that the ministry should continue to move forward with its commitment to invest in CCACs, as indicated in the ministry's business plan. It did not have any terms and conditions that that be done only in the event that some of the other management issues be dealt with.

I understand that the ministry, in conjunction with the association, is putting together or has put together a committee to deal with some of those other issues. But the funding issue remains and, as far as I'm concerned, stands alone in terms of a very concrete recommendation that was made, which was: put more money into the system. That's not dependent on doing some of those other things.

Hon Mr Clement: I suppose we might have to agree to disagree, but I would argue that we have shown our funding commitment year after year, including this year. From our perspective, from my perspective, we have shown a commitment to funding.

In order for the CCACs to meet their potential, we also have to look at their management and their standards. That's exactly what Minister Johns's responsibilities entail.

Ms Martel: Minister, might I ask you about a $175 million-shortfall that has been identified for this year? When will this financial resource issue be dealt with?

Hon Mr Clement: I'm not sure where you get that number from, in the first place, but from our perspective, we have continued to fund CCACs. A lot of the additional equity funding and part of the $585 million that we committed to was flowed for this year; it was flowed in the previous but it was for this year. So we continue to meet our commitments and we will continue to do so.

Ms Martel: Let me ask about the equity funding, then. How many CCACs received equity funding this year, just equity funding by itself, that they had been promised?

Hon Mr Clement: I think I need a bit of help on that.

Mr King: I'll just check to see if we have that exact number here. Oh, this year?

Ms Martel: Yes, because the minister said—

Mr King: No. We did not. There was no equity funding this year. As the minister indicated, a number of the multi-year funding arrangements that were previously made for CCACs did flow last year. They were funds from this year that actually were pre-advanced to the CCACs.

Hon Mr Clement: We pre-flowed them last year but they were for this year. That's exactly what I was saying.

Mr King: But the equity funding for last year, we can clearly get you numbers on that.

Ms Martel: A couple of things: I would appreciate receiving a list of the CCACs which are receiving equity funding now. I'm assuming we're all understanding that equity funding is over and above anything that everyone else gets to a base budget allocation.

Mr King: Right.

Ms Martel: So number one, I would like a list, if you can provide it to me, of which CCACs are receiving equity funding at this point.

Second, I would like to know the value of the receipt of those dollars. I would like to know which ones are receiving money and how much they have received to date, since the announcement was made in 1998. Is that a possibility?

Hon Mr Clement: Help me out here. How is that different from the first question that you asked? Is it a different number that you're looking for in the second question?

Ms Martel: Yes, I think there will be a different number and I'll tell you why. Sudbury, for example, was promised equity funding beginning in 2000-01. In the first years of the announcement we did not receive any equity funding. We haven't received any equity funding. I assume there has been a staggered implementation of equity funding in other CCACs as well, not just our own, so that no one single CCAC is receiving eight years of equity funding; there is a staggering of that allocation among CCACs over that eight-year period. Am I correct?

Mr King: There would be a staggering of the funding. It's based on a number of factors that we apply every year for the equity funding formula. I think I understand, and I think our staff understands your question, to try and bring forward the numbers you require.

Ms Martel: You mentioned that a number of CCACs received equity funding last year and in essence had their allocations doubled up last year and for this year. Can you tell me why the Manitoulin-Sudbury CCAC has not received equity funding despite a very clear commitment that was made by Cam Jackson in 1998? I'd be happy to provide a copy of it to the ministry. I've used it in the Legislature a number of times. I'll just read you the relevant paragraph.

"Starting in 2000-01, and in each of the next five years, the Manitoulin-Sudbury CCAC will receive additional funding based on our equity formula." They did not receive it last year, they obviously haven't received it this year, but if you doubled up equity funding, as you say you did last year, they should have, last year, received two years of equity funding, as other CCACs clearly did. Can someone from the ministry explain to me why equity funding has not flowed to this CCAC, as promised?

Hon Mr Clement: We'll certainly look into that. When I look at the percentage increase from 1994-95, it's 24.3% for Manitoulin-Sudbury, compared to 23% in Algoma and 21% in Cochrane. Some are higher. Kenora-Rainy River is higher, for instance. There are different percentages, but certainly they've had quite a substantial increase in the six years under consideration. I certainly undertake to get an answer to you.

Mr King: We will undertake for that information.

Ms Martel: I will provide you with a copy of the letter, because I have checked and rechecked this on numerous occasions with our CCAC. To be clear about this information, they did receive 2% as an increase to base budget when all other CCACs did, but they have not received an equity funding allocation, certainly not in the first two years, and I don't know what's going to happen with the next three that they were promised, because they were certainly promised over five years.

Mr King: I am actually somewhat puzzled, as I think the minister is, because our notes are indicating a 24% increase. I would assume there would be equity funding in there. I think it's best that we come back with that information, because it has thrown me off a little.

Ms Martel: That would be very helpful, because the view at the community level is quite a bit different. So if we can get it sorted out, I would be very happy.

What I would like to know, then: can you give me just at the moment an indication of how much of the equity funding that was announced in 1998 has indeed flowed to date? If I understand it, the announcement was about $550 million. How much has been flowed since that time?

Mr King: Minister, if I could, I have to defer to staff because I don't have those details.

They're asking to table that also; sorry.

Ms Martel: So that I'm clear, what you're telling me is that this year is not a lost year in terms of equity funding.

Hon Mr Clement: No. That's my own characterization. I want to be fair. The way it was explained to me was that there was an equity component for this year but it was flowed last year. I'm trying to be fair. In my public statements, I have never tried to include last year's number, even though it was flowed for this year, because I didn't want to confuse people or double-count. But the reality of the situation is that that money was flowed last year for this year.

1720

Mr King: The other part of that that the minister also hasn't shared at this time is, last year we also reviewed all of the deficits at the CCACs and we did move dollars around among the CCACs to look at some sort of equity funding. It was that little year-end arrangement that we did within the CCAC envelope to help those out that were in a deficit situation. So we have worked very closely with the CCACs to manage their budget situations, particularly after last year, and then, of course, you have already made your comments relating to this year.

Ms Martel: Just so I'm clear, you have a pool of equity funding which is separate and apart from your regular base funding in CCACs and some of that money was used last year to deal with deficits?

Mr King: No, I'm sorry. The total amount of funding for CCACs—we do a review on a quarterly and a third-quarter report. Some of the CCACs were in fact reporting a surplus position last year. We reallocated those funds to help those within a deficit position.

Hon Mr Clement: And that's in addition to—

Mr King: It's an internal arrangement that we've done to help out. It addresses those communities that feel they have not been recognized under the equity formula. We did it on a one-time basis last year.

Ms Martel: Is there any other circumstance under which you would have taken money from what I would describe as the equity pool—maybe I'm misrepresenting it—and funded other programs? For example, did you do a general funding for AIDS programs out of the equity pool?

Mr King: The dollars within the CCACs were not moved elsewhere within the ministry. So the dollar vote for the CCACs was directed toward CCAC funding.

Ms Martel: But it might have shifted in terms of particular programs. For example, you could have taken money and, in a number of CCACs, provided money for AIDS services.

Mr King: We have a number of community programs that are funded that are special programs through CCACs, and we also have mental health funding that goes through CCACs. So that's a tough question.

Ms Martel: What I'm getting at is they wouldn't normally appear as part of a base budget for CCACs. Did you, at any point, make an allocation out of money you would have targeted as equity to deal with challenges in providing home care and to fund specific programs that, in essence, were not part of the regular budget of a CCAC?

Mr King: We have our director of finance for my division here. It would be helpful.

Mr John McKinley: I'm John McKinley. I'm director of finance for health care programs. The equity allocation is based on what is available in the fiscal year, and it's an allocation that we determine after we decide what the priorities are within the funding envelope for all of community services. There isn't a separate equity pot; it's all part of the allocation that goes towards CCACs.

Ms Martel: My apologies, but my understanding of your 1998 announcement was that there would be about $550 million allocated over eight years—

Mr King: Multi-year announcement.

Ms Martel: —and I understood that to mean that it was a pool of money that was outside of money specifically allocated for base budgets for CCACs. I thought that it also included community-based agencies outside of CCACs.

Mr McKinley: That's correct. The $550 million was in addition to that current level of funding for CCACs. It's not all equity funding, though. That's what I'm trying to say. There are other programs, as you said, some funds available for other community services.

Hon Mr Clement: That's a good point. The $551-million announcement wasn't all just equity funding. It was a community service funding multi-year announcement, I think part of which was equity, but part of which involved other community services that we wanted to fund.

Ms Martel: And does the ministry have a certain percentage which is provided to CCACs, and then a certain percentage that is provided to other community-based long-term care agencies? Do you work on a 75-25 split?

Hon Mr Clement: Factually it works out that way, yes.

Mr King: We have worked on a 75-25 split before.

Mr McKinley: Yes, the original plan was to go towards a 75-25 split. That hasn't always worked out as being the actuals because, as we said, there have been internal reallocations to meet individual agency requirements. But generally speaking, that's what we have done up to this time.

Ms Martel: Now the formula that you're using for equity payments, just those: my understanding is that the ministry had a committee and was working in conjunction with the Ontario Association of Community Care Access Centres and that this has been underway for some long time now, more than a few years. Is there a new equity formula that the ministry is using at this point to make funding allocations?

Mr McKinley: No. The committee you're referring to as the community equity funding committee has been restruck to review the current equity funding formula that was used in previous years. The process is to update this as information becomes available to us in terms of the Ontario health survey, the actual experience of services provided in communities. We review all of the adjustment factors that are made inside the equity funding formula to try to make it more up to date and more germane to the current situation.

The ministry is working with the Centre for Health Economics and Policy Analysis. They've been contracted to do that analysis for us on that part, and the process is taking a long time. It's a very complex academic exercise to go through in order to redevelop the equity funding formula.

Ms Martel: When was the committee struck?

Mr McKinley: The second generation of the first committee was struck a year and a half ago.

Ms Martel: The first committee, when was it struck, in 1995-96?

Mr McKinley: In that neighbourhood; I don't know the exact date.

Ms Martel: My concern is that a committee was struck because there are obviously inequities. We would make an argument in northern Ontario that we have a great challenge in providing home care as well, just due to distances. My understanding was that there was a committee that was struck soon after your government was elected, Minister, and as I understand the conversation now, despite a great deal of work, there was a not a change in the formula.

Mr McKinley; There hasn't been yet.

Ms Martel: But it's been at least four or five years.

Mr McKinley: Yes, this information, the Ontario health survey, only comes out every couple of years. The population statistics that are used for this are only updated every four years. As I say, this is a huge exercise in order to link data sets to try to determine what an appropriate way of allocating need is in the community sector.

Ms Martel: Do you have an idea when there will be a result to all of this work that may result in a new formula? We would argue that in northern Ontario our health status indicators around smoking, heart disease etc are far higher than the average across the rest of the province and we should receive equity funding to compensate for that.

I'm not trying to ask this facetiously. I think there are some really serious health indicators that would point to a need to change the formula so there is a greater allocation of equity to northern CCACs.

Mr McKinley: CHEPA has said that the analysis they have undertaken to do will take six months from the beginning of the time they got the full set of information, what they have just received in the last six weeks. We are pushing them as hard as we think we can in terms of doing the work. I can't give you an exact date, but that's what they plan to come back to the committee with.

Hon Mr Clement: Can I interpose just for a minute and say, when I look at the annualized budget, the comparators over the six-year period in the northern region, clearly something is going on which is positive and beneficial, when some of those service areas are getting a 58% increase and a 42% increase. The 58% is in Thunder Bay and the 42% is in Kenora-Rainy River. Nipissing did not fare as well; it only got 19.9%. But when I look at those, clearly there is some equity funding going on, there is some meeting of the needs that have been articulated to the government that is transpiring.

I think it would be a wrong characterization—I'm not trying to put words in your mouth—to suggest there is no equity funding or no progress on equity funding that has occurred in the last six years. I think there has been progress made.

The Chair: You have about 20 seconds.

Ms Martel: Minister, if I only go to our own case, I think we'll have to have a discussion about the numbers in Sudbury and see if that has been the case, because clearly their view of the world is different from yours.

One final question: there was a decision rendered by the Health Services Appeal and Review Board at the end of June regarding a case involving the North York Community Care Access Centre and your ministry; they were both participants. The outcome was that the board made it clear that neither the ministry nor the North York Community Care Access Centre could use legislation to support eligibility criteria for homemaking and personal support services. The board argued that the legislative framework did not exist to establish criteria.

It's my understanding from our CCAC that your ministry was to develop a regulation to remedy that, and their discussion with MOH on that was on September 4. Can you tell me what is happening? Clearly, it has an impact on a number of other CCACs.

1730

Hon Mr Clement: Certainly, in developing legislation as well as regulations.

Mr King: The particular case you're referring to is actually being appealed by the ministry, so it is before the courts right now.

The Chair: Ms Martel, I think we'll have to accept that answer, in the interest of time and fairness to the other caucuses, but you're welcome to come back to that.

We'll turn to Mr Wettlaufer and the government caucus.

Mr Wayne Wettlaufer (Kitchener Centre): I read in the newspaper not too long ago that the ministers and our government expect the toughest questions in estimates committee from the members of the government, so I hope you're prepared.

Some time ago we announced a program to increase the number of nurse practitioners. I have to say that in the area of Waterloo region, in my riding of Kitchener Centre, where we have a rather dramatic shortage of physicians, where we were hoping the numbers of nurse practitioners would take away from this shortage and would solve some of the problem, we haven't seen an increase in nurse practitioners solving this problem. I was just wondering what the status is.

Hon Mr Clement: Let me just say at the outset that this is a program that we're quite proud of. I won't get into the details, but there certainly has been placement of nurse practitioners, and we've targeted underserviced areas, of course. Having said that, could I have your indulgence to defer to Kathleen MacMillan, who is the Chief Nursing Officer for the province of Ontario, who can give you some specific details.

Mr Wettlaufer: Yes.

Ms Kathleen MacMillan: I'm Kathleen MacMillan, the provincial Chief Nursing Officer. This government has done a number of things around introducing nurse practitioners to the system, although as you know, nurse practitioners have been a feature of the health care system for about 25 years. We were able to pass legislation to expand the legal scope of practice for nurse practitioners in 1998. Since then, the government has provided $1.7 million to fund the nurse practitioner education program and $5 million annually to upgrade 87 full-time-equivalent nursing positions in CCACs to nurse practitioner positions and also to create 34 new full-time-equivalent nurse practitioner positions in community-based settings.

More recently, as a result of recommendations from the nursing task force in 1999, the ministry set aside another $10 million annually to fund an additional 106 full-time-equivalent nurse practitioner positions, which takes into account underserviced areas, long-term-care facilities, some initial primary care reform networks and aboriginal community health access centres. In addition to that, another $1 million was provided for a two-year pilot project to hire nurse practitioners in five public health units in which we had very low participation in cervical screening programs and also very high rates of cervical cancer.

At this point in time we have issued a request for proposals to do an evaluation of the impact of nurse practitioners on the system, on patient care and on providers. We are just in the process of evaluating the response to that request for proposals. This is part of the initial plan for implementing nurse practitioners in Ontario that was committed to back in 1994. We would like to see the results of that evaluation. We're not waiting for that, though. In addition to that, we're also looking at a very substantial role for nurse practitioners in the

Ontario Family Health Network project, and we are discussing that with the board of the Ontario Family Health Network strategies to implement nurse practitioners as part of that initiative for primary care reform.

Mr Wettlaufer: So how many new positions have been created to this point?

Ms MacMillan: In total, we had 34 new positions and 106 new positions with the $10 million.

Mr Wettlaufer: That's what we were authorized to create, but have they actually been filled?

Ms MacMillan: Actually, we've done very well. The 34 new positions with the $5 million from 1998 have been filled, and of the 106 positions that we provided the funding for in 1999 as a result of the Nursing Task Force, as of September 1 we have filled 97. Some communities did have difficulty recruiting, so we did some reallocation of just a couple of them, and with others, we waited for them to arrange to send local nurses to the nurse practitioner program so they would be able to take advantage of that.

Mr Wettlaufer: OK. I may want to follow this up tomorrow, but that's fine for now.

I have another question. Minister, you may want to call Mr Zegarac back because it relates to the recruitment of foreign-trained physicians.

I have recently had, and my staff has had, a number of discussions with the multicultural centre in Kitchener-Waterloo. Additionally, I have talked to a couple of local physicians who advised me that they're going to be retiring. We already have this shortage of physicians in our area, and these retiring family physicians have no one to sell their businesses to. I have been advised that the College of Physicians and Surgeons, of which I am a major critic—in fact, in another couple of years I may be public enemy number one as far as they're concerned—is directing their efforts under this program to attract Canadians who were trained and educated here but are practising elsewhere in the world, and that there is a bias against foreign-trained physicians.

According to one of the physicians to whom I talked, there are 352 foreign-trained physicians in the region of Waterloo, none of whom is eligible for the agreement that we made with the College of Physicians and Surgeons. I'd like a reply to that, and then I have a couple more follow-ups to that.

Hon Mr Clement: Sure. Let me ask Mr Zagarac to reply, and then I will add something at the end of his reply, if that's appropriate.

Mr Zegarac: If you're referring to the two international medical graduate programs, maybe I can differentiate between the two. One is our graduate training program, which is our traditional program, into which we've increased our enrolment from 26 to 50 positions. That program is geared to international medical graduates, whether they're Canadians trained overseas or foreign. There's no distinction there.

The assessment program right now, which was recently announced by the government and was a recommendation of the expert panel—the expert panel recommended 25 positions; we went beyond the 25 positions to 40. We're working with both the CPSO and the faculties of medicine. The faculties of medicine have hired a manager for the program and the program is currently being designed. I am unaware of any design feature that would exclude international foreign graduate practising physicians from this program. The program is geared to ensure that we have a design feature that would encourage those who have been most recently practising and those who have experience in the specialties that the communities themselves are looking for. So if they have pediatric or obstetrics or general surgery experience, that would be a criterion they would review that on, but it's not based on citizenship.

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Hon Mr Clement: If I can just add that parenthetically, Mr Chair, with your indulgence, Mr Wettlaufer has been a great overseer and reviewer of the CPSO and all of the policy and decisions that flow from that. I want to give him this public commitment that I'm going to be watching very closely the design of this endeavour. I want it to be a success. I have a community that I represent that I think is similar to Mr Wettlaufer's, and I think Mr Hastings would have a similar community as well. We have a huge pool of talent that is being wasted because of previous design flaws, if I can use that neutral language, and I for one will not abide something that reinforces that. I want to blast through that and get to a place where we are utilizing these individuals and the skills they bring to this country and to this province. That's certainly my intention.

Mr Wettlaufer: Thank you, Minister.

There's an estimate—don't leave, Mr Zegarac—that it costs $10,000 to $15,000 for these foreign-trained physicians to write the exam and take any upgrading that may be necessary in order for them to practise in Ontario. Is that correct?

Hon Mr Clement: Does that include the lost income in terms of the time it takes to write this? Do you happen to know?

Mr Wettlaufer: I was told it was a cost.

Hon Mr Clement: A cost.

Mr Zegarac: There is a cost for the exam. It's not that large. I can get you the exact number. But I would anticipate that number must include other costs, whether it be lost income opportunities or others. I can endeavour to get you an answer on what the costs would be.

Mr Wettlaufer: What is the cost of writing the exam?

Mr Zegarac: I don't recall off the top of my head.

Hon Mr Clement: It's in the hundreds, though, isn't it?

Mr Zegarac: I think it's $500, but I would have to get back to you with the exact amount.

Mr Wettlaufer: Any upgrading of education: what would the cost of that be?

Mr Zegarac: We would cover the upgrading of education. That is the international medical graduate program, so we actually cover the cost of that graduate training.

Mr Wettlaufer: OK. Of those 90 positions that you were talking about, how many of those have been filled in the medical schools or in the graduate program?

Mr Zegarac: For the international medical graduates?

Mr Wettlaufer: Yes.

Mr Zegarac: We have filled all the ones through the McKendry report that were announced, so the 24 to 36 positions were immediately filled. We have just announced right now the expansion to 50, and they're in the process of filling those. Those will be filled throughout the year. The 40 assessments: that program is currently being completed in terms of the design features. That, we anticipate, will be started in the fall, so that program will be underway very shortly.

Mr Wettlaufer: Is there a list of underserviced areas that are getting these doctors? You had mentioned that these doctors must practise in the underserviced areas. Do we have a list of which underserviced areas are getting them?

Mr Zegarac: We have a list of underserviced areas identified through the ministry. That would be one program criterion, and there are others that would be identified by the Council of Ontario Faculties of Medicine and CPSO, as they're working with us to design the program.

Mr Wettlaufer: Is that list going to be made public?

Mr Zegarac: It will be announced and it will be made available.

Mr Wettlaufer: I would appreciate getting a copy of that list because my region doesn't have any. We suffer a great shortage of physicians. We are one of the largest recipient areas—in terms of numbers, not percentages—of actual numbers of immigrants. We are third only to Toronto and Vancouver in all of Canada and we need doctors.

Hon Mr Clement: We hear you loud and clear.

Mr Wettlaufer: Thank you, Chair.

The Chair: You have about five minutes.

Mr Miller: In my riding of Parry Sound-Muskoka there are some communities that are hoping to get nursing stations. I believe Dunchurch and Rosseau are doing community fundraising, and they've been lobbying me for support in trying to get nursing stations in those communities. I certainly understand these are challenging times in the health area, with all the demands you have for money, endless demands for money. But I'm wondering, with these types of projects, whether there is a budget for them or how they might fit into the plans of the Ministry of Health.

Hon Mr Clement: Are you referring to what we would call community health centres, that they would be staffed and salaried medical professionals? Do you think that's what you're referring to?

Mr Miller: I believe so. They may have nurse practitioners in them as well.

Hon Mr Clement: Yes, that's right. This is the current status. I actually met recently with the representatives of the community health centres, and it comes up certainly from time to time. The community health centres have been a program of this province for a number of years. The development of new community health centres was put on hold for a period of time until we had a handle on their relationship and their connection to the family health networks, which is of course a huge and important program. So it might be referring to that too.

Let me just answer directly: the community health centres at least have to be connected to in some way the family health networks that we seek to create throughout the province. I'm of the view that we're getting very close to sorting that out as we move forward on the family health networks in the next few weeks and months.

I've been advised that we also have an underserviced area program specific to 23 rural and northern communities for nursing stations, and that's probably closer to what you were referring to. We provide nurse practitioner salary funding to hire three nurse practitioners, typically. We've upgraded 17 of the nursing stations. That's what I know to date. The particular situation—I'd have to get back to you unless Mr King or Mr Burns or somebody—

Mr Miller: I believe that's what they are. We currently have one, I believe, at Britt and also at Pointe au Baril, and Dunchurch and Rosseau have applied. I know, as I mentioned, they're raising money in the community. There's a lot of support in the community in these remote areas for a nursing station, I guess it would be called. I'm certainly keenly interested in it.

Hon Mr Clement: Thank you for bringing it to my personal attention. That's helpful.

The Chair: Another few minutes.

Mr Mazzilli: Thank you, Minister. I want to move on to a different subject, one that I think we need to explore and one in which we need to work better among the different ministries, and that is to promote participation. We put a lot of focus on organized sport, if you will, but in fact it's taking a walk and simple participation that have benefits. I will be promoting at some point with your ministry—there are some joint programs—the idea of an Ontario fitness path to promote fitness among our young people. We know that inactivity continues to be a problem with young people, and some older people, and I believe it's an area that can reduce some medical costs. You never actually see the savings, because new procedures come around. But I think there are benefits on quality-of-life issues that we need to explore and promote. I'll end it with that.

Hon Mr Clement: I'm very happy that Mr Mazzilli has been charged with this responsibility. I've met with Bruce Kidd and others, for instance, on these very issues in the past and look forward to working with him in the near future. I think there are ways that his proposals, when they're fully developed, and our ministry can work together. We're got a whole raft of preventive medicine issues, wellness issues that we want to promote as well, so I think there's a way for us to work together.

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The Chair: Now to the official opposition.

Mrs McLeod: I have just a couple of questions that I want to table for information for tomorrow, just to have it in writing, if I may, following up on the last discussion. Could I get the numbers as to how many patients are now receiving radiation therapy in the Cancer Care Ontario public centres, in PMH and in the private clinic, and then how many patients would have to be seen—and I suspect it's a straight 7% calculation—by CCO in order to receive the $1.8-million bonus, and what that would mean by estimate in terms of a cost per case for those patients?

I would also appreciate a clarification: if the private clinic sees 1,001 patients, what do they get in terms of a cost per case? Do they get $3,000 for the first 1,000 and $3,500 for one, or do they get $3,500 for each of the 1,001? I understand it's the latter. I'm seeing nods, but those don't translate into Hansard. Could you please put that on Hansard? Nods don't translate at all.

Mr Burns: For each, for the total.

Mrs McLeod: They get $3,500 for each of the 1,001. Thank you. So could I just get those numbers?

I do want to acknowledge, Mr Chairman, the receipt of written answers to most of the questions I tabled at the last session, except for one, and that's the critical care bypass/redirect numbers. Will those be forthcoming?

Mr King: Actually the issues surrounding critical care bypass and redirect are presently in front of the Privacy Commissioner, so we are awaiting now—

Mrs McLeod: I'm sorry, referred by? Why is it in front of the Privacy Commissioner?

Mr Burns: We have an FOI for data on the same subject area you just raised. We are in discussion with the Privacy Commissioner and the person who asked for the data about the form of the data and when we can get it out.

Mrs McLeod: So the ministry has actually balked at releasing that material publicly, even when asked specifically for it?

Hon Mr Clement: I think that's a characterization, Mrs McLeod. I think we're trying to work out the best way to release the data in the most accurate and fair manner possible.

Mrs McLeod: We'll look forward to some form of public release, then.

I want to note for the public record that the number of full-time nursing equivalent positions across the board is 8,555, according to the ministry's tabled documents today. I just want that to appear in Hansard.

I guess I have, what, two minutes left? Three?

The Chair: No, I think you have about eight minutes.

Mrs McLeod: Oh, good, all right. Tomorrow, whole new areas.

The Chair: You look a little happier than the minister, Mrs McLeod.

Mrs McLeod: I'm much happier.

Hon Mr Clement: I think we're 22 minutes over in Newfoundland.

Mrs McLeod: I do just want to note, because my colleague has tabled a number of questions and we do want devote a significant amount of time tomorrow to a discussion about home care and long-term care, that if there is written material, as there was today—I had asked at the outset of today's meeting if there was anything to be tabled, and at that point there wasn't—if it could be provided as soon as that material is prepared. If it is in fact available before the committee convenes, it would help to just make our time—

The Chair: I'd be happy to take that question to the ministry, but I would also like to commend this ministry for having responded in a timely fashion. If the further courtesy could be extended to make that available, I'm sure the clerk would be willing to distribute that in advance or some short minutes ahead of time, if that's what you're seeking.

Mrs McLeod: I agree. In fact, I'll also pass on an unexpected compliment to the ministry, because I really appreciated the answers on hospital restructuring capital and on how far the ministry has worked to make sense of what they were left with by the restructuring commission—and you don't need to respond to that, Minister.

On the issue of OHIP, you have made a commitment with the OMA one or two contracts ago to find $50 million in efficiencies, ie delisting. I understand you have now found $7 million in the delisting of audiology services, although I'm not sure how that's going to be recaptured if those people are seen by ENT specialists there. But I understand the paper saving is $7 million. On physiotherapy it's $17 million from delisting schedule 5, the G code clinics. Can you tell me where the balance of the $50 million is to come from? What further services are about to be delisted?

Hon Mr Clement: I don't think we have an answer to that yet.

Mr Burns: There is a body, called the physicians' services committee, which brings together the ministry and the OMA and works on the implementation of the agreement and collateral issues. It sponsors the work of reviewing the fee schedule and the committee process. While it's looking at a range of current fee practices and other ways of constraining the expenditures in this particular pot, it does not have a specific set of recommendations about to come forward. We expect it some months from now, not weeks.

Mrs McLeod: How much would you estimate is left to be recaptured of the $50 million in "efficiencies"?

Mr Burns: I think the ones we've done so far are a bit over half of it, so a little less than half is what we're still looking at.

Mrs McLeod: So something in the order of $25 million still needs to be transferred?

Mr Burns: Yes, between $20 million and $25 million.

Mrs McLeod: That fits. I had $17 million and $7 million, just from the two we were aware of.

Mr Burns: And there have been some other changes made as well already.

Mrs McLeod: I know of at least one alternate plan that was put in place, and let me express my appreciation—that makes twice in the last 15 minutes—for the

fact that where the G code clinic was the only form of non-hospital physiotherapy clinic in the northwest, there was an alternate payment plan put in place in my community. I appreciate the recognition of the dilemma that was faced there.

I am, however, concerned about physiotherapy services and about audiology services in public centres. I'm wondering whether or not the ministry is looking at alternate payment plans for both physiotherapy clinics, additional schedule 5 clinics and/or some other alternate payment plan for public clinics for physio; and second, whether or not you are considering alternate funding mechanisms to provide for public clinics for audiology services.

Hon Mr Clement: I think we have to be careful what is said on the record. There are a couple of pieces of litigation involving this file, so I feel a bit constrained—

Mrs McLeod: If I may, Minister, the litigation would have no effect on the government's ability to provide some alternate funding, would it?

Hon Mr Clement: I think lawyers would say that anything pertaining to the file is rather sensitive. Can I take your question under advisement until I find out what I can or can't say?

Mrs McLeod: Actually, I think what you're telling me is on the audiology side, that if you were to provide alternate payment schemes for audiology clinics you would have to acknowledge that the audiologists have an independent scope of practice, and that indeed is before the courts. Can you answer the question on the schedule 5 clinics for physio, then, because you're not in front of the courts on that one?

Mr Burns: I would just say broadly that in the fall, all ministries examine the activities they fund and the demand for those services, and put in front of ministers and the government forecasts and options for meeting them. In that sense, we are looking at all 120 or 130 areas that we fund, to some degree or other, and looking at next year's activity levels.

Mrs McLeod: Do I have any more minutes to pursue that, Mr Chairman?

The Chair: You have two minutes in total.

Mrs McLeod: How many hospitals—

Hon Mr Clement: Do you want it alphabetically?

Mrs McLeod: As you look at one of your 120 areas of service, one of which is to provide public access to physiotherapy, do you have any idea how many hospitals have discontinued outpatient rehab?

Mr Burns: I don't, sitting here right now, know what changes may have taken place in hospitals.

Mr King: Actually, we're trying to continue to encourage the operation of outpatient physio in hospitals. Many of those hospitals are also opening rehab in-patient beds, so that also promotes the need to have support systems for outpatients.

Mrs McLeod: Are you encouraging them with targeted dollars? Is that how you're encouraging the hospitals to have outpatient physio?

Mr King: We have actually targeted dollars for opening up rehab beds, and we are also moving on some commission direction for ambulatory care services, of which rehab is a part.

Mrs McLeod: Is there a figure in these estimates to support that, the ambulatory portion?

Mr King: There is a $10-million note in the estimates for ambulatory care programs, but it relates not just to outpatients but also to emergency department expansion. That is also in there. But I didn't want to get into that. I actually wanted to indicate that of course we are encouraging that hospitals continue to provide rehab services for both in-patients and outpatients.

Mrs McLeod: I appreciate verbal encouragement, but this is estimates. I'm looking for how you're actually encouraging them.

Mr King: We do have a set number in the estimates, both for rehab in-patient beds and for ambulatory outpatient care, of which some would go to rehab programs, if that's the answer you'd like.

The Chair: We'll continue until the House recesses, which should be momentarily, if you'd like to—

Mrs McLeod: To finish off some of my questions on physio then, in the time we have, do schedule 5 clinics and their operating funding continue to be capped as a total budget?

Ms Susan Fitzpatrick: I'm Susan Fitzpatrick, the director of the provider services branch.

There is a budget for the schedule 5 physiotherapy clinics, and they're expected to stay within that budget. To the extent they don't, we can take some action to reduce the payments. We have not taken any action at this point.

Mrs McLeod: Can you tell me how many schedule 5 clinics existed last year and how many exist this year?

Ms Fitzpatrick: I believe the number is the same. It's 103. They've been grandfathered since late 1968.

The Chair: Thank you very much. With that, the House is adjourned and so are we.

The committee adjourned at 1801.

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