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Tuesday 9 October 2001

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Mardi 9 octobre 2001

Standing committee on estimates

Comité permanent des budgets des dépenses

Ministry of Health
and Long-Term Care

Ministère de la Santé et des Soins
de longue durée

Chair: Gerard Kennedy
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 9 October 2001

Mardi 9 octobre 2001

The committee met at 1540 in room 228.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr Gerard Kennedy): Just before we get underway, we may, because of the delayed start, be looking at 15 or 20 minutes, commencing there. Is there a will to stand that down to the next time so we could have a more coherent overall presentation? How do the parties feel about that particular element? The implication is simply 20 minutes one way or the other.

Ms Shelley Martel (Nickel Belt): I agree.

The Chair: OK. If there's that agreement, then we'll advise the Ministry of the Environment that we will commence tomorrow rather than bring everybody out, and the ensuing changeover and so on. We have, I should say, a strong representation here from the Ministry of Health. We wouldn't want anyone injured on the way out and so forth. Thank you for that agreement. I think it's a courtesy to the ministry. With that, we will commence. I believe we were with the government.

Mr Norm Miller (Parry Sound-Muskoka): Can you tell me about the flu program for this year? I know you just started. I think it's at the stage of near implementation for this year. Can you give me some details on that program for this year, please?

Hon Tony Clement (Minister of Health and Long-Term Care): Certainly. It's a $44-million program this year, Mr Miller. I was able to announce on Friday at police headquarters in Toronto that the flu program is now in the process of delivering the vaccines to medical facilities and family physicians. There will be a total of 5.9 million doses available. If more are needed, we have the ability to contract for more. That total is higher than last year by about 15% or 20%, I believe.

From our perspective, we are expanding the program this year. We are getting into more workplaces. Last year we concentrated on institutions: nursing homes, hospitals, facilities like police services and fire services, places where employees come into contact with a lot of people in the course of their employment. We're expanding, with the assistance of private sector and public sector places of employment, to get it into more workplaces.

One of our partners, for instance, Ontario Power Generation, has had a program for a number of years. They were there at the launch as well. They have had quite remarkable success; over 50% adherence in the workplace to get their flu vaccination shots.

I'm particularly proud of the results from last year. I am now told that this is the only program of its kind in the world—not only North America, but the world—in terms of its reach and support by the government, which is the jurisdiction for these things.

I can tell you—I think I mentioned this in response to Ms Martel last time—that the numbers bear out that it has had a positive impact last year compared to the year before. I mentioned, I believe, at the last session that the number of cases in our nursing homes declined by 97%. I believe it went from a total of 341 down to nine. I'm also told that as a percentage of cases, Ontario went from 40% of the cases in Canada the year before last to 20% of the cases last year. So again, these are numbers that seem to defy the view that this is just because of the strain or just because of particular circumstances. There has been a very large impact and we're quite hopeful that this year we'll have the same impact.

Mr Frank Mazzilli (London-Fanshawe): Minister, on a broader policy issue, we continue to hear that there are needs in health care and our government is spending some $23 billion, representing approximately 44% of Ontario's spending, yet we continue to hear that there's not enough in some areas and not enough in other areas.

When you look at the broader policy issue between the federal government and the provinces, I know the federal government has acknowledged that perhaps there's some sort of a problem and has appointed Mr Romanow to look at the situation. Is there any idea or any indication as to when and what type of recommendations he's prepared to make to the federal government on this very important issue?

Hon Mr Clement: I can tell you a couple of things. First of all, Mr Romanow's commission, which is a free-standing commission—I guess in a sense a royal commission; it has all the powers and authorities vested in that—is ongoing. I am told that in January or February there will be an initial report. The ambit of the initial report is going to be what he's heard around Canada as to what sorts of things need improvement. Mr Romanow has mentioned in the past that he is of the view that not everything our medicare system in Canada does now is sustainable if we remain wedded exactly to the status quo, so he has made intimations that some things might have to change. How far he is willing to go with that

suggestion remains to be seen. After his preliminary report—I think he is expecting nine to 12 months later—he would then issue a final report on his recommendations to the federal government on any changes to the Canada Health Act, any changes in Canadian policy with respect to these issues.

We have made several submissions to the commission on behalf of the people of Ontario, one involving funding. We have been quite clear that we felt the first thing the Romanow commission should identify is that, for any proper and sustainable functioning of our health care system, the federal government should have to live up to its responsibilities when first the Canada Health Act was created, that is to say, a 50-50 responsibility, and that in the first instance, when it comes to funding, they should be back to their 1994 levels of funding, that is to say, 18% of the total health care costs. That's an initial representation we have made.

The other thing that is going on out there of course is that Senator Kirby, a Liberal senator from Nova Scotia, has Senate hearings on the future of medicare as well. I understand that later on in the month, he'll be taking his senatorial committee out on the road throughout Canada to hear representations from various groups and citizens in the country, and I expect Ontario will have its share of locations for that. He has released a series of papers over time—I believe four of them to date–indicating potential avenues for health care reform. I must say he has been bold. I'm not agreeing or disagreeing with what he has said, but certainly the types of issues he's willing to at least discuss are quite expansive. So his committee and their recommendations are obviously part of the public record and form part of the public policy debate.

Mr Mazzilli: On that, as you've said, there is an indication to look at these things, and whether it is Mr Romanow's commission or the senator's commission, likely we are looking at one or two years out by the sounds of your description of the consultation they will be undertaking.

At the present level, without any new technologies, just regular inflation and with the age groups in our population going up, what type of increases are required to the health care budget just to maintain the status quo as far as services?

Hon Mr Clement: It is estimated, when you look at inflation historically in the health care sector, that adds a couple of points. When you add utilization and population growth and the demographic impact of an aging and growing population, that usually adds two to three points per year. So you're looking at 5% per year before you go through the long list of program improvements and specific areas that might be in excess of that.

1550

We have made the point to Mr Romanow that a two-year commission with results coming out at the end of two years, and then you have to go through the whole legislative process—the whole consideration on a national level and goodness knows how long it will take to draft legislation if there are already changes contemplated to the Canada Health Act—and have a fulsome debate, you're looking at two and a half to three years before anything meaningful would be accomplished. Our point has been–and this is a point that has been underlined by other Premiers and health ministers in other jurisdictions—that we cannot wait that long to have federal government policy frozen in some form of stasis until Romanow completes everything that Romanow has to complete.

The reaction of the federal government is, "Well, we are in the middle of a royal commission. We have to wait for the results of Roy Romanow" etc. That is slowly becoming a mantra that is used as an excuse not to act and not to hear the provinces' concerns; not only Ontario's concerns but Quebec's concerns, British Columbia's concerns, concerns in Atlantic Canada and so on. They have a new Liberal government in British Columbia that has made the same point that Mike Harris made very forcefully–it is pretty well the same concern—that we cannot continue to deliver excellent health care, universally accessible, available when we need it, where we need it, unless the federal government is part of the solution as well, and we are hoping that does not fall upon deaf ears.

Mr Mazzilli: Recently—and I know in London there have been some issues that I've stayed on top of—the opposition benches have chosen to play politics with a certain issue on a hospital in relation to some services that that hospital feels it may or may not be able to provide. What I'd like to know is, beyond the usual babble, have the opposition submitted any solutions to you?

Hon Mr Clement: I would say that the answer would have to be no. The opposition, as befits an opposition, raises questions, which they have done. But the fact of the matter is, I think we could all agree around the table that we want quality health care delivered by those who can deliver it in a sustainable way, in a way that the clinical outcomes–

Mr Mazzilli: So they haven't said that they've gone to Ottawa and gotten more money for this service and you can keep the service in London? They haven't put any of those solutions forward to you?

Hon Mr Clement: I would have to say no. We've asked the opposition parties to join us in the dialogue with the federal government when it comes to our appropriate share of what is, in effect, the same taxpayers' money. Our position has been that it is even more apparent in Ontario, where the ridings are the same ridings provincially and federally. The people in Ontario who are concerned about health care, which is a goodly portion of the population, are the same people who elect the provincial member and the federal member. If their number one issue is health care provincially, it is their number one issue federally as well. Indeed there is public opinion research that backs them up.

Mr Mazzilli: Before one starts criticizing, whether it be an opposition leader like Dalton McGuinty or Mr Peters, I would have felt they would have gotten a

commitment out of their federal cousins before they started criticizing a hospital board and its administrators, whether they feel they can keep certain specialists there based on whatever criteria or best practices. But barring any of those decisions that the hospital board and its administrator felt they had to make, if one were to keep all those services, you would think that the opposition would have written to the federal MPs and the Prime Minister and would have brought some money along with their accusations of you and your ministry.

Hon Mr Clement: I'm not aware of any such communication. I can tell you from our end, we want the best clinical outcomes for kids when it comes to pediatric cardiac care, or for other citizens in London or wherever. The name of the game has got to be the best clinical outcomes. If a particular course of practice cannot guarantee that, then you've got to review the scope and size of what you purport to be a hospital. To me it's like what we were talking about in the last session, it has to be outcomes-based. How can we deliver, not only pour the money in—we're very good at pouring money in; any government has done that. It's the question of, what sorts of results do you get out? Unless you're focused in on the outcomes, you are not doing your job, I would put it to you, as either a government or an opposition. We're focused on the outcomes.

Mr John O'Toole (Durham): This morning the MPPs for Durham met with distinguished members of the hospital foundation, Chuck Powers and Don Blight, as well as members of the Lakeridge health board: Anne Wright, Judy Spring and of course Brian Lemon, the CEO. They were really responding to a question asked earlier, as well as a memo that was issued from your ministry dated October 3 and signed by Paul Clarry and David Stolte with respect to the Lakeridge health challenge. We spoke on this before. I just want to put on the record that I respect the memo of October 3 and I just want to point to a couple of points made in there. It's quite a directive letter, and in that respect what we all need is to be more results-focused on getting this project together. The strength is in words like:

"In order to proceed with the cancer project, the following information is required:

"The updated costs associated with constructing a two-storey" addition over the cancer centre, and some other technical things. Other strong language here is, "In order for the ministry to consider this component of construction"—in other words, it's sort of under the decision point here—"the following information is required." It goes on to talk about a unit there to create its own power for the facility.

I guess the point they were trying to make with us was that under the redevelopment, which is one part of the project—the cancer treatment centre is number two in my mind, but they're linked in their minds, and they're linked in the respect that they need updated, more appropriate facilities for critical care, emergencies and lab facilities, which are all part of the redevelopment cost.

I'm very supportive of the foundation's initiative here to raise considerable capital. I just want to put on the record, I've seen the capital project, as you've outlined as well in the memo, raise from something in the order of $175 million up to something like $360 million. Being one of the many representatives elected in that area, I don't want to shed any negative light on this, but I just want to, with the conditional language that has been put forward in the memo, have some reassurance that the project, either phased or otherwise, can proceed to the target date of the calendar year 2003. That's the commitment. I think before the foundation can start rolling out a major fundraising project—and these are significant donors, in the millions-of-dollars range—can I get something in terms of a response?

Hon Mr Clement: Sure.

Mr O'Toole: But I do respect—the memo of the 3rd I thought was quite directive and had those four requirements very specifically: "The following is required"—and there are about four different areas here. Are we happy with what's going on there, and can I reassure my constituents that we're going to get the redevelopment and the other piece, or is there some other hook here?

Hon Mr Clement: Sure. I will defer to John King in one second, but let me just state also for your consideration that of course there are a number of different projects at that particular hospital, and deservedly so, and they will proceed. But we were facing a situation where, because of the sequencing, the cancer centre was missing some deadlines. From our perspective it's important that we meet those deadlines. It's government policy that there's going to be a cancer centre there; it should be there. So I think we've had that dialogue with the hospital, but I'll defer to John King to give you some detail.

Mr John King: I'm John King, assistant deputy minister. We have been dealing very closely, as the minister said, with Lakeridge, and we have had their commitment that the cancer centre will continue and will be ready by 2003, which was the date they were looking at. That will be a project that will be separated off. Unfortunately, for a number of these projects, they have included them as part of their master plan, and that's why we got a little off track on this. But we are working very closely with them. We do have to phase these projects, because many of the hospitals are going beyond the commission direction. Of course, they want to have a vision for 2020, but that's not where we're moving right now. So we will look at a phased approach to many of these projects. I think you can be assured that we are working closely with them, that we still will follow through on the commitment at that cancer centre. We will separate that project off so we can continue as planned for the cancer centre. We have received that in writing from them.

1600

Mr Paul Clarry: Paul Clarry, director, capital services branch. I just wanted to add, the memo, if it seemed directive, is a reflection of a series of meetings and discussions we've had with the hospital as well as the board members and the foundation members. If it does seem directive, I think it reflects the agreements we had

reached with the hospital on how to proceed. It needs to meet some very specific requirements to keep the cancer centre moving. As well, it was deemed helpful to the hospital to use the language in the letter, recognizing that they are in the process of reconstituting their project management team. It also lent credibility to the community and foundation as it is out talking the project up with its major donors.

Mr Miller: I have a question to do with community care access centres. My riding of Parry Sound-Muskoka is unique in that we are covered by three community care access centres.

The Chair: One minute, please

Mr Miller: Very quickly then, I had a constituency complaint to do with the administration of one particular CCAC that too much money is being spent on administration. My question is, what is an appropriate amount, maybe a percentage, that should be spent in a CCAC on administration?

Hon Mr Clement: I think it's a legitimate issue and a legitimate concern. Mr King, do you want to say something?

Mr King: I think it is difficult to give a specific percentage, but generally we had looked at about 6% to 8% in administrative costs. I think we have to really be clear on what's included in administration because often health records, finances etc are part of administration. Apples and oranges are sometimes used in these settings. Without being specific–and I wouldn't want to go back and accuse a CCAC of going above that–that's generally the guideline that we would use for administrative costs.

Mrs Lyn McLeod (Thunder Bay-Atikokan): There are a number of issues I want to cover today. Again, I just want to thank the ministry for having tabled answers to the questions from last day.

I do want to note, for the record, there was only one day of public consultations scheduled by the committee that is looking at the cancer care centre mergers. The remaining four requests from local groups to have hearings outside of Toronto all came from Liberal members, and there is an error, whether it is in the recording of the requests that were made or whether it is in Dr Hudson's understanding of it. The requests have come from London, from Kingston, from Thunder Bay-Atikokan and from the northeast region, which is in Sudbury. We will be fortunate to get one hearing in Thunder Bay; we were looking for two.

First, I want to turn again to the hospital issue. You've indicated that 60 hospitals will be projecting deficits this year. Can you tell me please what time frame the government has now given to hospitals to have balanced budgets?

Hon Mr Clement: Can I just say this about the 60 hospitals? Again, there is a lot of negotiation that goes into what sort of deficit they're forecasting and what goes into that. As we have a dialogue with them, that number does get reduced.

Mrs McLeod: I understand that. My second question will come to that.

I specifically wanted to know the time frame you've given hospitals. I know there was legislation. The legislation is no longer in front of the House. There is a time frame that's been given to hospitals, I understand, for having balanced budgets. Is it this year or next year, this May or next May?

Hon Mr Clement: Sure, yes. I can't answer that conclusively because we're still in discussions with the hospitals on what is reasonable and fair to expect.

Mrs McLeod: There was a directive given. Has that directive been withdrawn? I believe the directive was to balance budgets by the end of this coming May.

Hon Mr Clement: No, I'm not aware of a directive of that sort.

Mr King: We continue to ask hospitals to work within their means, but there was no directive that went out to hospitals to balance budgets. As the minister said, we are still working through the other part of the legislation.

Mrs McLeod: So each of the 60 hospitals that are currently projecting a deficit are essentially in negotiations with the ministry in terms of what's reasonable. So then the decision of the London hospital board to cut the 18 programs at this point in time, for a saving of some $2 million, under a directive from the Ministry of Health that they had to cut $17 million, would have been part of an approved operating plan submitted by London to the ministry and having received your approval?

Hon Mr Clement: We'll give you the context on that.

Mr King: The specific situation in London was not part of a balanced budget situation. We did an operating plan there in London some time ago. We've looked at a number of areas. One of the areas happened to be programs that are offered as tertiary or quaternary programs. The London board decided that there were programs that—it wasn't for the dollars, it was for the volumes—they felt were not necessarily providing good, quality, safe patient care. They selected those based on that. They also happened to contribute to their overall recovery plan that we're working on through their operating plan.

Mrs McLeod: Can hospital boards make decisions about service reductions in order to meet their—because they've had to submit operating plans to you. Granted, they're in negotiations. To deal with their deficit situations, can those hospital boards make decisions about the cutting of programs without specific ministry approval?

Mr King: Yes.

Mrs McLeod: In that case, I assume that each of the 60 hospitals is working on a different operating plan with different proposals to scope their programs and that each of those operating plans would have separate ministry approval but would not necessarily require that approval before they make the decisions to cut.

Hon Mr Clement: I know it's not your intention, but there is a bit of apples and oranges going on here. The London case directly involves the Health Services Restructuring Commission reports on which hospitals should be responsible for what clinical outcomes. That is a very different kind of discussion with the ministry than each year's operating plans of each hospital. I wouldn't

want to mix the two, because then one would make assumptions that are not correct.

Mrs McLeod: All right. I'll accept that. I'll come back to an apple if you would deal with the orange first, please. The operating budget plans which have deficit reduction plans each have to be approved by the ministry, but you've indicated that the hospital can make those decisions before the minister gives approval of the plan. So each hospital independently can make decisions to cut programs in order to deal with cuts. That's a correct statement, taking it away from the apple of London for the moment, Minister?

Hon Mr Clement: Operating plans are different, though, Mrs McLeod. They are—

Mrs McLeod: I'm talking about the budget reduction plans within the operating plan.

Hon Mr Clement: Yes, but my earlier point was that there has to be a discussion between the ministry and the hospital on each operating plan because some of the assumptions they make, which create a number that is a deficit number, turn out not to be so. For instance, in our announcement of hospital funding there are a number of programs on our list of priority programs that get ongoing funding that they may not have been aware of. So these things take a little discussion.

Mrs McLeod: I think the answer to my question, however, was Mr King's answer that a hospital board may make a decision to cut programs without specific ministry approval.

Mr King: The only thing I would qualify that with is that we did send out a note to them that they would of course minimize the impact on patient activities and also minimize the impact on labour. So within that budget—but, you see, some of the funding announcements just came out and we are just revising our plans with them. The minister is correct in saying that some of the assumptions of new programs etc that have not been approved by the ministry were also part of that deficit.

Mrs McLeod: In terms of what you've described as the apple rather than the orange, then, and I'll take London as the apple, what you're saying is the hospital restructuring program, and that makes it clearly a ministry responsibility, because hospital restructuring is a directive from the ministry.

Hon Mr Clement: I think it's always been our position that the hospital restructuring commission was an independent commission which was designed to make some conclusions which then became part of the public record. So I'm not sure how to answer to your question other than—

Mrs McLeod: So you're saying that London was acting on a direction from the hospital restructuring commission?

Hon Mr Clement: Yes.

Mrs McLeod: You've indicated, Minister, in the House that there are plans to provide those services elsewhere. Were those plans included in the details of the hospital restructuring commission's directives to other hospitals?

Hon Mr Clement: The plans would automatically come about as we go through our consideration and research based on what is now before us from the board of trustees as to how to proceed. So before any of that stuff becomes operational, of course we would ensure that there would be no gaps in the system.

1610

Mrs McLeod: So if I can just understand it, and I'll move on to another area, the London hospital then made a decision about restructuring based on a directive of the hospital restructuring commission but in the absence of any specific plans for the accommodation of those programs elsewhere.

Hon Mr Clement: Well, no. Don't forget that this does not occur instantaneously. The board of the London hospital made its decisions. That doesn't mean tomorrow or next Monday automatically there is a different situation. Before we get to that different situation, I think it is the responsibility of the Ministry of Health to ensure that what is not available there is picked up somewhere in an acceptable fashion for the delivery of services in Ontario.

Mrs McLeod: I appreciate that. I won't belabour it. But the basic thing is that the hospital restructuring commission, you've told me, directed those cuts but did not in turn direct another hospital to pick up the services.

I want to turn now to the northern health travel grant. I have a series of fairly specific questions. I hope it doesn't cause a constant rotation in ministry personnel at the table. The northern health travel grant on page 71: first of all, could you tell me why it is intended to spend somewhere between $3 million and $4 million less on the northern health travel grant program this year than last, than was actually spent—not what was estimated to be spent, but what was actually spent?

Hon Mr Clement: We're going to have George Zegarac take the stand.

Mrs McLeod: I think we are going to go into rotations.

Mr George Zegarac: I'm George Zegarac, executive director of the integrated policy and planning division. I believe on page 71 the note is the $6.8 million that's in the budget for this year.

Mrs McLeod: That's right.

Mr Zegarac: It has always been $6.8 million. We've always funded the full travel, regardless of the fact that we continue to fund beyond the allocation. As you know, the government is reviewing the program and will make the adjustments according to any new structures to the program.

Mrs McLeod: And every year I think I ask the question as to why it is not planned to spend at least what the program was costing last year. Can you tell me the status of the review, which I assume is done but has not yet been readied for release by the minister?

Hon Mr Clement: I think I can jump in. Certainly, of course, we had a new context with the Ombudsman's addition to the public policy debate in this area, but I think I can confidently say we're in the final stages of our consideration of the situation.

Mrs McLeod: When would we expect to see a public release of the review?

Hon Mr Clement: I think we will be responding to the review that we have done, as well as the Ombudsman's consideration of matters. Of course, on the consideration of comparing programs, we are now out of the re-referral situation at Cancer Care Ontario, both outside the province and also inside the province, at least to northern Ontario. So in that respect, part of the puzzle has been solved.

Mrs McLeod: But there was a general review of the northern health travel grant program quite apart from the breast and prostate cancer re-referral program.

Hon Mr Clement: That is correct, and we're in the final stages.

Mrs McLeod: You're in the final stages. So can you give me an estimate of when that review might be presented publicly?

Hon Mr Clement: I guess when every "t" is crossed and every "i" is dotted and I feel confident it's the best it can be. That's certainly what our intention is.

Interjection.

Mrs McLeod: We all asked him that question last year, Mr Bisson.

On public health—should I give advance notice of where I'm going so that you can rotate a little more quickly?—I'd like to know what the projected deficit for the public health units is.

My next question will be on ambulance services.

Dr Karim Kurji: I'm Karim Kurji, physician manager, public health branch.

In 2000-01, the provincial payment, which is the interim actual amount to all 37 boards of health, totalled $186.663 million. The 2001-02 estimates are $180.17 million, which is $6.493 million less than the 2000-01 interim actual amounts.

During 2000-01, the boards of health faced some extreme and unexpected pressures that required additional in-year funding—

Mrs McLeod: Sir, I'm sorry to interrupt, because I am interested, but I did read the estimates book, and that's contained in the estimates books. Could you just tell me, in their requests to your ministry this year, what their projected deficit is?

Dr Kurji: We are still in the process of reviewing the budgets that have actually been submitted by the local boards of health. Normally these budgets would have been submitted earlier in the year. We had two health units that submitted their budgets in August, and we're in the process of reviewing those particular budgets. However, I would like to remind you that under the Health Protection and Promotion Act the board of health approves a budget for the delivery of the mandatory public health programs, and it's the municipalities within its jurisdiction that are responsible for the costs. Per policy, the province has been providing grants to offset the costs of the municipalities. The grants are currently 50% of the approved budgets.

Mrs McLeod: This is a question for the minister. Can you tell me what the responsibility of the minister is in determining the implementation of the law—I believe the mandatory programs would be part of what is legally required for the health units to deliver—and why the ministry would be indicating to the public health units that they may wish to consider dropping one or more mandatory programs for financial reasons?

Hon Mr Clement: I can you tell you that from our perspective mandatory programs are certainly ones we feel are particularly important to the public health of the province. We also work with each board of health to ensure they are adequately rolled out as per the circumstances in each area, the ambit of each board of health.

Mrs McLeod: But you would agree that mandatory programs are legally required to be provided, whatever the cost-sharing arrangements are?

Hon Mr Clement: Can you be a bit more specific as to what you're thinking of?

Mrs McLeod: Actually I can't, because I'm not sure which mandatory programs they're being advised to consider dropping, but I know that is advice that was provided—

Hon Mr Clement: By whom?

Mrs McLeod: By the Ministry of Health in a session with business administrators for public health units across the province.

Dr Kurji: To the best of my knowledge, that certainly has not been the advice we have provided to local health units. Under the legislation, they are required to provide all mandatory programs. Indeed, we actually check on the compliance levels through a few mechanisms such as the mandatory program indicator questionnaire that they're expected to fill in.

This may be getting confused, with due respect, with some revisions to the mandatory programs that are underway. In those revisions there are some areas that will get dropped and new areas will be brought forward. But that process is still underway and hasn't yet been completed.

Mrs McLeod: I appreciate that answer. My reference point is a presentation that was done by the Ministry of Health—these are copies of Ministry of Health overheads—on September 18 in Kingston, in which it was indicated that a potential cost-reduction strategy could be to reduce the scope of one or more mandatory programs or drop one or more mandatory programs. I would ask, then, if there is a contemplated reduction in specific mandatory programs so it's no longer a legislative requirement to offer certain mandatory programs, that that information be provided to the committee so we're aware that there has been a change.

Hon Mr Clement: Sure. I think maybe the slide was a bit inaccurate. If it's a mandatory program by legislation, it's a mandatory program by legislation.

Mrs McLeod: That's why I was somewhat surprised by the presentation that was made, Minister. I would appreciate any further information.

Hon Mr Clement: We'll get to the bottom of that.

Mrs McLeod: On the issue of ambulances, which I think I'll go to next, can you tell me what the severance cost is that has just been experienced for the privatization of the air ambulance—the most immediate one, in the month of September when the air ambulances were fully privatized?

Hon Mr Clement: I can't remember off the top of my head, so I'll ask Mary Kardos Burton.

Ms Mary Kardos Burton: Mary Kardos Burton, executive director, health care programs.

The severance costs for the air ambulance—that decision was just made in terms of the change to the private sector or to change the remainder to the private sector this fall, so the costs aren't in there as yet.

Mrs McLeod: Yes, but can you tell me the cost? The costs have now been incurred.

Ms Kardos Burton: There will be some costs. I don't have those with me.

Mrs McLeod: Is it possible to obtain them? All the air ambulance paramedics were severed. The majority, I understand, have been rehired, but there would be a severance cost that I'm sure the ministry anticipated.

Ms Kardos Burton: The majority will be hired. We'll certainly look into that.

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Mrs McLeod: Minister, the reason for asking the question is that I'm really trying to understand how it could possibly be conceived there is a cost efficiency in privatization of the air ambulance program when you've just paid out whatever significant dollars we can ultimately conclude you've paid out severing people you've then rehired. I fail to see the efficiency—

Hon Mr Clement: The labour cost is certainly one of the components of the cost, but there are also, as a result of the contract, some things that are being brought into our air ambulance program that would have cost the government were it not for the fact it is now being tendered out.

Mrs McLeod: Give me an example of that.

Hon Mr Clement: Yes, by all means. We have some good examples of that.

Ms Kardos Burton: There's an additional helicopter that's been put on in Toronto. There are additional services that are being provided on the ambulances. There's an enhanced service for the air ambulance.

Mrs McLeod: That's interesting, because that's an increased cost, not an efficiency, that you just described. I think what the minister was looking for was where you had made some cost reductions that would give you the efficiencies.

Hon Mr Clement: If we hadn't contracted out, Mrs McLeod, then the government would have been responsible for that directly. That's my point. So in that sense it's not a cost reduction, but it is—

Mrs McLeod: So you are no longer responsible for how many particular aircraft are available for medical emergencies in a given community? Is that how you get the efficiency?

Hon Mr Clement: What I'm saying is that where before, if we saw as a result of demand the need to get a new helicopter or hire more or add to services, that would have been borne by the ministry. Now it is part of a tendered bid. So in that sense—

Mrs McLeod: But it still is a ministry cost. Unless you reduce—

Hon Mr Clement: We think that can be provided—

Mrs McLeod: There's no immediate saving.

Hon Mr Clement: We think that as a result of the tender, that is provided at less direct cost to the government than the alternative.

Mrs McLeod: That's interesting, because that leads to my next question, which was the unavailability of air ambulance in Sudbury this weekend. I would be very interested in knowing why the backup helicopter, which was mentioned, is now based in Toronto and why that now leaves Sudbury, which would have had backup air ambulance service over the weekend, without service this weekend. Is that because it was part of the contract that any backup services would be provided out of Toronto at reduced cost to the private operators?

Hon Mr Clement: I'd have to look at the situation. You've thrown me for a loop.

Ms Kardos Burton: We'd have to look into the specifics around the Sudbury situation.

Hon Mr Clement: It's the first I've heard of anything in Sudbury. I'll have to look at that.

Mrs McLeod: I would appreciate that, and I would further appreciate understanding how the government sees itself paying less for the air ambulance service—ie, finding efficiencies—when you've just paid a yet-unnamed but significant sum in severance costs. Presumably—

Hon Mr Clement: That's a one-time cost versus the cost over the period of the contract.

Mrs McLeod: So we would expect to see some increased funds for this budget year, even though they're not in the current estimates. Somewhere along the way you have to be anticipating some reduction in costs through the tendering process in order to find these so-called efficiencies and to warrant even a one-time severance cost. I will appreciate knowing where those efficiencies will be found, because the first weekend of the operation gives some of us in the north cause for concern about how adequate the service is going to be under the privatized system.

We've been waiting for standards for land ambulance services to be put in place. The standards were supposed to be done by July. Are the standards in place?

Ms Kardos Burton: When you say standards, what are you referring to specifically?

Mrs McLeod: The standards for response times.

Ms Kardos Burton: There are a number of activities going on in terms of response time as well as standards. You'll recall that the funding for ambulance services is being done in phases. The first phase was deciding, with the municipalities, what in fact are approved costs. We've done that, and we've identified that.

The second phase is response time. What we're currently doing is working with the municipalities to

identify what it would take from them in terms of meeting the current response times. Those are underway right now.

In terms of standards, the response time standard is a standard which I know you know, based on what it was in terms of 1996. We have a standards committee with the ambulance steering committee that has to look at all standards.

The Chair: I'm going to have to ask you to wrap up that question. Mrs McLeod, I apologize for not giving the warning, but I gave you a little bit extra to get that finished up.

We now turn to the third party. Ms Martel.

Ms Martel: Minister, because you spoke again about the flu vaccine, I am compelled to return to our proposal for meningitis vaccine province-wide, because I'm not convinced the province is doing enough in this regard. I listened carefully to the answers that were provided but note that two provinces have gone ahead on their own with provincial programs, a significant investment, without some of the federal discussion being complete. I do think, as well, that you need to consult some other experts in this regard, not solely the expert whom you are consulting with, so I ask you to consider the following. Dr Gold, who was supportive of this proposal, was at our press conference, I believe has written to the ministry to express his support, would be an expert whose advice I think you should seek in this regard. His credentials are quite outstanding, and I'd like to repeat them again, because I was reading them into the record at the end of the day and I want to make sure they got on the record. He is a medical adviser for the Meningitis Research Foundation of Canada; professor emeritus of pediatrics, faculty of medicine, University of Toronto; former head, division of infectious disease at the Hospital for Sick Children. He has a great deal to offer in this regard, tremendous expertise, and I would ask you if you would now consider soliciting his views with respect to a province-wide program as well.

Hon Mr Clement: Well, you know, we're always open for business, so if he has a perspective—you said he has communicated with us?

Ms Martel: I believe that he has communicated his support of this to the government. We will obviously check with him again and, if not, make sure we get a letter to you on this.

Hon Mr Clement: Sure, I'd appreciate that.

Ms Martel: I do think we can do more, and I think this program can be as successful as the flu vaccination programs is. Thank you.

Mr Michael Prue (Beaches-East York): I have some questions on a subject near and dear to me in the riding, and I see Gail Paech here. It's good to see you again. I guess it's probably near and dear to you. It's about the Toronto East General Hospital and the new wing that's been built. You were there at the opening, and it was right there in the local newspaper, the wonderful new opening but with no funds to keep it going or actually to staff it up. It's still very much that way. It's a brand new beautiful wing with 75 complex continuing care beds and no staff in it.

Also, Wellesley Hospital is being closed because of the restructuring plans and it's estimated that 14,000 patients per year will be going to Toronto East General Hospital. My question is, when are there going to be sufficient funds to operate it?

Hon Mr Clement: I recall signing a funding letter a few weeks ago with respect to Toronto East General, but I'll leave it to Mr King to provide the details perhaps.

Mr King: We have been working very closely with Toronto East General, as well as a number of the hospitals still in the province with respect to their funding rollout for this year. I think you'll find, with the recent funding announcements that have been made, that Toronto East General should be able to work within that funding allotment. I can't say that they can open up fully the 75 complex beds, but they are working through to see what part of that operation they can operate this year. So dollars have gone out, as the minister stated, to Toronto East General for the operation of that wing.

Mr Prue: OK. I'm given to understand that it costs about $9 million to operate that wing in operating per year and the announcement that was made two weeks ago was for $2.7 million for current patient services and $4.5 million to operate the complex continuing care beds in the new wing. I'm new to all this: is that $4.5 million out of the $9 million or is that $7.2 million out of the $9 million?

Mr King: I don't have the exact numbers, but that was based on the cost of operating that for part of the year rather than the full annual funding that normally they would use.

Hon Mr Clement: So when you annualize it, it would be more.

Mr King: I think you will find with Toronto East General—and of course I don't have all the numbers in front of me, so I have to apologize—in the recent week the president of that organization indicated that they will be able to operate within those dollars of the minister's announcement for this year.

Mr Prue: The whole J wing?

Mr King: I can't tell you exactly how many beds are opening this year, but they have told me that when these dollars the minister has assigned have gone to them, they will be able to manage within their program volumes for this year.

Mr Prue: Again, I'm trying to understand this. There's a brand new wing that has 75 beds in it and some monies are going to be given, but that is not necessarily going to open all of the 75 beds. Have I got that right?

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Mr King: I can't specifically tell you how many beds are opening this year. I'm happy to come back with that information. As far as I understand—and I dealt with Toronto East General; I don't deal with every hospital directly but lately we have dealt with them—the dollars announced by the minister will provide for the programs that they wanted to open in that new wing.

Hon Mr Clement: Based on their submissions to us as to what their plans were.

Mr King: But specific beds being open and that, I don't have that. I'd have to get back to you on that point.

Mr Prue: When is that money going to be made available? Because in my discussions with them—granted it was more than a week ago—nothing had been forthcoming up to that point.

Mr King: We always have the letters go out to the organizations. The money flows probably by the end of the month or within the month. When the minister signs something, they're guaranteed that the money will flow.

Mr Prue: All right, the money will flow, but the hospital board of directors then can assume that sometime by the beginning of November that—

Mr King: That money should have been received by the beginning of November for sure.

Mr Prue: So, therefore, it will be open for two months this year and the following three months of the fiscal for next year?

Mr King: It's just not a matter of funding a program. Then they need to recruit and it takes some time to open. That's their business of when they open that program, but they have received assurance from us through the money that was provided.

Mr Prue: Thank you.

Mr Gilles Bisson (Timmins-James Bay): I've got three or four questions, and I'll try to keep it as short as I can for the time we have.

The first one is on audiology services. I've been getting faxes, I've been getting e-mails, I've been getting letters, phone calls by a fairly large number. I'd say when this came out there were probably in the neighbourhood of five to 10 phone calls, faxes or e-mails a day, and since then we've collected probably over a hundred just in my riding alone. Here's just one of them because I think it's topical to this. Mrs Greco out of Timmins sends me the following e-mail:

"Dear Mr Bisson:

"I'm concerned about the withdrawal of OHIP funding for hearing tests and other audiology services. I believe that a child's hearing is important to their learning and development. My three children have had many ear infections. From August 1996 to June 1997, one of them had had four ear infections. From January 1995 to September 1998, he was on antibiotics another 11 times probably for ear infections. They've had tubes in their ears at least two times, and my third child has had tubes a few times. For the first years of his life, one of my children had more periods with some degree of hearing loss than periods of hearing with normal limits. They have had all at least 10 hearing tests."

It goes on and on to talk about the types of things that her family is going through.

I've got a letter from the Cochrane District Early Childhood Speech and Language Services that says:

"As a member of the local provincial preschool speech and language initiative in the district of Cochrane, we are writing to express our concern regarding a recent OHIP funding decision made by the Ministry of Health. This decision has severely restricted the preschool children we serve from access to audiologists. New OHIP rules have not only delisted hearing aid evaluation and re-evaluation but have also made OHIP-funded services from audiology virtually non-attainable."

They go on to make the point that you can't get services now because we're in an underserviced area. Kids are going to go without services and, as a result, if those children aren't attended to in the early years, it's going to cost us much more money in the later years when it comes to what it means for their education and others.

So I want to know from you, what are you prepared to do as the Minister of Health in order to restore services so that people are able to get the type of services they need when it comes to hearing tests, not only in northeastern Ontario but across the province?

Hon Mr Clement: I can certainly give you a couple of assurances, Mr Bisson. First of all, the hearing tests are still available via qualified physicians and audiologists who work with those physicians. They are paid for by OHIP under the rules that have been in place. There are also audiology services that are available via hospitals and means such as that, so that has not changed.

I believe we also made some special arrangements in some areas of the province where there was a concern about accessibility. Perhaps somebody can remind me as to what specific areas of the province that took place in, but it did take place.

Mr Bisson: Minister, I appreciate what you're trying to say, but just because of the time that we have—you understand the issues: our hospitals are plugged up for waiting lists, they can't get in. We don't have doctors in many of our communities, because they're underserviced. We don't have ENT specialists in most of the communities. The only way you're able to get service is through the service of audiology clinics or somebody who is in that line of work. That's the issue. They can't get to them because you have delisted them. If you ain't got doctors and the waiting lists in the hospitals are too long to get into, what are you going to do for the kids in communities like Hearst, Kapuskasing, Timmins, Dryden and a whole bunch of other communities that don't have anything else?

Hon Mr Clement: I would say this, Mr Bisson. I'm not trying to pick at nits here, but they were not delisted, they never were listed. That's been the case for 30 years. What we are doing is making sure that listed services are available by those who are listed.

Mr Bisson: But, Minister, you were paying the bill. In fairness, the bill was being paid. It was being covered by OHIP. Now people have to pay and they're not going in.

Hon Mr Clement: I think it's fair to say that we will still cover the bill by OHIP if it's done through qualified physicians, ENT doctors or audiologists working with ENT doctors. There are ways to get this done. There were some specific arrangements that were made in some specific areas of the province.

Mr Bisson: Listen, we can go around this—

Hon Mr Clement: Would you like to hear the details on that?

Mr Bisson: I want something from you that's going to say that if you've got a parent somewhere in northeastern or northwestern Ontario who needs services they're going to be able to get those services from the audiologist. We ain't got the specialists, we ain't got the family doctors, and the waiting lists are backed up when it comes to services out of the hospital. I realize what you're saying is that they weren't listed before, but the ministry was paying the bill and now people are going without.

The problem we know is that if we leave those kids unattended, if we don't catch the problem soon, it's going to affect them in their later years when it comes to their ability not only to cope in society but when it comes to education, and you know that's going to cost us more money. I'm trying to say, can you do something, especially in underserviced communities, to cover the bill so those kids can go to the audiologists?

Hon Mr Clement: Can I ask Ms Fitzpatrick on the specifics?

Ms Susan Fitzpatrick: Susan Fitzpatrick. I'm the director of the provider services branch. One of the changes made was that basic hearing tests can still be delegated by a qualified physician to an audiologist. It doesn't have to be a specialist.

Mr Bisson: It ain't the physicians. That's the problem. What do you do if you're sitting in communities like Smooth Rock Falls or a whole bunch of other communities across the north that don't have the doctors?

Ms Fitzpatrick: Prior to the changes, the changes were all paid through the physician's schedule, so what I was clarifying is what the changes were. There are still provisions in the schedule to delegate services to audiologists by GPs and specialists. It isn't just ENTs.

Mr Bisson: But you have to have a referral and they have to do it within a doctor's office. It's the same stuff you're doing with the—

Ms Fitzpatrick: It's a delegated procedure under the physician's schedule.

Mr Bisson: That's right. We understand that.

Ms Fitzpatrick: As the minister said, there is no direct funding for audiologists. So all we've changed is the provision under the physician's schedule.

Ms Martel: No, it's more complicated than that, because audiologists could work in their own private practices and people did not have to have a referral.

Ms Fitzpatrick: But that was not a legitimate billing practice for the physicians and we made a number of referrals—

Ms Martel: It went on for 33 years. For 33 years you let it go. Come on.

Ms Fitzpatrick: We made approximately 20 to 30 referrals to the medical review committee on it. It was not allowed under the schedule and that was communicated very clearly. So physicians and audiologists knew that.

Ms Martel: And for 33 years the ministry has allowed this practice.

Ms Fitzpatrick: We have not allowed it. Every time we have seen it, we have taken care of it.

Hon Mr Clement: You shouldn't say that it's been allowed, Ms Martel. That's a bit of a stretch.

Ms Martel: But they've been paid.

Hon Mr Clement: If you have a particular concern in a particular community, Mr Bisson, I'd be happy to take a look at it to make sure we're being fair to everybody.

Mr Bisson: All right. We will bring those to you.

The other thing I want to bring is on the issue of the CCACs. I know where we're going to go; we're going to get into another one of these discussions. But the problem we've got is that the CCACs have had their budgets frozen for a number of years now, as you well know—

Hon Mr Clement: That's not true. They haven't been frozen for a number of years, sir.

Mr Bisson: Well, go tell it to the CCACs, tell it to the patients. The point is that we now have in our community, as in a whole bunch of other communities across the province, CCACs that are not able to respond to the needs of the people in the communities. In our particular case, in the city of Timmins and the Cochrane district, I've got a number of seniors now who are contacting us and saying, "My services are being reduced." What we're being told by the CCACs is they don't have the money to meet the demand and as a result services such as home care and others are being reduced. In the case of new people going into the system, the CCACs aren't even offering the services at all.

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I've got one woman, Gina, who called my office on October 9 in a complete panic. She calls up and talks about her sister, who lives down in Downsview. She was told that her sister in Downsview had been in the hospital for five weeks. When she returned home, she needed home care to stay independent, because that's what she used to have before—nothing, zero, a 100% cutback in her services. This woman can't live alone on her own. We're forcing her to go into an institution, and that's much more expensive. So on behalf of her and on behalf of people like Madame Plouffe in the city of Timmins and other people I've had to deal with, are you prepared to make sure that the CCACs get the type of funding they need to provide the services so seniors can live at home with dignity in their own homes?

Hon Mr Clement: Certainly we would all like to see that. I can say to you, Mr Bisson, that the Cochrane CCAC has seen an increase in home care funding by this government to the tune of 21% since the 1994-95 year. From our perspective, we have to review all of the aspects of CCACs: resources, how those resources are allocated, how they're managed, how the standards are set. All of those issues I think are important to make sure that we get the 21% increase in your community to the people who need it and to provide the services that are necessary. So your support of that process would be most appreciated.

Mr Bisson: The problem is that when you talk to the CCACS, not only in our area but in other places, they're

telling us the complete opposite of what you're telling us now. They're saying, "We don't have the resources to be able to provide the level of service that we know we need to provide to our communities." In Sudbury—and I'm sure Mrs Martel can elaborate—the CCAC there is at its wit's end trying to deal with the demands in the community. They've had to resort to a number of different things as far as reducing services to stay within their envelope; the same thing in the city of Timmins, in Downsview. All across the province, you've got people who either can't get any services, especially if they're new patients coming into the system, or, in the case of existing patients, are having their services reduced.

I met with Mrs Plouffe in the city of Timmins a couple of weeks ago, and she has had her services reduced. It means for her that at some point she's going to have to make a decision about whether she stays at home or goes into an institution. She doesn't want to go; she wants to stay at home. That's where you want her, that's where I want her, but we need to have the support.

Are you prepared to give the CCACs what they need to be able to make sure that people like Mrs Plouffe and others—

Hon Mr Clement: I can't discuss the particular circumstances. There are some people who of course we would like to see stay at home for as long as possible. There are some people who quite frankly need such an amount of institutional support that it makes sense that it be provided in a place other than the home.

Mr Bisson: Nobody argues that. There comes a point when people need to go into an institution, we understand that, but what we're saying is that a lot of people who don't need to be there, who want to stay at home, are being forced to make that decision quicker—

Hon Mr Clement: That's the frustrating part about this area, Mr Bisson. I can tell you that overall in the province funding for home care has increased by 72% since we were elected. Part of what we want to do together is to make sure the money is spent in a way that provides the results you want to see.

Mr Bisson: We'll bring the specific cases to you, and we'll see if we can do something—that commitment?

Hon Mr Clement: Minister Johns is the one on the case, so I'd be happy to pass it on.

Mr Bisson: Can I have whoever's responsible for the Moosonee-Moose Factory hospital issue in regard to the transfer from the federal to provincial statute, the hospital? There's a federal hospital up in Moose Factory.

Mr King: Yes, it's dealt with by two divisions at the ministry.

Mr Bisson: Can you just give me quickly where you're at with that? I understand what's happening at the local level. We don't need to go through that. I just want to know from the province itself, have there been any approaches from the federal government, and where are we in that process?

Mr King: If I recall, we're still in the process of negotiations with them. We have not finalized those arrangements, but they are going well. There are no major concerns. One of our divisions in our northern office is handling that specifically, but I can get back to you on the specifics of that. But there are no concerns with the transfer.

Mr Bisson: Please, if I can get that. The only point I want to make is, and it's important to the First Nations, can you make sure the federal government doesn't get off the hook and that the money they are going to be saving when it comes to what they don't pay for hospitals they put back into the system for long-term-care services or whatever we need in those communities?

The Chair: Thank you, Mr Bisson, for making that final point. We now turn to the government caucus.

Mr O'Toole: I have just a couple of questions following up on some of the previous questions I've heard, and not specifically to my own riding in all cases. In a general sense, the Health Services Restructuring Commission, which arguably some could say was started by the NDP when they looked at the acute care study, basically that's the foundation starting point for looking at beds per population and trying to drive services closer to patients' needs, which I commend as a very important vision for patients first. We're working through that, as we have just talked about, at Lakeridge. I'm happy to say that there will be enhanced services closer to home for patients when all of the wrangling is figured out.

One of the questions that was asked by the NDP which I think is important is, once we get the capital dollars figured out—these are at the macro level that I'm looking at—the health services restructuring commitment by this government for the province of Ontario was what amount? How many billions? Part 2 of that: what's the anticipated operating cost?

I know a particular hospital in Durham has moved up to, I think, a $175-million annualized operating budget, something in that order. What do you see the impact for health services restructuring on the operational level? What's the cost of adding this capital part called health services restructuring and the operational part?

Hon Mr Clement: Can I ask one question, Mr O'Toole? Do you mean the original cost, the capital cost as identified by the HSRC, or do you mean that cost plus what is now committed to? The cost has increased substantially.

Mr O'Toole: Yes, because every site has their, "Well, what about the elevator?" or "What about the plan here?"

Hon Mr Clement: "If only the commission had understood this about our hospital."

Mr O'Toole: Yes. You can answer it in two parts, because it was part A which was answer 1, which means it went from this to this, and the operating side will of course go from this to this. It's the back rolled number I want, really. What's the capital and what's the operating impact?

Mr King: Paul will give you the actual numbers on the capital, and then we can talk briefly about the operating implications.

Mr Clarry: As we discussed earlier, the commission itself, the HSRC, estimated total capital costs of its

directions at about $2.2 billion. The ministry currently has approval on a multi-year capital funding plan totaling $2.45 billion. That's based on an estimated project cost for all of its directions somewhere between $3.4 billion and $3.5 billion, and the hospitals would have to make up that roughly $1-billion difference.

Mr O'Toole: That's the macro on the capital.

Mr Clarry: As the minister pointed out, some hospitals that are still planning are looking at costs even beyond that plan, and part of the due diligence that we're working on is to make sure that we fund only the appropriate level of capital, and if we do need more funds, we need that information.

Mr O'Toole: I could go into the minutiae there and say that the rurals get better support than the urbans based on assessment or growth. I don't want to bother going down that road; that's a bigger issue.

What is the operational impact? That's the deal. We're about eight-point-something today.

Mr King: Today we're at $8.6 billion for hospital operations. I will tell you that that's not an easy question to answer. We have to take each individual project and work through the implications of the commission direction. Each year we're adding additional beds, whether it be complex continuing care, acute, rehab. They're funded on an annual basis, but for some of the out-years we're still working through the process. Each project has a post-construction operating budget being developed for their operations. It would be difficult for me, Minister, to come out with a number right now on what that impact would be on all of the hospitals under review right now.

Mr O'Toole: There would be tremendous pressure. We've heard several Premiers talk about how much of the total budget is health care, and ours is going up at a fairly rapid pace, and the debate is still out there whether it's under the Senate review or Romanow. All of them are talking about how we're going to pay for it. I think all of us here from all parties need to pay attention to what services are provided where and who pays for what services. It's an important debate, and we need to make sure we find solutions.

I know the $8.6 billion will probably be $10 billion. Where's that $2 billion "operational" coming from? Good luck. The solution I hear from the Liberals is to increase the taxes, and from the NDP it's just to spend the money, it doesn't matter. We're a government fundamentally based on accountability. We've got to really narrow in and focus down. It's a very difficult decision. It's going to take very fiscally focused leadership.

1650

My part two question was to follow up on the CCAC funding. The CCAC funding is a very important issue. I've looked at the increased grants for Toronto and the relationship. What I'm trying to find out is a formula here on a per capita basis. Is that what we're moving to? All new funding is supposed to be shared on an equitable basis. I know we're a high-growth area—Durham is the largest-growth area in the province—and we don't want anything more than our fair share.

There are two requests here. One is a list of all the CCACs, total dollars, per capita dollars. Do we have that available? That would be easy: there are 43 CCACs; here's the population; here are the total dollars; here are the per capita dollars. We can do all the minutiae on how many over 65 and all that kind of stuff. I'm sure it all works out in the statistical model somewhere, doesn't it?

Mr John McKinley: John McKinley with the health care programs. The analysis of putting together a per capita thing will show tremendous differences between individual areas because the content of the population varies drastically across the province. You may see a great variation in per capita numbers, unless you adjust them for the age/sex characteristics of the individual population. That's what the equity formula does. It makes that adjustment so there is a fair way of allocating the funding. That's what you see in the table, appendix—

Mr O'Toole: I'm having some trouble with that table, appendix 3, equity at $0.041 million cut to—

Mr McKinley: If you look at appendix 4, the last page, it shows how we allocated the equity funding allocation over the three years.

We can take you back to the details of the formula, but it's basically saying as we adjust every population for the content of the different gender, the different age cohorts in there or the different home care utilization, we can predict how much the same amount would be across each geographic region. That's what this equity formula does. It adjusts for all of the different characteristics of the population we have found to be part of the cost drivers for home care services.

Mr O'Toole: I don't want to go on with this, but I do want to establish a point. For us as front-line—for lack of a better term—marketing or salespeople—maybe that's tokenizing our job too much. But what I would say is that we have an important job to communicate fairly boiled-down information, little nuggets. There must be in all these statistical models some number; taking out all these anomalies and saying the number is roughly $10 per head or whatever it is. Of course, there are going to be rare exceptions. If we can show there are a lot of brain injuries in a certain area, whatever the age group or something, it would be better off to explain what the core number is and then say for all of these anomalies, like when 20% of your population is over 65. Can we do that today, provide a number that says this is the template that we work to?

Mr McKinley: There isn't a number that I can give you right off the top of my head that will work easily.

Mr O'Toole: Then I don't have any confidence in it. We're out trying to explain to people who are elderly or looking toward retirement—and they may even relocate. How are you going to track all this stuff when everybody wants to retire in my area? And I'd encourage them to. Durham is a beautiful area. Have you ever been there? Seriously, there are a lot of retirement communities being built. They're going to actually expect the services to

move. Do you understand? If you're going to do these demographic models, age/sex models, and they're going to all move to my area, I want to know the core number and what you're using as forecast templates, boilerplate.

Hon Mr Clement: We're going to have to get back to you.

Mr McKinley: We can get back to you, but the idea is that the funding follows the patient here. If in fact you do get an increase—

Mr O'Toole: Once you've identified—

Mr McKinley: It's an allocation methodology. It takes a defined pot of funds and allocates it fairly across the province. As your population grows or changes or if the demographics show the older population is greater and there's a greater need for home care services, then you're entitled to a greater piece of the equity allocation. That's the way it works. It is a little bit difficult to communicate, but it is a much fairer way to allocate the funding to the geographic regions of the province.

Mr O'Toole: It's going to be a tough one. I guess the expectation level, if you looked at demographics and David Foot and all his models, you say, if we don't focus in on what the entitlements are—we're now training people "To get your lawn cut, just move to my area and you get your lawn cut." That's not on.

Let's define what the bundles of deliverables are, however tight that is. I'm just a citizen. In fact, I'm 59 so I'm moving toward that. I want to find out where the best funding is because I'm moving there. It could be Windsor—well, I wouldn't move to Windsor; the reputation there is—in all seriousness, what I'm trying to find out is, are we moving toward an equitable funding?

Mrs Sandra Pupatello (Windsor West): Your daughter goes to school there, John.

Mr O'Toole: She graduated. Fortunately, she moved. I'm not serious.

Do you follow me, if I were to say in five years the funding will be equitable?

Mr McKinley: That is the goal of the funding allocation, to move over a multi-year period of time over the investment the government has committed to, to have an equitable distribution of funding in five years.

Mr O'Toole: And the date? September 2002.

Mr McKinley: No. I can't remember what the last year of the allocation is.

Mr O'Toole: We have a goal, though. We measure everything. What's the goal here? Is it 2020?

Mr McKinley: We can get back to you on the date of the commitment.

Mr Miller: Mr Chairman, I have a question, if I can, just a clarification on conflict of interest. The West Parry Sound Health Centre administers the community care access centre in that area. They also, in the new hospital, have plans to run the long-term-care facility. It's their understanding that they need a separate organization, a separate board, to run the long-term-care facility because of conflict-of-interest guidelines. So they've created Lakeland Long Term Care Services Corp to run the long-term-care beds within the new proposed hospital.

Apparently, somebody on the board received a response from the ministry questioning that, and so I was asked by the administrator, the chief executive officer of the West Parry Sound Health Centre, is this new board required for the ministry's conflict-of-interest rules? They prefer not creating a new board, if possible, but it's their understanding that they do need to create this new board to administer the long-term-care beds and, as well, the hospital and CCAC out of the same body.

Hon Mr Clement: Gail Paech might have some particular detail about this situation, I'm hoping.

Ms Gail Paech: Gail Paech, assistant deputy minister, long-term-care redevelopment. If I'm understanding your question correctly, and from memory, what we were recommending to the hospital was that they create a separate organization so that they could operate it as a long-term-care facility and not run into the problem that if it was a joint hospital/long-term-care facility they would have to pay the salary and wages that the hospital pays hospital personnel.

The funding that is given to long-term-care facilities is less than to the hospitals, and so this is a way that enables them to live within the allocation that is given to them for their long-term-care facilities. Otherwise, they will be paying hospital wages and rates and will be funded at long-term-care wages and rates, and that will create a problem for them.

They are able to do this because this is a new long-term-care facility. They have not been in the business previously and so they do not have that historical relationship. We do have facilities that are being caught by this and that will create financial difficulty for them in the future.

Mr Miller: So it's not about conflict of interest, it's about saving money, really?

Ms Paech: It's living within the allocations that you are being given by the Ministry of Health.

Mr Mazzilli: I have a question, Minister.

We heard, I believe yesterday, from the Prime Minister that he has committed Canada's resources to this war on terrorism, and along with that made some commitment of equipment and personnel. On the equipment side I don't know what he has to offer, but on the personnel side there are many medical practitioners in Ontario who have ties to the armed forces. I know that because I have spoken to many in the past in hospitals—surgeons, psychiatrists and so on. Do we have any idea, if those medical practitioners are called upon to serve, how many we're talking about in Ontario?

1700

Hon Mr Clement: That's a good question. I don't know the answer to that.

Mr King: I think some of the professional associations did take a record of those individuals who were willing to serve if they were called upon to go, but most of the individuals we're dealing with here are with the armed services, the federal resources. So they are under that regulation right now and they are still working in the armed forces. We do have a number who are working in

our hospitals, but they are doing that more for their ongoing credentialing and their ongoing work experience. Are you specifically referring to the Canadian Armed Forces?

Mr Mazzilli: Yes. Some may have commitments they need to live up to, depending on where they got their training or who paid for their training, some of those issues. They may have worked their way through the system. Some are in hospitals; the question is, how many, and whether it will have a significant impact or a minor impact if they are called upon to fulfill their obligations with the Canadian Armed Forces.

Mr King: We can certainly get back on that question of the numbers, but of the Canadian Armed Forces and their impact on the provincial resources, it would be minimal, because many of them don't even practise in our hospitals; they practise in their own settings and their own clinics right now. Some of our hospitals have specific relationships right now with the armed services that allow them to operate on their personnel in our hospitals, but they're kept quite separate. Their personnel cannot just operate in any of our hospitals without regulations through our own colleges here.

Mr Mazzilli: On another issue, if I can go back to the ambulance situation—I know it was approximately four or five days ago since I first brought it up—have there been any decisions made on ambulance funding or ambulance applications that have been submitted to the ministry since I last asked the question?

Hon Mr Clement: I think we're still trying to finalize the decision.

Mr Mazzilli: I'll be waiting for that as soon as it comes available.

In relation to the fact that 44% of all spending goes to health care in Ontario, what range are other provinces in overall, assuming they have balanced budgets? Let's go to a balanced budget situation. What percentage?

Hon Mr Clement: I've heard numbers in the range of 40% to 45%. We're in the upper end, quite frankly, which befits the increase in spending we've had over the last six years in Ontario. For instance, my counterpart in British Columbia has announced a three-year freeze in spending for all health care. They're flatlining it for the next three years because in his particular budget he's got a deficit of $400 million, which is part of the multibillion-dollar deficit that was left by the NDP in British Columbia. That's one example of how another government is tackling some of the sustainability issues. Of course, we didn't have a freeze this year; we had an increase of 5.6%, 5.4%, somewhere in that range.

The Chair: That completes this part of the session. We now turn to the official opposition. This is not a game show but we are into the hurry-up rounds, I guess. We have approximately 10 minutes each. I actually have to make a small time adjustment with the official opposition, but it will be painless because we went a little bit over the last time. We'll start with Ms McLeod and each party will have approximately 10 minutes.

Mrs McLeod: My first question is on drug and alcohol addiction programs. I have a number of letters from drug and alcohol addiction centres that are concerned that the $5.2 million that was given in one-time funding last year is not being renewed this year, and yet the estimates books are showing an increase of some $7.6 million for these programs. Can you explain why they would be losing the $5.2 million in an overall budget increase year?

Hon Mr Clement: I'm not sure about the estimate books, but I can tell you that the $5.2 million was always intended to be a one-time-only 2% announcement. I've made that clear. I am in the midst of arranging consultations with the stakeholders in this area to talk about the future and how we can be helpful in the future. But that's the situation for this year.

Mrs McLeod: This is going to be a series of quick questions. Can you explain to me why the ministry would have decided to contract out the examination of laboratory technologists, not respiratory technologists, to the Ontario Medical Association when that's under the mandate of, and I understand is being done by, the college?

If there's not an almost instant response, Mr Chair, would I have the luxury of being able to table the question for a written response?

The Chair: It would be referred to the ministry. Is that acceptable?

Mrs McLeod: Thank you very much.

I was looking at the response to questions that were tabled at the last meeting and I did note that there was some attempt to explain the delisting of G-code clinics for physiotherapy by saying that there was a lack of clinical evidence to support the value of the G-code clinics when delegated by a physician to untrained staff. That's the first indication I've ever had that G-code clinics were actually—where service was being delivered by other than trained physiotherapists. That certainly wasn't the experience of the communities that I was aware of. Do you have evidence that these actual physiotherapy services were being delegated to people who were not trained in physiotherapy?

Hon Mr Clement: Were these the questions and answers that were tabled today? I'm sorry.

Mrs McLeod: No, I think they were tabled the last day.

Ms Fitzpatrick: This is Susan Fitzpatrick of the provider services branch. That came from a recommendation from the OMA; that was from their central tariff committee. It was what physicians had reported to them, that in a lot of the clinics they were running they were delegating the services to untrained staff.

Mrs McLeod: You don't actually have evidence of communities where that was happening?

Ms Fitzpatrick: No, we don't have details on it. It was a recommendation that the OMA had put forward.

Mrs McLeod: I'm going to table a number of questions that I think will be for tabling, if I have your agreement to that, because they're specific financial questions. In tabling these questions, I have made a real

effort to sort it out in the estimates books but I just can't quite figure it out.

The first is an explanation of the $72-million reduction in related emergency services under the ambulance section.

The second would be—and this is probably a quick answer—the $44 million in community mental health programs. It's a multi-year program. Do you know how many years that is to be funded over?

Hon Mr Clement: Did you want us to—

Mrs McLeod: If that's not immediately available, I would appreciate it being tabled.

Hon Mr Clement: Yes, we'll get back to you.

Mrs McLeod: I tried to sort out the divestment question. From the psychiatric hospitals, five of six have now been divested. What the transfer of funds is from those hospitals in terms of their existing budget dollars and their immediate past budget dollars and how much of those budget dollars has actually been transferred to the hospitals that are accepting the service, if I could get some figures on that. What I'm obviously looking for is that I want some evidence, which I can't find in the estimates books, that there has not been an actual reduction in dollars. What I find in the estimate book is overall a $13-million reduction, year over year, in mental health facilities.

Mr King: I can get those numbers for you. What's happening here is there are some one-time costs that are coming in year after year as we divest.

Mrs McLeod: I appreciate that.

Mr King: But the full budgets are moving over to the host hospitals. That will be shown in the other line of the operation of hospitals.

Mrs McLeod: I think that's the line where I am picking up a net reduction of $13 million at the bottom of the page.

Mr King: It could be from some one-time, but we can show how the divestment went and how the dollars did flow to the host hospitals.

Mrs McLeod: If you could attempt to do the same thing for me on land ambulances, because I really struggled to sort out the divestment costs, the severance costs, the one-time-only costs and come up with a figure—

Hon Mr Clement: Air ambulance, Mrs McLeod?

Mrs McLeod: No, land ambulance, in this case. You've already undertaken, I believe, to get the air ambulance severance costs. It's difficult to work with because you haven't yet negotiated the response time standards or what it's going to cost municipalities to get up to the 1996 standard. I appreciate the difficulty. What I don't know is what's in the estimates book, what you've estimated in terms of separating out the expected severance costs, because there's clearly a reduction in that, having transferred in January. There are figures here related to response time commitment, but I'm just looking for, how much is the ministry's cost now for the response time standards this year, and what's the municipal share of that, if that's suitable?

Do I have another minute?

1710

The Chair: You have two more minutes.

Mrs McLeod: There's an indication here that there will be an $8-million increase for laboratory services in this year. Can you tell me what the status is of negotiations and/or discussions with the various providers of laboratory services on the whole quota division issue?

Hon Mr Clement: Yes, we've pretty well completed all of that. That's pursuant. That's why it's not completely—

Mrs McLeod: Will there be some change in the current allocations in terms of smaller providers being able to have some allocation of dollars to be able to deliver service?

Hon Mr Clement: I defer to Alison Pilla.

Ms Alison Pilla: I'm Alison Pilla. I'm acting assistant deputy minister for health services division. I'm sorry. Can you clarify your question? You want to understand what the status of negotiations was?

Mrs McLeod: I'm seeing that there's an $8-million increase in lab services, which I assume is a result of increased volume. That was my reading of it. I'm wondering whether or not there is going to be, as a result of the review of the way in which labs are—because it's done by division up right now. Is there going to be some reallocation among the existing service providers so that some of the smaller lab operators are able to benefit from some of this increased volume in their own operations?

Ms Pilla: You made reference to negotiations with the lab providers. We had been in discussions with the OAML on lab services, and we do have an agreement with the OAML that will provide some extra funding for lab services, I think both for new tests and to recognize utilization. The industry itself works under a corporate cap and there are individual caps within that. But the specifics as to sort of how that's divided out, right now I don't have that. I could undertake to see if we could make that available to you.

Mrs McLeod: If you could, I would very much appreciate that, because there's obviously a lot of concern when you're working with individual caps as well as a corporate cap. It has a very direct effect on business operations as well as the—

Hon Mr Clement: They should be aware of it in the industry because of the agreement that we've signed. But we certainly could make that available to you.

Mrs McLeod: I would appreciate that.

The Chair: I think those were a well-filled eight or nine minutes. Now to Ms Martel in the third party.

Ms Martel: Minister, I'd like to thank the staff for the responses that came in from questions last week. Let me go back to them because, as I look at Appendix 4, Equity Funding Model Allocations for Manitoulin-Sudbury, it shows zero all the way through the piece, which I think would support the concern I raised that in fact Manitoulin-Sudbury have not received equity funding despite the promise that had been made by Cam Jackson in 1998 for this to start in 2000. Am I correct?

Hon Mr Clement: It certainly appears that way, but John McKinley is going to—

Mr McKinley: John McKinley with health care programs. Yes, the allocations that you see there are the distribution of the funding that was actually provided under the equity funding allocation. The reason why Manitoulin-Sudbury was not eligible for funding is that, when we review the equity funding model every year with new demographic information, the difference between regions changes year by year. So there is a chance that some geographic regions that would have been considered eligible for the equity funding under the first run of the model—as population changes, as demographic changes occur, we incorporate that information into the model.

Ms Martel: If I might, the minister responsible for seniors, on August 27, 1998, made a very specific commitment with respect to equity funding for Manitoulin-Sudbury. The commitment was that beginning in the fiscal year 2000-01, they would receive equity funding for the next five years. It was as clear as that. There was no mention that this was going to be reviewed and that that promise might change based on demographic changes. I can also tell you that the CCAC has never received a letter from the ministry after that to state that in fact that promise was going to be broken if there was a change in demographics. So I am clearly very unhappy about what I am hearing and would say to the minister, this needs to be reviewed. I believe I gave your staff a copy of the letter. It was very clear in terms of its commitment, very clear in terms of its promise, and they have never received information contrary after that to say they would not be receiving funding. So I believe they are entitled to equity funding.

I also believe they should have received this year's and last year's equity funding, given that you told this committee last week that CCACs received equity funding for two years last year. They should have been entitled last year to receive two years of equity funding.

I would appreciate it if you could get back to me with respect to what is going to happen now to Sudbury-Manitoulin. Thank you.

Hon Mr Clement: Let the record show that the minister was nodding his head.

Ms Martel: He said yes. Thank you. And this will be done as soon as possible?

Hon Mr Clement: Yes. As you know, in terms of the CCAC review, Minister Johns is taking the lead on this, so I'll work with her on this.

Ms Martel: Thank you. Secondly, I notice there is no further information with respect to the discrepancy I raised regarding our read of the contract between CCO and the private radiation clinic at Sunnybrook. I'd like to know when we can expect a response to that.

Hon Mr Clement: We have some PHIPA issues, as I understand it, so I think we're still working our way through that because we want to be on the right side of PHIPA. So I think we have a little bit more work to do on that.

Ms Martel: And you will be responding to this committee?

Ms Maureen Adamson: Maureen Adamson, ADM, corporate services. The information that we did table a day or two ago around CCO and the contract is accurate. We did table that.

Ms Martel: This was the very information that I—

Mr King: The contract arrangement we have with CCO has been tabled with you. We do not have access to their contract with the after-hours clinic, so that is the issue at hand. I can't confirm the information you gave us, and we're just working through trying to get access to that information. It's a business arrangement with them.

Ms Martel: I understand that, but it's public money, as I said last week, that's used to pay this contract. I think the best thing you could do would be to release this information to clear the air on this matter.

Hon Mr Clement: Yes, but again let me just state on the record, we're not a party to the contract. Let me just state that for the record. There are lots of contracts by lots of providers to which we are not a party.

Let me also state for the record that we do have a financial arrangement with CCO which presumes the presence of this after-hours clinic. Those financial arrangements are on the record, so we have provided those financial arrangements. Those are the arrangements for which we are responsible. There are other contractual arrangements that have been made between CCO and the provider. Those arrangements we are not responsible for financially, nor are we a party to that. So that's the difference the assistant deputy is trying to draw here.

Ms Martel: But if I might, then, Minister, who is paying for the additional side arrangements made between CCO and this private sector company? CCO gets its money from you. Who is paying for the side arrangements that are above and beyond what was tabled with us?

Hon Mr Clement: I agree that it's a complicated relationship.

Ms Martel: Yes, it is, but who is paying for it is what I'm trying to get at. I read into the record our numbers with respect to the contract.

Hon Mr Clement: I know what we're responsible for as a ministry on behalf of the taxpayers. That I'm fairly clear on, and we've provided that information. Whatever other information we can provide, we will provide.

Ms Martel: If there are discrepancies—and I have clearly said there are, but that might be a separate arrangement between CCO and the private sector company involved—then I also want you to table who is paying for those separate arrangements and the additional funding which I clearly believe is inherent in the contract.

Hon Mr Clement: You have my undertaking to provide what we can.

Ms Martel: Thank you. My next question has to do with audiology. Minister, because you have said to us to bring some specific cases to you, I would encourage your

staff to follow up on a question that I actually raised on this with you a couple of weeks ago.

Hon Mr Clement: This is in the House? Yes.

Ms Martel: Your ministry now has a letter from Dr Karen Dockrill dated September 7, 2001, to Marlene Stein, your speech and audiology consultant in the public health branch. Dr Dockrill outlines very clearly the concern she has with the high-risk infants at Sudbury General who are not being tested as we speak.

I want to say clearly on the record that her solution is to take money which has not been spent from the province's newborn hearing screening program, because the program is not up and running in our district, and allocate it to the screening of these high-risk infants.

1720

I'm making it clear here today, and I've made it clear to her, that that's not an answer for me in the long run. I think the decision you made on audiology should be reversed, because these same children who might benefit by screening, if you transfer money from the provincial program now, are still going to need ongoing screening, and someone has to pay for that when they're out of the infant screening program. It's a very specific case. There are a number of high-risk infants who are at risk, who need to be tested, who are not being tested, and I believe the ministry has to respond to this situation.

Minister, I wanted to ask some questions about an announcement that was made by you on September 17 with respect to medical equipment grants to Ontario facilities that included hospitals, independent health facilities, CHCs etc. I noted, as I looked through the grants, that grants were made to a private hospital, for example, the Shouldice Clinic, and grants were made available as well to independent health facilities. Is that a common practice when the ministry allocates capital funds?

Hon Mr Clement: I would have to say no, because we haven't had this money available before.

Ms Martel: Is this federal funding?

Hon Mr Clement: This comes out of the agreement that we managed to wrestle out of the federal government on behalf of the people of Ontario, yes.

Ms Martel: So this is a new procedure whereby you would fund private institutions.

Hon Mr Clement: You have to look at the two tranches together. There were two tranches of funding. The first one went exclusively to public facilities.

Mr King: The first one mainly went to hospitals, and Cancer Care Ontario and Princess Margaret. That was the main bulk. That was phase 1. This second phase then extended to other facilities in the province.

The Chair: Approximately one minute, Ms Martel.

Ms Martel: My read of it was about $67 million for hospitals and $52 million for independent health facilities.

Hon Mr Clement: That was phase 2.

Ms Martel: Can you tell me what the terms and conditions are for independent health facilities to receive this funding?

Mr King: We have very strict guidelines for them. There is a sign-back on all of them for proof of purchase etc that they must provide for the equipment. Independent health facilities provide an incredible amount of resource to the public here in this province, so many of our public go to these for OHIP, through radiology etc. That's why the decision was made to fund them.

Ms Martel: Can you table the template used for the terms and conditions for funding?

Mr King: You mean our actual contract arrangement with them for the purchase of equipment?

Ms Martel: I'm assuming you had a template that is used for the purposes of funding which would outline what their needs were. Are you funding retroactive purchases of equipment?

Mr King: No, it is for new purchase of replacement equipment.

Ms Martel: I'm assuming, perhaps incorrectly, that there are some kind of guidelines that are being used generally.

Mr King: Yes, absolutely.

Ms Martel: Can you table those guidelines for this committee?

Hon Mr Clement: Sure.

Mr King: Sure, that's not a problem at all.

The Chair: With that, I think we are complete. Now to the government caucus.

Mr O'Toole: It's extremely refreshing to have such professional—and an opportunity to speak to people who deliver these programs. I commend you, Minister, for being completely open on the consultations.

Hon Mr Clement: I've learned a lot.

Mr O'Toole: I've just learned that there are a lot of very complex issues in the ministry, as we are hearing, with, as you mentioned, Kirby, Romanow and everybody else looking at it.

I just have a couple of questions here of a general nature. We always use the number $24 billion in health care. The first part of this is fairly simple. Is that all taxpayers' money or does that come from another revenue source?

Hon Mr Clement: No, that's all taxpayers. That's the publicly funded portion of health care.

Mr O'Toole: What's the other part? The Prime Minister, I think, during the election, said there was no private money in health care. He said there wasn't any. I'm talking insurance money, I'm talking WSIB. How much more than the $24 billion is already being pumped into the system?

Hon Mr Clement: It is about two thirds/one third, as I understand it.

Mr King: Yes, 70-30.

Mr O'Toole: So 70% is taxpayer—

Mr King: Public.

Mr O'Toole: That's worth knowing. So it is actually more than $24 billion.

Hon Mr Clement: Absolutely. When you look at dentistry, when you look at alternative medicinal products and other things that are not funded—

Mr O'Toole: Pardon me for interrupting, Minister, but we always use a number that the federal government aren't at the table. That's not said in any political way at all. You've first got to start by making it clear that the federal Liberals aren't up to the job, and neither are the provincial. I think 11 cents or 12 cents on the dollar is actually from the federal government.

Hon Mr Clement: It's 14 cents.

Mr O'Toole: It's that high?

Hon Mr Clement: It will go down to 12 in the next three years.

Mr O'Toole: I'm surprised. So it isn't 50-50 like all of the taxpayers believe.

The point I'm trying to make, though, is this: it's very convoluted. Some of it comes through research money and other forms of supports, which are important; there's just not enough of it. I'm going to focus on one specific area. I'd like the members of the opposition to pay attention. The reason I say this is that it's a particularly novel idea. I try to explain this percentage, the 70-30 and 11 or 12 cents that is federal money, and it becomes convoluted.

Interjection: It's 14.

Mr O'Toole: I think, on further investigation, it's more like 12. Here's the point I'm trying to make, though—

Hon Mr Clement: It will be 12 very soon, I can assure you.

Mr O'Toole: I'm looking at one specific ministry where I'm trying to settle this now, to try and explain this minutia to a taxpayer who's concerned about access to care. They don't really care about who pays what. I have a suggestion and I want it on the public record here. I've written to you on this. It's a little bit off the wall but we're supposed to think outside the box. The suggestion is this: let's devolve—they don't like that word—let's sort it out, meaning that the federal government pays for these programs and the province will pay for these programs. Let's not confuse the public by saying, "Oh no, the federal share, blah, blah, blah." It doesn't mean anything.

I look at the rising cost of ODB, and I'm looking at your actual budget. It's going up 22.5% on drugs—huge costs. Dr Coombs, one of the scientists here, wrote a report. Half of all the drugs are wasted, to start with. They're thrown out and not used. There's a lot of waste in that drug part of the Ministry of Health.

Hon Mr Clement: Over-medication, yes.

Mr O'Toole: Two billion dollars. Now, I don't know if the approvals process is in the budget. There's a drug therapeutics committee, there's a federal level, and then it comes down and we stall it for another few months before we list it. There are some 2,000 drugs listed on the formulary.

There is a question in this, more than just a statement. Have we considered giving all of the drugs—the approvals, the listing and, by the way, the paying—to the federal government, and we're out of it? If somebody is getting Prozac, "Call your federal member. Everything else, call me." I've got the prescription for Prozac already so—

Interjections.

Mr O'Toole: Just cool it down.

Hon Mr Clement: The answer has to be yes. As you may recall, Mr O'Toole—and you've got a memory for these things—the federal government, campaigning as the Liberal Party, in one of their red books, promised a national pharmacare program.

Mr O'Toole: Yes, the pharmacare. Exactly.

Hon Mr Clement: We were excited about the prospect of the federal government finally recognizing this area of health care, which was not recognized in the Canada Health Act. They don't contribute a plug nickel to pharmacare. We're still waiting. That's two elections ago and we're still waiting for the national pharmacare program. We have communicated to them that if they wished to involve themselves in this area, we would not stand in the way. We would not let constitutional niceties or section 91 or 92 be an impediment to this. We haven't had any takers, funnily enough. The pharmacare promise has gone by the way of "We'll scrap the GST," I suppose.

Mr O'Toole: Let's just focus on the ODB, because it's such a huge, complex program. Do other provinces in this country support access to proper medications to the tune of Ontario?

Hon Mr Clement: Well, there are a lot of provinces that don't meet our standards. For instance, Saskatchewan has a deductible of, I think, $600.

Mr O'Toole: A deductible? A copayment?

Hon Mr Clement: Yes. They have a copayment of $600 before their drug plan kicks in. Newfoundland and Labrador, which is another little government, their drug benefit plan is 20%, 30%, 40% less generous than ours. So when you compare apples to apples across the nation, Ontario's is one of the richest, I would have to say, and the most generous when it comes to these kinds of medications being available to our seniors.

Mr O'Toole: I commend you, because as we look back at the earlier comments with respect to age, demographics, sex and all these things, that problem of getting the patients out, giving them some meds or painkillers, whatever it is, is going to increase. In fact, I think we'd be doing everyone a service by saying, "The standard in Canada is this and the feds are paying for it." Could we work on that? It's just a very novel idea from a little backbencher, if you will.

1730

Hon Mr Clement: I appreciate that. That's part of the discussions. I can tell you that the Premiers, and now the provincial health ministers, are working on arrangements. You mentioned the drug quality and therapeutics committee and what Health Canada does. They do more on whether the drug is safe to take for the purposes intended. We do more of a cost-benefit analysis and how to gain access to our drug benefit plans. Is there a way—rather than having 14 different considerations of a drug therapy, that is to say, every province and territory, plus

the federal government, which is 14—we can make that less? Can we make it one consideration? That is certainly under active consideration. To be even more precise, we are working on a plan to present to the Premiers in January for that very consideration.

Mr O'Toole: I just think if you want to make a lifelong contribution to health care, there is one there. It will sort it out. It will sort out the confusion in people's minds of who's paying for what and get out of the argument of 11 cents or 14 cents. That's just a stall mechanism for the person at the end of the needle. I'm thinking that drugs is the way to go, especially as you look at the aging population. Everyone's going to have a need for all these high-order designer drugs, incremental designer drugs, at $100 a pop. Let the feds take it on and make all Canadians equal citizens here. I'm confident you'll take that suggestion forward.

Hon Mr Clement: Thank you. In fact, some medication therapies are in the tens of thousands of dollars. When you look at some of the new wonderful medications that are made available, $100 a pop would be one of the least expensive ones. I'm not denigrating their presence; it's simply a case of how best to ensure that these kinds of things are available in the way that the population expects them to be.

The Chair: You have 30 seconds, Mr O'Toole.

Mr O'Toole: In conclusion, I say, even small employers who want to provide a benefits package, when they see these numbers and the convoluted way it is funded, they don't want to provide those health benefits because of the high cost. Anything we can do—mass buying by the federal government would certainly save money, if they could bulk purchase and deal with the patent issues.

Hon Mr Clement: That's certainly another area where I think the provinces would like to see some progress. Other jurisdictions like Australia have made great strides in bulk purchasing, so we're looking at that.

Mr O'Toole: Thank you for your time, Minister.

Mrs Pupatello: On a point of order, Mr Chair: just a clarification on the answers that were submitted to questions I had advanced last week. I need a clarification, if it could be provided to me. Page 12 of the answers is specifically referring to institutions accounting for a certain percentage of CCAC admissions. I need clarification on what constitutes institutions, because I was referring specifically to hospitals. I need to know if it's also including long-term-care institutions or is it just hospitals as institutions?

The Chair: I have to look for a one-word answer. I have to look for the goodwill of–

Mrs Pupatello: I can get it after.

Mr King: It is all hospitals.

Mrs Pupatello: Is it only hospitals?

Mr King: Yes.

Mrs Pupatello: The second question is appendix 3, if I could have that chart revised to include, as opposed to public funding announcements, it would be actual funding of other community services, because as you and I know, the announcements have nothing to do with what actually flows. I need to know actual spending.

The Chair: I'm going to rule that that's not a point of order. I want to comment, though, that the ministry has shown, I think, a high standard of goodwill in terms of providing information and I would encourage you to avail yourself of that.

Mrs Pupatello: It is not the right information.

The Chair: Unfortunately, we have a lot of tabled information here. We also are under the estimates constraint. We don't set our own rules.

Mrs Pupatello: Mr Chair, on a different point of order: I'd like it on the record that I would like the Minister of Health to invite me to his federal-provincial negotiations and I'd be happy to act on his behalf.

Mr Gerretsen: I'll second that.

The Chair: We have that duly noted.

I now turn to the business of the committee, which I'm sure will be of some relief to the significant contingent we have. It is the approval of the estimates for the Ministry of Health. I will ask for the votes. I would draw your attention to votes 1401 through 1407. I would ask your permission to combine the votes. Is that agreed? Agreed.

Shall votes 1401 through 1407 carry?

All those in favour say "aye."

All those opposed say "nay."

In my opinion, the ayes have it.

Shall the estimates of the Ministry of Health and Long-Term Care carry? Carried.

Shall I report the estimates of the Ministry of Health and Long-Term Care to the House? Carried.

Thank you very much for everyone's co-operation today. We are recessed until the Ministry of the Environment tomorrow.

The committee adjourned at 1736.

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Dr Karim Kurji, physician manager, population health service, health care programs division
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Ms Susan Fitzpatrick, director of provider services, health services division
Mr John McKinley, director, finance and information management, health care programs division
Ms Gail Paech, assistant deputy minister, long-term care redevelopment project
Ms Alison Pilla, director, operational support branch, health services division
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